Innovation for Scale:
Enhancing Ethiopia's Health Extension Package
in the Southern Nations and Nationalities People's Region (SNNPR)
Shebedino and Lanfero Woredas

"The death of children has reduced, so we no longer waste our time or land burying the dead."

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REPORT OF THE FINAL EVALUATION

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Submitted by:
Save the Children Federation, Inc.
54 Wilton Road, Westport, CT 06880
Telephone: (203) 221-4000 Fax: (203) 221-4056

Contact Persons:
Eric A. Swedberg, Senior Director, Child Health and Nutrition
Carmen Weder, Associate Director, Department of Health & Nutrition

Principal writers and editors: External Evaluator/Team Leader: Dr. Peter Waiswa; Save the Children Home Office: Dr. David Marsh, Senior Child Evaluation Advisor/CCM Global Team Leader; Karen Z. Waltensperger, Senior Advisor, Health-Africa; Sharon Lake-Post, Editorial Consultant; Save the Children Ethiopia: Dr. Hailu Tesfaye, Child Survival Advisor; Getenet Kebede, Health Program Coordinator; Worku Tefera, M&E Coordinator; Partners: Asres Bedaso, MNCH Officer, Lanfero DHO; Bedio Badego, Shebedino DHO; Tofik Handegeba, MNCH Officer, Silti Zone Health Department; Agaro Godanam, Disease Prevention & Health Promotion Officer, Sidamo Zone Health Department; Demisse Denebo, Disease Prevention & Health Promotion Officer, SNNPR Regional Health Bureau; Luwei Pearson, UNICEF Ethiopia, Health Unit Head

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<td>ACT</td>
<td>Artemisinin Combination Therapy</td>
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<td>ANC</td>
<td>Antenatal Care</td>
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<td>BC</td>
<td>Behavior Change</td>
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<td>BCC</td>
<td>Behavior Change Communication</td>
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<td>CCM</td>
<td>Community Case Management</td>
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<td>CCM/P</td>
<td>Community Case Management/Pneumonia</td>
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<tr>
<td>C-IMNCI</td>
<td>Community-Integrated Management of Newborn and Childhood Illnesses</td>
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<td>CS</td>
<td>Child Survival</td>
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<td>CS-23</td>
<td>Child Survival-23 (USAID CSHGP 23rd cycle project)</td>
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<td>CSHGP</td>
<td>Child Survival and Health Grants Program</td>
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<td>District Health Office</td>
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<td>DIP</td>
<td>Detailed Implementation Plan</td>
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<td>EDHS</td>
<td>Ethiopia Demographic and Health Survey</td>
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<td>ENC</td>
<td>Essential Newborn Care</td>
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<td>EPI</td>
<td>Expanded Program of Immunization</td>
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<td>FE</td>
<td>Final Evaluation</td>
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<td>FMOH</td>
<td>Federal Ministry of Health</td>
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<td>GOAL</td>
<td>Irish Non-governmental Organization</td>
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<td>HC</td>
<td>Health Center</td>
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<td>HDA</td>
<td>Health Development Army</td>
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<td>HFA</td>
<td>Health Facility Assessment</td>
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<td>HEP</td>
<td>Health Extension Package</td>
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<td>Health Extension Worker</td>
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<td>HH</td>
<td>Household</td>
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<td>HMIS</td>
<td>Health Management Information System</td>
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<td>HP</td>
<td>Health Post</td>
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<td>HSDP-III</td>
<td>Health Sector Development Programme III</td>
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<td>Integrated Family Health Program</td>
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<td>Integrated Management of Newborn and Childhood Illnesses</td>
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<td>IMR</td>
<td>Infant Mortality Rate</td>
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<td>IR</td>
<td>Intermediate Result</td>
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<td>ITN</td>
<td>Insecticide Treated Bednets</td>
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<td>IYCF</td>
<td>Infant and Young Child Feeding</td>
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<td>Kebele</td>
<td>Village, neighborhood, smallest administrative unit, Peasant Association</td>
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<td>KPC</td>
<td>Knowledge, Practices and Coverage</td>
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<td>M &amp; E</td>
<td>Monitoring and Evaluation</td>
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<td>mHealth</td>
<td>Mobile Health Technology</td>
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<td>MNC</td>
<td>Maternal and Newborn Care</td>
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<td>MNCH</td>
<td>Maternal Newborn and Child Health</td>
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<td>MTE</td>
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<td>MTMCG</td>
<td>Mother-to-Mother Care Groups</td>
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A. PRELIMINARY INFORMATION (Executive Summary)

Background: Save the Children was awarded a five-year Standard USAID/CSHGP Child Survival Project (CS-23) - Innovation for Scale: Enhancing Ethiopia’s Health Extension Package in the Southern Nations and Nationalities People’s Region (SNNPR) - to address four main causes of child death: (1) pneumonia, (2) malaria, (3) diarrheal diseases (that together account for 68% of under-five mortality); and (4) neonatal infection, responsible for half of all neonatal mortality. The project was implemented in the SNNPR in the districts of Shebedino (Sidama Zone) and Lanfero (Silti Zone) and reaches 69,491 children 0-59 months of age; and 87,496 women of reproductive age (WRA). The overall goal of the project was to enhance the government iCCM strategy in order to contribute to reduced childhood mortality, with a strategic objective to increase use of key childhood services and behaviors.

Four intermediate results (IRs) IR-1: Access and availability of child health services and supplies increased; IR-2: Quality of child health services increased; IR-3: Knowledge and acceptance of key child health services and behaviors increased; IR-4: Child health social and policy environment enabled.

Principal project strategies (1) Capacity-building, training, and supervision for improved systems and provider performance; (2) health extension package (HEP)/community-integrated management of neonatal and childhood illness (c-IMNCI) for behavior change (BC) delivered at health post (HP) and household (HH) levels by health extension workers (HEWs) and volunteer community health workers (vCHWs) (now the Health Development Army/HDA); (3) Technical communication and advocacy directed at government, professional associations, civil society, and the Federal Ministry of Health (FMOH) for policy change. The project focused on the implementation of the three pillars of the Integrated Management of Neonatal and Childhood Illness (IMNCI) strategy in health centers (HCs), including: clinical IMNCI, health systems support, and community and family practices.

Main conclusions of the evaluation In general, the project was successful in implementing all pillars of IMNCI, including: clinical IMNCI training of HC staff, and HEWs in HPs; provision of supervision and supplies for IMNCI; and training and support to vCHWs and others to improve family practices through c-IMNCI. The project also successfully operationalized zinc and pneumonia treatment for childhood diarrhea and pneumonia respectively at HCs and HPs. The treatment of diarrhea with zinc, and pneumonia with antibiotics, was the first at scale in Ethiopia, resulting in the project contributing to operationalizing the national policy. These achievements were accomplished as a result of a comprehensive strategy with strong partnership and collaboration with local health authorities in project implementation. However, main gaps existed in care for newborn babies, both in terms of care practices at home and care seeking, and care for sick newborn babies; each of which were low.

Main recommendations of the evaluation Based on the findings, the following were the main conclusions endorsed by the regional and district partners:

1) Engage traditional and spiritual healers as they are still trusted by the community in case of certain illnesses;
2) Strengthen the capacity of the district to sustain regular integrated and clinical supervision for HCs, HPs and community volunteers;
3) Revise and distribute behavior change communication (BCC) materials to include key IMNCI messages;
4) Strengthen maternal and newborn care (MNC) with special focus to skilled and clean births, and care for both the well and sick newborn baby;
5) Strengthen HPs to be able to provide 24 hour services by ensuring that each HP has the recommended two HEWs and other key requirements such as solar/electricity and water;
6) In the long term, strengthen the pharmaceutical supply chain to ensure that HPs are adequately stocked with key commodities for IMNCI;
7) Expand ICCM to include treatment of the sick, young infant at the HP level.
8) Save the Children should continue fostering a strong partnership at the local, regional and national levels to ensure that lessons learnt are scaled-up all over the country.

### Summary of Major Project Accomplishments

#### Table 1: Summary of Major Project Accomplishments

<table>
<thead>
<tr>
<th>Strategic Objective: Improved use of key child health services and behaviors</th>
<th>Project Inputs</th>
<th>Activities</th>
<th>Outputs</th>
<th>Outcome</th>
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<tr>
<td><strong>IMNCI training packages</strong></td>
<td>Training of HEWs and HC staff in IMNCI;</td>
<td>84% (103/121) of HEWs trained in IMNCI (1 HP per 1000 U5s); 90% (9/10) HCIs with IMNCI trained staff;</td>
<td><strong>14,700 U5s treated</strong> with antimalarials annually (291 malaria/fever cases treated per 1000 U5s); <strong>10,346 U5s treated</strong> with antibiotics annually (205 pneumonia cases treated per 1000 U5s); <strong>7,017 U5s treated</strong> with ORS annually (1,927 with ORS+zinc) annually (139 diarrhea cases treated per 1000 U5s)</td>
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<tr>
<td>IMNCI and other supplies (referral slips, timers, chartbooks, registers, furniture, medical equipment)</td>
<td>Provision of IMNCI supplies and drugs to HCs and HPs (initial &amp; through supervision visits)</td>
<td>&gt;80% of HPs with IMNCI supplies (except timer);</td>
<td>91% of HPs with zinc, 100% with ORS, 100% with chloroquine, 18% with ACTs on day of assess. visit</td>
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<tr>
<td>IMNCI drugs (ORS, zinc, ACTs, ABs, CQ) &amp; logistics support (transport, petrol)</td>
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**IR-2 Quality of child health services improved**

| Transport, supervision tools/checklists, joint planning; Joint supervision Job aids to | Supervision visits, provision of job aids | 100% of HEWs/HPs report supervision in previous month; 97% of HPs meet FMOH “functional” criteria | In case scenario of pneumonia at 11 HPs: 100% of HEWs would classify & refer/treat correctly; 82% classify correctly & 9% reported |
B. OVERVIEW OF THE PROJECT, OR STRUCTURE AND IMPLEMENTATION

1. Goals and objectives
Save the Children Ethiopia was awarded a five-year Standard USAID/CSHGP Child Survival Project (CS-23) - *Innovation for Scale: Enhancing Ethiopia's Health Extension Package in the Southern Nations and Nationalities People's Region (SNNPR)*. The project was designed to address four main causes of child death: (1) pneumonia, (2) malaria, (3) diarrheal diseases (that together account for 68% of under-five mortality); and (4) neonatal infection, responsible for half of all neonatal mortality. The overall goal of the project was to reduce childhood mortality, with a strategic objective to increase use of key childhood services and behaviors. The project focused on the implementation of the three pillars of the Integrated Management of Neonatal and Childhood Illness (IMNCI) strategy in HCs and HPs including: 1) clinical IMNCI; 2) health systems support; and 3) community and family practices. The strategic objective was "Use of key child health services and behaviors improved." Based on the project’s Results Framework (Figure 1) the project had four Intermediate Results (IRs):
- IR-1: Access and availability of child health services and supplies increased;
- IR-2: Quality of child health services increased;
- IR-3: Knowledge and acceptance of key child health services and behaviors increased; and
- IR-4: Child health social and policy environment enabled.

![Figure 1: Save the Children, Ethiopia CS-23 in SNNPR - Results Framework](image)

**Goal: Under-five mortality reduced**

**Strategic Objective: Use of key child health services and practices increased**

**IR-1:** Access & availability of child health services and supplies increased

**IR-2:** Quality of child health services improved

**IR-3:** Knowledge & acceptance of key child health services and practices improved

**IR-4:** Child health social and policy environment enabled

**Overall implementation strategy:**
Community case management, capacity building, and behavior change at the household level

2. **Project location and estimated project area population**

This project was implemented in the SNNPR in the districts (*woredas*) of Shebedino (Sidama Zone) and Lanfero (Silti Zone). The project reached a total population of 366,898 in Shebedino (255,209) and Lanfero (111,689) districts, including 16,645 infants 0-11 months of age; 13,948 children 12-23 months of age; 40,815 children 24-59 months of age; 69,491 children 0-59 months of age; and 87,496 WRA. When project implementation commenced, SNNPR reported Ethiopia’s second highest IMR and U5MR, at 107/1,000 and 157/1,000, respectively. Its neonatal mortality rate (NNMR) – contributed nearly half of the infant mortality of 49/1,000, which was considerably higher than the national NNMR of 39/1,000. TT2+ coverage for pregnant women was 61.4%; while for non-pregnant women it was 36.9%.

3. **Technical and cross-cutting interventions**

- During this project, Save the Children enhanced an existing government package already operating at national scale. The main implementation strategy - CCM in the context of the existing health extension Program (HEP) and IMNCI/c-IMNCI - is designed to enhance the package of evidence-based assessment, classification, and curative interventions for common, serious, childhood infections (pneumonia, diarrhea, malaria, and neonatal infection) delivered at the HP (community) level. This strategy was supported by EPI, capacity-building, and BC at the household level. The project reinforced the potential of an existing government vehicle (HEP) to improve access and availability (IR1), quality (IR2), demand at scale (IR3), and to strengthen the social and policy enabling environment (IR4). Specifically, the technical interventions addressed in CS-23 included: **Pneumonia case management (PCM) (35%)**: Initially the project promoted management of pneumonia with antibiotics at HCs, assessment and referral at HPs, promotion of early care-seeking; and advocacy at the regional and national levels.
for inclusion of pneumonia management at HPs within the HEP. Following policy change
to allow community treatment of pneumonia with oral antibiotics, HEWs started treating
pneumonia in the second half of the project implementation period.

- **Prevention and Treatment of Malaria (20%)**: Prevention through appropriate use of
  insecticide treated nets (ITNs), early care seeking, appropriate case management at HP,
  including rapid diagnostic tests (RDTs) and Artemisinin Combination Therapies (ACTs);
- **Newborn Care (25%)**: Recognition of danger signs, birth preparedness, promotion of
  use of antenatal care (ANC), delivery and postnatal (PNC) at HPs, HCs and in the
  community; and
- **Immunization (5%)**: Promotion of immunization through HEWs and vCHWs.

In order to deliver the above, interventions were integrated across the main technical areas and
these included:

- Capacity building (of districts, HCs, HPs and communities), training and supervision for
  improved systems and provider performance;
- Strengthening the integrated management of neonatal and childhood illness (IMNCI) and
  improving the Expanded Program of Immunization (EPI) in the community, at HPs and
  HCs;
- Promotion of HEP for 16 key behaviors at the community and household levels delivered
  by HEWs and vCHWs (HDA);
- Technical communication, policy dialogue and advocacy at the regional and national
  levels for CS activities, IMNCI, and PCMt at the community level; and
- Strengthening monitoring and evaluation (M&E) of the progress toward objectives in
  conjunction with local health systems, the local community and other key stakeholders.

4. **Project Design**

In this project, Save the Children enhanced an existing government package already operating at
national scale and is a priority strategy. The HEP is the government’s pro-poor strategy that
ensures increased efficiency, expanded coverage, and equitable access. Through the HEP, the
FMOH strives to bring a set of evidence-based promotive, preventive, and limited curative
interventions closer to the household level. Under the current Ethiopian government HSDP-III,
the HEP is being taken to scale nationally. Delivered by trained community-based government-
salaried HEWs – who assisted with BC interventions by vCHWs - the HEP comprises “16
packages” including HIV/AIDS prevention, water and sanitation, hygiene, immunization, and
best practices for maternal, newborn, and child health at the household level. HEWs are the
pillars of the program and are responsible for working with householders in the community to
create “Model Families” with the 16 packages in place. According to guidelines, 96 hours per
month, per HEW are dedicated to “Model Families”. It was expected that each of the two HEWs
assigned to a HP would spend approximately two days at the HP and the other three days in the
community. However, due to attrition and evolving responsibilities, this arrangement has been
changing.

Prior to this project in the two districts, the limited set of curative interventions delivered by
HEWs included use of oral rehydration solution (new formula ORS) and zinc therapy (as yet not
operationalized) for diarrhea; Rapid Diagnostic Testing (RDT) for malaria with Coartem® for
falsiparum and chloroquine for vivax; and assessment and referral of pneumonia, dysentery, and

CS-23 Ethiopia, Final Evaluation Report, Save the Children, December 2012 9
neonatal infection. Government policy did not yet authorize use of antibiotics at the HP level. At the time of project initiation, HEWs were unable to treat pneumonia, dysentery, or neonatal infection. Working with many national and international partners, Save the Children advocated for policy change so that HEWs were able complete a basic but full package of life-saving community case management (CCM) interventions at the HP level. The result was that HEWs were authorized to be trained to assess and treat pneumonia with oral antibiotics.

In Lanfero and Shebedino districts, Save the Children through the CS-23 project and with support from partners enhanced the existing HEP system by implementing and supporting the three pillars of IMNCD. This was accomplished in close coordination with local health authorities. These two districts were among the first in Ethiopia to implement all three pillars. Save the Children provided initial clinical IMNCI training to HEWs working in rural kebeles, including the diagnosis of malaria with RDTs and treatment with either ACTs (falciparum) or chloroquine (vivax); treatment of diarrhea with oral rehydration salts (ORS) and zinc and initially, the assessment of respiratory illness and referral for pneumonia. After policy change, the HEWs were trained and started assessing and treating pneumonia with oral antibiotics. The IMNCI trainings for HC staff and HEWs had a high facilitator-to-participant ratio (1:4 for HC staff, 1:5 for HEWs). Trainings used the Ethiopian-adapted WHO IMNCI training package which includes participatory teaching methods and four to six clinical practice sessions.

In order to support clinical IMNCI, Save the Children provided BCC and other guidelines in the local language, including IMNCI registers, chartbooks, timers, referral slips and other supplies to all HCs and HPs. HC staff also received clinical IMNCI training, including treatment of pneumonia with antibiotics, and job aids. Save the Children staff, in coordination with the Regional Health Bureau (RHB) and District Health Offices (DHO), provided regular, ongoing support and supervision to health workers providing IMNCI clinical services. The Outpatient Therapeutic Program (OTP), which manages acute severe malnutrition, was not integrated with IMNCI services. In 2010, Save the Children worked with the DHOs to provide on-the-job training to HEWs in the integration of OTP and IMNCI services.

In promoting community and family practices, HEWs coordinated with vCHWs in the communities to promote BC in the use of available services and early care seeking, immunization, growth promotion and appropriate feeding practices, hygiene and sanitation, and home management of illness. The HEWs meet with vCHWs on a bi-monthly or monthly basis to coordinate activities. Save the Children provided initial trainers’ training in community-IMNCI to HEWs who then trained 1080 vCHWs. Save the Children also provided ongoing support through community visits and supervision meetings. The vCHWs and HEWs received Information, Education and Communication (IEC) materials and counseling cards from CS-23 to support this work. Additionally, the CS-23 project coordinated with the RHB and DHOs to support preventive practices, such as distribution of ITNs, EPI and sanitation campaigns, etc.

The CS-23 project promoted health systems support for IMNCI services. In addition to providing ongoing support for supervision and training, Save the Children also assisted with supplies and drug stocks. These activities included working with the RHB and DHO to ensure adequate drug supplies and the purchase of ORS, ACTs and chloroquine for HPs and HCs when adequate stocks were not available. Save the Children facilitated the introduction of zinc for diarrhea
management in IMNCI algorithms in coordination with PSI. Lanfero and Shebedino were among the first districts in Ethiopia to pilot the introduction of zinc for diarrhea.

In addition to the full implementation of IMNCI, Save the Children conducted advocacy at the international, national and regional levels to promote CS activities, with an emphasis on policy change to include pneumonia management in the community (within HEWs’ responsibilities). Based on the project documents and findings from the final evaluation, it is evident that the technical package was clear, comprehensive, well implemented, and well documented.

5. Partnerships and collaboration
The key partners of the project were collectively the local health authorities, including: 1) the SNRP Regional Health Bureau (RHB), especially the Family Health Department, the Child Health and Nutrition Team, the RHB HEP and Planning and Programming Department; 2) the Sidama and Silti Zone Health Departments; and 3) the Lanfero and Shebedino DHOs. These partners were involved since project start-up, through briefing meetings, the DIP workshop, the baseline Knowledge, Practices and Coverage (KPC) survey, dissemination workshops, district-based planning and capacity building trainings for health professionals (facilitated by experts from the FMOH, and integrated supportive supervision, as well as participating in the MTE and in the final evaluations. The key implementers of the IMNCI strategy were HEWs and vCHWs, which ensured local partnership and capacity building at the community level. Save the Children also strengthened local partnerships by participating in the Regional Child Survival Task Force, the Technical Advisory Group (TAG) meetings and the EPI working group chaired by the RHB. Save the Children also worked in collaboration with other non-governmental organizations (NGOs) and development partners at the local and national levels. HCHPUNICEF was a principal national and regional partner, especially in Lanfero District. Other partners included JSI/IFHP, L10K, UNICEF, WHO, GOAL, Plan Ethiopia, Population Services International, and the Malaria Consortium.

6. Partnerships and Relationship with USAID in Ethiopia
There was a strong collaboration with the USAID-bilateral Integrated Family Health Program (IFHP) in the use of IEC tools, IMNCI training for HEWs and sharing key CS job aids for health facilities. IFHP, managed by John Snow International (JSI), provided training of trainers (TOT) for the Save the Children team to build its capacity in the facilitation of IMNCI training for HEWs. Save the Children collaborated with UNICEF to provide essential medical supplies to HPs and with WHO on the joint effort for policy influence on CCM/P. PSI provided zinc for piloting in Lanfero and Shebedino districts, which were among the first in the country to introduce zinc into IMNCI protocols. Save the Children worked closely with GOAL Ethiopia to share ideas and organize joint trainings (i.e., zinc treatment). This partnership was evidenced in the final evaluation interviews and at the dissemination of the preliminary final evaluation findings where partners and stakeholders were visibly present.

The USAID Mission, Ethiopia was engaged in the project since its initial stages through the provision of technical advice and revision of the project document. The Save the Children national health unit head periodically met with USAID-Ethiopia’s child survival (CS) focal person, the Health Population and Nutrition Officer at the Mission, to provide updates on the status of the project and interventions.
C. EVALUATION ASSESSMENT METHODOLOGY AND LIMITATIONS

The final evaluation of the CS-23 project was conducted by a team led by an external evaluator. The team included two senior representatives from Save the Children headquarters; Save the Children national and regional offices; members from the RHB, Zonal Health Department and DDHO staff; CS-23 project staff; and National and Regional representatives from UNICEF. The final evaluation was conducted between September 18 and September 30, 2012.

On the first day of the final evaluation, the team met to agree on the focus of the evaluation, to review and agree on tools, and to form and orient field teams. Four principal methods were used for the final evaluation: 1) Document review, including policy documents, program reports, technical reports, reports of evaluations or study findings, training and health education materials. 2) Field visits to Shebedino and Lanfero Districts. The team spent four days in the field making site visits to district headquarters, HCs and HPs, and to conduct in-depth interviews (IDIs) with district staff, HC staff, HEWs and community members (both IDIs and FGDs). 3) Observation of HCs and HPs (HEWs); and 4) In-depth interviews with regional and national stakeholders. Some intended national level interviews that were planned, were not carried out due to a public holiday following the death of the Ethiopian PM (in the case of PSI) or because the responsible officer was out in the field (in the case of USAID staff). (Annex 8 shows a summary of the contacts and respondents in the final evaluation.)

Following the field work, both field teams met in a joint meeting to discuss and synthesize the findings. A final summary of main findings and recommendations was reviewed and discussed with CS-23 program staff and the staff of UNICEF, FMOH/RHB and districts, and all the evaluation team members. At the meeting, key recommendations were outlined. These were later presented in a half-day stakeholders’ feedback meeting in Awassa on August 29, 2012. Program data, documents and reports were generally available to the evaluation team, and interviews were conducted with key stakeholders at all levels.

In addition to the baseline and endline KPC surveys, other assessments conducted by the grantee included:

- Baseline and endline health facility assessments (HFA) (see Annex 12);
- Assessment of the potential of mHealth to support HEW Supervision in Ethiopia’s SNNPR (Annex 1);
- Exploration of causes for low utilization in Shebedino vs. Lanfero District (Annex 1);
- How did USAID’s Child Survival and Health grant’s CS-23 Project to Save the Children Contribute to CCM of Pneumonia Policy Change and iCCM Scale Up in Ethiopia? (Annex 1); and
- Mother-to-Mother Care Group, Pregnant Mothers Forum, and Increased Institutional Delivery in Lanfero District, Ethiopia (Annex 1).

Taken together, these documents provided rich data that enabled the final evaluation team to understand the project impact and effectiveness.

However, there were a few gaps and limitations. Although at the time of the final evaluation the KPC assessment had been completed and analyzed, the narrative report was not ready. During
presentations by the project team of the KPC results, we noticed some findings that were not clear, especially those related to care seeking for pneumonia-like symptoms. The data suggested that care givers do not make high use of HPs for treatment. We followed up on this issue during the field visits, and discovered that the finding was incorrect and likely due to the fact that community members are not always able to differentiate HPs from HCs when such questions are asked in the local language.

In addition, whereas we found that the IMNCI/iCCM recordings at health facilities and at HPs had generally improved, there were still gaps such as in recording of age, weight, etc., in HCs and HPs.

D. DATA QUALITY AND USE

The final evaluation As already stated, the final evaluation included field visits. Although we achieved a high response rate, we also had some problems that affected the field work. During the period of the evaluation, we learnt of the passing of the Ethiopian Prime Minister. As a result, the field team in Shebedino was only able to spend three of the planned four days in the field. In addition, the survey period took place during the rainy season and many roads, especially in the more rural areas, were not accessible. Thus the final areas for the field visits were purposively selected to exclude inaccessible areas.

Population-based baseline and endline surveys The standard CSHGP KPC survey instrument and methodology were adapted for use. The KPC is designed as a before and after study with no control. This has limitations of causality attribution as similar changes could be occurring elsewhere. However, several evaluation techniques were implemented in order to triangulate the findings, and clearly these showed a dose-response in the relationship of findings to interventions.

Background characteristics of the sample population at baseline and endline were similar. The sampling frame for the baseline survey comprised the entire population of the two districts. It was a random cluster household survey with 600 respondents (300 per district). Because there was no complete report of the final KPC at the time of the evaluation, it is difficult to judge the methodological challenges and sampling assumptions used. Given the differences in population size, it would have been expected that the sample size per district would have been weighed so that the larger district proportionately contributes more to the total sample than the smaller one. However, this was taken care of at analysis.

Certain endline indicators were not collected at baseline. For these indicators it is not possible to determine whether changes in knowledge or practices are associated with project activities. Matching surveys to ensure that they collect the same key data is important for project comparisons. More attention to this issue is recommended in the future.

Another challenge encountered in the endline KPC was that the communities tended to refer to HCs and HPs the same way, that is, they could not differentiate HCs from HPs. We later found out that the use of “HP” in the local language is not common. Because of this, the final KPC results erroneously show that HPs are not used especially for pneumonia treatment.
Health Facility Assessments  HFAs on the quality of MNC were conducted at baseline and endline. Surveys measured availability of facility supports including essential medicines, supplies and equipment, availability of services and some aspects of health worker knowledge and clinical practice. Standard facility assessment tools were used and adapted for local use. The surveyors conducted a census of all health facilities in the two districts and a random survey of half the HPs. None of the two districts had a hospital.

The final evaluation and process evaluation data  Routine monitoring data: The project used routine data to monitor progress, presented in internal quarterly and annual reports, as well as annual reports to USAID. The monitoring plan included reporting on: 1) health communication activities; 2) findings (successes and gaps) observed during integrated supervision; 3) use of curative child health services by illness at HCs and HPs; and 4) advocacy activities. The project found that the data regarding processes and health service utilization collected through the routine Ethiopian Health Management Information System (HMIS) needed strengthening and definitions of collected information often did not correspond with standard IMNCI or maternal, neonatal and child health (MNCH) definitions. In response, the project organized a five-day training with the RHB to ensure coordination of CS-23 activities and supportive supervision with the planned improvements to the FMOH HMIS. During field visits in the final evaluation, we found that at the time health workers were using HMIS for children under-five that is based on IMNCI definitions. This has greatly improved the quality of the data for sick children under-five coming to HC or HPs.

Health Information System (HIS) Data  The community-based surveillance system was not fully operational during the project implementation period. Availability of data from the community would greatly enhance decision making and programming. Improving availability, quality and use of community based data should be considered as a key priority if future. Data from the routine HMIS were available and used for following trends in some key indicators, including ANC visits, timing of ANC visits, facility deliveries and PNC visits.

Special studies and operational research  To address operational issues that have arisen in the course of the CS-23 project, Save the Children conducted formative research to assess the existing HEP supervision plans and actual implementation. The special embedded studies conducted have been outlined above. Briefly they included: Assessment of the potential of mHealth to support Health Extension Worker Supervision; Exploration of causes for low utilization in Shebedino vs. Lanfero Districts; and studies on use of zinc by HEWs to treat diarrhea.

Use and dissemination of routine project M&E information  Results from the baseline KPC survey were used to set targets, and the HFA was used to better understand the context and target project activities. The project used routine data to document project progress and to identify gaps that could be addressed through project activities. The M&E data from the various sources (KPC, HFA, routine monitoring) was collected in collaboration with FMOH partners and shared through written reports, review meetings and workshops. In addition, preliminary implementation experiences from the project were shared at national and global meetings and were used to pilot the global iCCM indicators (Annex 2). The preliminary findings from the endline evaluation have already been presented to the regional stakeholders and also discussed
with Save the Children and the head of Child Health in Ethiopia. In addition, the team has already published one paper in a peer reviewed journal: Degeffie T, Marsh D, Gebremariam A, Tefera W, Osborn G, Waltensperger K. Community Case Management Improves Use of Treatment for Childhood Diarrhea, Malaria and Pneumonia in a Remote District of Ethiopia. Ethiop. J. Health Dev. 2009; 23(2).

E. PRESENTATION OF PROGRESS TOWARD ACHIEVING PROJECT RESULTS

Table 2 presents the M&E matrix from the DIP and updated based on the final survey findings. The FE used the results framework to guide data collection and was a participatory process.

<table>
<thead>
<tr>
<th>Goal, Objective, Intermediate Result</th>
<th>Indicators</th>
<th>Data Source/Method of Measurement</th>
<th>Baseline Value</th>
<th>Final Value*</th>
<th>Final Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal: Under-five mortality reduced</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strategic Objective: Use of key child health services and practices increased</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appropriate hand washing practices</td>
<td>% of mothers of children 0-23 months who live in a household with soap or a locally appropriate cleanser at the place for hand washing and who washed their hands with soap at least 2 of the appropriate times during the day or night before the interview</td>
<td>KPC</td>
<td>28%</td>
<td>60%</td>
<td>45%</td>
</tr>
<tr>
<td>Increased feeding during diarrheal episode</td>
<td>% of children aged 0-23 months with diarrhea in the last two weeks who were offered the same amount or more food during the illness</td>
<td>KPC, 2011 EDHS</td>
<td>29%</td>
<td>25%</td>
<td>43%</td>
</tr>
<tr>
<td>Increased fluid intake during diarrheal episode</td>
<td>% of children 0-23 months with diarrhea in the last two weeks who were offered more fluids during the illness</td>
<td>KPC, 2011 EDHS</td>
<td>20%</td>
<td>59%</td>
<td>36%</td>
</tr>
<tr>
<td>Appropriate care seeking for pneumonia</td>
<td>% of children age 0-23 months with chest-related cough and fast and/or difficult breathing in the last two weeks who were taken to an appropriate health provider</td>
<td>KPC, 2011 EDHS</td>
<td>32%</td>
<td>45%</td>
<td>60%</td>
</tr>
<tr>
<td>ORT use</td>
<td>% of children age 0-23 months with diarrhea in the last two weeks who received ORS and/or recommended home fluids.</td>
<td>KPC, 2011 EDHS</td>
<td>57%</td>
<td>55%</td>
<td>72%</td>
</tr>
<tr>
<td>Zinc therapy</td>
<td>% of children 0-23 months with diarrhea in the last two weeks who were treated with zinc supplements</td>
<td>KPC, 2011 EDHS, DHO/RHB service data</td>
<td>7%</td>
<td>34%</td>
<td>25%</td>
</tr>
<tr>
<td>ITN use by child</td>
<td>% of children age 0-23 months who slept under an insecticide-treated bed net (in malaria risk areas, where bed net use is effective) the previous night</td>
<td>KPC, 2011 EDHS</td>
<td>40%</td>
<td>39%</td>
<td>65%</td>
</tr>
<tr>
<td>Postnatal visit to check on newborn within first 3 days after birth</td>
<td>% of children age 0-23 who received a post-natal visit from an appropriate trained health worker within three days after the birth of the youngest child</td>
<td>KPC, 2011 EDHS</td>
<td>4%</td>
<td>14%</td>
<td>30%</td>
</tr>
<tr>
<td>Immediate and exclusive breastfeeding of newborns</td>
<td>% of newborns who were put to the breast within one hour of delivery and did not receive prelactate feeds</td>
<td>KPC, 2011 EDHS</td>
<td>62%</td>
<td>93%</td>
<td>69%</td>
</tr>
<tr>
<td>Exclusive breastfeeding (0-5 months)</td>
<td>% of children age 0-5 months who were exclusively breastfed during the last 24 hours</td>
<td>KPC, 2011 EDHS</td>
<td>3%</td>
<td>29%</td>
<td>25%</td>
</tr>
</tbody>
</table>

IR-1: Access and availability of child health services and supplies increased

<p>| Access to immunization | % of children age 12-23 months who received a DPT1 vaccination before they reached 12 months | KPC, 2011 EDHS | 80% | 97% | 80% |</p>
<table>
<thead>
<tr>
<th>Goal, Objective, Intermediate Result</th>
<th>Indicators</th>
<th>Data Source/ Method of Measurement</th>
<th>Baseline Value</th>
<th>Final Value*</th>
<th>Final Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical IMNCI coverage</td>
<td>% of HEWs/VCHWs trained in IMNCI</td>
<td>RHB/ZHD/DHO documentation, project training records</td>
<td>0%</td>
<td>100%</td>
<td>60%</td>
</tr>
<tr>
<td>Community IMNCI coverage</td>
<td>% of HEWs/VCHWs trained in e-IMNCI</td>
<td>RHB/ZHD/DHO documentation, project training records</td>
<td>0%</td>
<td>100%</td>
<td>60%</td>
</tr>
<tr>
<td>Availability of zinc</td>
<td>% of HPs that report no stock-out of zinc in previous month</td>
<td>RHB/ZHD/DHO documentation, rapid inventories of HPs, stock-out reports</td>
<td>0%</td>
<td>100%</td>
<td>75%</td>
</tr>
<tr>
<td>IR-2: Quality of child health services improved</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health system performance regarding immunization</td>
<td>% of children age 12-23 months who received a DPT3 vaccination before they reached 12 months</td>
<td>KPC</td>
<td>47%</td>
<td>71%</td>
<td>75%</td>
</tr>
<tr>
<td>Measles vaccination</td>
<td>% of children age 12-23 months who received a measles vaccination regardless of age</td>
<td>KPC, 2011 EDHS</td>
<td>60%</td>
<td>84%</td>
<td>75%</td>
</tr>
<tr>
<td>Child with fever receives appropriate anti-malarial</td>
<td>% of children age 0-23 months with a febrile episode during the last two weeks who were treated with an effective anti-malarial drug within 24 hours after the fever began</td>
<td>KPC, R-HFA, health facility record review</td>
<td>17%</td>
<td>47%</td>
<td>60%</td>
</tr>
<tr>
<td>Use of medicine during diarrhea</td>
<td>% of children 0-23 months with diarrhea in the last two weeks who were no treated with anti-diarrheals or antibiotics</td>
<td>KPC, health facility record review</td>
<td>41%</td>
<td>4%</td>
<td>22%</td>
</tr>
<tr>
<td>HEW performance</td>
<td>% of trained HEWs who followed correct IMNCI steps to assess, classify, treat, refer childhood illness</td>
<td>R-HFA, performance observations, supervisory records</td>
<td>TBD</td>
<td>81%</td>
<td>60%</td>
</tr>
<tr>
<td>Functional supervisory system</td>
<td>% of HPs that have received supportive supervision 1x/mo in past quarter (according to FMOH criteria)</td>
<td>R-HFA, monthly worked reports</td>
<td>80%</td>
<td>100%</td>
<td>Target not set</td>
</tr>
<tr>
<td>Functional health system</td>
<td>% of HPs meeting FMOH “functional” criteria (refer to Annex 18)</td>
<td>RHB/ZHD/DHO reports, records</td>
<td>80%</td>
<td>100%</td>
<td>Target not set</td>
</tr>
<tr>
<td>Functional health system</td>
<td>% of HPs that have met all reporting requirements in past quarter (according to FMOH criteria)</td>
<td>RHB/ZHD/DHO reports</td>
<td>80%</td>
<td>100%</td>
<td>Target not set</td>
</tr>
<tr>
<td>IR-3: Knowledge and Acceptance of key child health services and practices improved</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neonatal danger signs</td>
<td>% of mothers report knowledge of at least 2 neonatal danger signs needing treatment</td>
<td>KPC</td>
<td>29%</td>
<td>28%</td>
<td>Target not set</td>
</tr>
<tr>
<td>Child danger signs</td>
<td>% of mothers who know at least 2 signs of illness in children needing treatment</td>
<td>KPC, 2011 EDHS</td>
<td>51%</td>
<td>74%</td>
<td>75%</td>
</tr>
<tr>
<td>IR-4: Policy and social environment enabled</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Policy change</td>
<td>HSDP-IV includes CCM as HEP strategy at level of HP - including antibiotics for treatment pneumonia, dysentery, neonatal sepsis</td>
<td>FMOH/RHB policy documents and operational guidance</td>
<td>100%</td>
<td>Target not set</td>
<td></td>
</tr>
<tr>
<td>Joint planning for sustainability</td>
<td>Joint planning takes place on annual basis with RHB/ZHD/DHO, Save the Children, ESHE, and relevant key community stakeholders</td>
<td>RHB/ZHD/DHO records, project documentation</td>
<td>N/A</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

*Final value = Endline Household Survey Result.*
F. DISCUSSION OF PROGRESS TOWARDS ACHIEVEMENT OF RESULTS

1. Contribution Toward Project and OR Objectives

We use the results framework to appraise the findings. Overall, the final evaluation findings indicate that this project has been a great success. Although no data was collected on mortality, the intermediate results show marked increases in key mortality proxies such as coverage of high impact interventions, care seeking, quality of care, and decreased morbidity. The section that follows discusses the progress towards achieving the intermediate results (IR) and strategic objective (SO) as outlined in the results framework. We discuss the remaining challenges and make recommendations to inform further scale-up or to sustain the project and make it even more effective.

Contribution Toward Objectives—IR-1: Access and availability of child health services and supplies increased

a. Access to IMNCI services for sick children at HPs and HCs, and e-IMNCI through vCHWs

Overall access and referral: The project has achieved its targets for improving access to IMNCI services for sick children at HCs and HPs. All HCs in the two districts offer full IMNCI services and 100% (11 out of 11) have at least one IMNCI nurse on-staff, although turnover of IMNCI-trained HC staff has been a challenge especially in Lanfero. Approximately 90% (109/121) of the targeted HEWs are trained in IMNCI (management of malaria and diarrhea, and now pneumonia, assess – classify and refer newborn infection and ENC), with approximately one IMNCI functional HP for every 1000 children under five years of age. There has been an increase in the number of children seeking care at either HCs or HPs (see Annex 6, Final KPC Report, Table 1 for more details). National policy now permits the management of pneumonia in the community, and implementation started in the fourth quarter of 2010. Key stakeholders, local health authorities, project staff and HEWs considered the IMNCI training for HC staff and HEWs, as well as the ongoing support to trained health workers and HEWs to be one of the most significant achievements of the project to date. Likewise, community members in focus groups also expressed appreciation for the availability of services through HPs.

A referral system is in place at each level in the community; vCHWs promote the use of HEWs and HPs and refer children to HPs using improvised referral slips provided by CS-23. At the next level, HEWs refer sick newborn babies and severely ill older children to HCs using referral slips provided by Save the Children. Although in the MTE it was found that HEWs also refer children from HPs to HCs because of drug stock-outs, especially CoArtem®, resulting in unnecessary referral, this practice has been reversed as stock-outs are now rare. Recently, the two districts acquired ambulances from the FMOH to refer women who cannot deliver at a HP or a HC. The HPs are now networked and if they get such a case, they just need to make a call and an ambulance will appear. The addition of the ambulance has further motivated communities to seek facility delivery. However, the free ambulance services are currently for women in labor; people with other medical emergencies can use the ambulance at a cost. Thus, referral from HCs to hospitals for severely ill children is a large challenge due to costs and transportation. Back referral from HCs to HPs happens infrequently and lack of feedback was reported to demoralize
some HEWs. Save the Children, through another resource, will provide additional ambulances to the districts which may address the challenge of sick child referral.

**Challenges and recommendations:** A significant number of HEWs have left or transferred to other posts, and many HPs currently have only one HEW. This one HEW has an increasing workload, especially the curative aspect. Although they are currently very enthusiastic and well-motivated, it is likely that they will soon face burn-out. This situation will be worse especially once the CS-23 project ends, as supported supervision and mentorship are likely to be reduced. Interviews with the RHB head revealed that the government is aware of these problems and strategies are being put in place to improve the staffing of HPs by addressing attrition.

Another challenge affecting access to IMNCI services for sick children at HPs was the availability of drugs and supplies. Although this is currently not a big problem in the two districts, district stakeholders, health workers and HEWs were concerned that there was no clear mechanism for continued high quality services at the HPs. This is because HPs lacked a budget and some of the drugs (zinc, antibiotics) were not part of a regular kit. A package of iCCM drugs will be provided to each HP by FMOH/FMOH/UNICEF and this may solve the problem. Overcoming challenges linked to referral for sick children is difficult; one ambulance for the whole district is not enough to do all the delivery referrals and also add children. Even if this was possible, lack of resources within communities and in the health system is a large constraint. A more workable solution will be to empower HCs to be able to deal with most of the sick children who would have needed referral. This will involve staff training and equipping of facilities so that HCs have the skilled staff, drugs and equipment to manage very sick children.

**b. Availability of IMNCI supplies and drugs at HPs and HCs**

HPs in both districts were well equipped with most IMNCI equipment and supplies on the day of the assessment during the final evaluation, including IMNCI chartbooks and registers, referral slips, thermometers, MUAC strips, scales, counseling cards and RDTs. These findings corroborated the final evaluation HFA findings which reported that HPs had all essential drugs, supplies and records.

HCs. The percentage of the population with year-round geographical access (within 5Km or one hour access) increased from 57% at baseline to 100% at endline; and most of these HCs had improved availability of all three child health services (increase from 38% at baseline to 91% at endline). These HCs witnessed marked improvements in infrastructure, with an increase from 38% at baseline to 100% at endline in terms of having all essential infrastructure present and functional. Staff availability also seems to have increased slightly; 27% of HCs did not have all the clinical staff on the day of the endline HFA. In terms of medical drugs and supplies, there was marked improvement at endline compared to baseline for availability of essential supplies (increase from 42% to 100%); and all essential child drugs (14% to 100%). However, performance on maternal and especially neonatal commodities was poor; only 37% of HC had all basic neonatal and delivery supplies and 73% had all required basic maternal and neonatal drugs.

HPs. In addition, all HPs had excellent availability of RDTs. This was confirmed during field visits as we found a good supply and no stock-outs. Zinc was introduced and supplied in coordination with PSI, with PSI providing zinc in-kind for pilot testing in the CS-23 districts. Using matching funds, CS-23 supplied ORS, zinc, chloroquine, CoArtem® and amoxicillin
syrups and capsules, as adequate drug supply through government health systems is an ongoing challenge in Lanfero and Shebedino Districts. However, private funds for drug supply will soon be depleted. The FMOH/UNICEF iCCM drugs package will address future needs.

Additionally, the Save the Children project often provided supervision and logistical support, such as transportation resources, to ensure adequate drug supplies in peripheral HPs and HCs. In interviews, we learned from the deputy head of the RHB that the government is already working on a system to sustain the medical supplies and drugs through provision of HP kits. He said “HPs are a government policy so sustainability is not an issue. The government, with the help of its partners, is working on strengthening the pharmaceutical supply chain, and are working on supplies using a pool system that is based on need”. The distribution of these kits has been tasked to the supervising HCs. However, we learnt from the field interviews that unless more is done, there will be stock-outs mainly due to: 1) Lack of adequate funds for the districts to routinely distribute the kits; 2) Poor supply chain information systems; and 3) General budget limitations in the national health sector. Although not formally assessed, most HPs and HCs appeared to have a functioning ORT corner. HPs generally had very well maintained buildings, furniture and clean water. This finding differed from that at the MTE visit, where the infrastructure was reported to be poor. After the MTE, Save the Children received support from Save the Children Korea which provided funds for renovations and for furniture, thus improving the situation.

Contributions of the CS-23 project: Overall, almost all HPs and HCs have adequate supplies to provide IMNCI services, as well as ORT corners, and this can be attributed to the CS-23 project support and supervision activities. Almost all interviewees at the RHB, district, HCs and HPs attributed this success mainly to the project’s efforts to strengthen the existing health system. It was reported that through CS-23, health workers, HEWs and vCHWs were trained and supervised routinely and also during more specific technical supervision. Save the Children also provided transport support to districts to distribute the commodities. However, this active involvement and support by Save the Children has consequences that might affect the project’s sustainability. During interviews, it did seem like Save the Children might have created some kind of dependency syndrome, as districts appeared unlikely to be able to adequately maintain support supervision and mentorship. Key stakeholders and almost every service provider noted the provision and follow-up on supplies as a large contribution of the CS-23 project. One of the District Health Officers said, “When the project ends, we will have problems with support supervision, review meetings and distribution of medical supplies”. Most of the key informants from the regional and zonal levels to vCHWs and caretakers in the community, reported maintaining adequate drug supplies as one of the largest challenges to child health activities. Although this is currently not a big problem in the two districts, district stakeholders, health workers and HEWs were concerned that there was no clear mechanism for continued high quality services at the HPs. This is because HPs lacked a budget and some of the drugs (zinc, antibiotics) were not part of a regular kit.

Challenges and recommendations: Relatively weak stock management systems within government structures and a lack of drug supplies at all levels of the health system are ongoing challenges faced by the CS-23 project. These threatened the sustainability of progress during the project and especially upon project completion. Additionally, the shortage of transportation and petrol for activities within the government health system negatively impacts logistics and the
provision of supplies to HPs and HCs. The sustainability of the zinc supply is also a large challenge. Thus, currently all zinc must be procured through private channels. The iCCM kit will include zinc in the package but the challenge is that this kit is not yet reaching all HPs. However, Shebedino District has received and distributed the iCCM kit to all HPs recently.

c. Access to (and use of) maternal and neonatal services at HPs and HCs
Overall: Access to maternal and neonatal services within Lanfero and Shebedino Districts, although more limited than for IMNCI services, did register some improvements. HPs have started providing delivery care, a service which was not available at that level before. Women report using ANC services at the HP and HC levels, and the promotion of these services is also reported at all levels. The promotion of assisted delivery at HCs was reported to occur at all levels—HCs, HPs (by HEWs) and in the community (by vCHWs).

The endline KPC showed that the institutional delivery rate increased from 2% at baseline to 25% (15% skilled birth attendance), which is far higher than the average for Ethiopia (10%). However, postnatal/partum visit (25% mother, 17% newborn) is low. Knowledge of two or more danger signs is also low (13% maternal, 27% newborn). Surprisingly, apart from immediate breastfeeding and giving colostrum to the newborn, the final KPC shows that essential newborn care (ENC) practices slightly worsened (or at least did not improve). In addition, during the field visits conducted as part of the final evaluation, it was noted that there is a generally low use of both HC and HPs for the care of the sick newborn. Several reasons were sited including cultural barriers that discourage a newborn from “crossing an imaginary border”, the fear of “the evil eye”, newborns are delicate to take out, communities not being aware of services for the newborn at HPs, and communities being unsatisfied with the care for newborn babies at the HP as the care is limited to only assessment and referral (and no treatment). The consequences are that some newborns developed danger signs and died at home without care seeking, or that care seeking was delayed. Other babies bled to death due to poor cord cutting and tying; or care givers would apply dangerous substances such as cow dung to the cord.

The use of vCHWs working under the supervision of the HEWs was been one of the key cornerstones of the maternal and newborn BC. The community health workers (vCHWs) were trained by Save the Children and given IEC materials on MNCH. Empowered by these, the vCHWs and HEWs made home visits or organized meetings to mobilize communities on MNCH care. It was noted in the MTE that often messages about assisted delivery and newborn care almost exclusively targeted young women. Yet it is fathers and older women (grandmothers) that often make key decisions about delivery and newborn care; however, they are not specifically targeted for key messages. As a result, the project came up with innovations to address these demand side issues. Other channels were developed including mother-to-mother groups, pregnant women groups, and engagement of community elders in MNCH.

In Lanfero district, following a pilot, mother-to-mother groups have been scaled-up as an initiative of the district. One of the strategies which led to recent surges in institutional birth especially at HPs is the use of the Pregnant Mothers Forum (PMF). The MTE (August 2010) recommended strengthening maternal and newborn health (MNH) promotion by pilot-testing Mother-to-Mother Care Groups (MTMCG) in three kebeles in Lanfero District. The district
health team observed that, after the MTMCG, a pilot *kebele* experienced increased deliveries at its HP. Thus, the team revised and scaled up the approach as a PMF in 25 of 27 *kebeles*.

A PMF is a group of five to 15 pregnant mothers who support each other and are facilitated by the vCHW and the HEW. Each group has a team leader, also a pregnant mother and an active community member. Each PMF meeting has a coffee ceremony and a “porridge ceremony,” a cultural ceremony of eating porridge with close friends and relatives when a mother gives birth. The DHO showed innovative leadership in using a special group of mothers, in this case pregnant mothers, to address their own issues in a network with local resources. It was reported that most mothers now give birth at HPs or are planning to do so. (Annex 1, Learning Brief 7)

The changes in maternal and delivery care practices were also reinforced by a couple of health systems strengthening interventions. These included renovation and equipping of HPs, training of health workers and HEWs in MNC care and in clean delivery practices, provision of drugs and supplies, and support supervision and mentorship. These were implemented by the district but facilitated and funded by the CS-23 project.

A combination of these community and health facility (demand and supply) interventions have led to drastic changes in long-held cultural practices that were documented in the MTE such as: families citing home delivery as a more culturally appropriate practice, and mothers reporting detesting the delivery tables; and families not being able to afford razors, gloves, towels and drugs, which were a barrier to delivery at HCs.

Despite these achievements, care seeking and postnatal care for sick and well newborn babies is still poor. Once the newborns reach the health facility, the only care is assessment, counseling and advice on referral to HCs or to the hospital. HEWs have not been trained in treating sick newborn babies nor does national policy allow them to do so. As a result, most mothers with sick newborns do not see a reason to seek care. This is different for mothers with older infants and children who are treated at HPs when they are sick.

**Challenges and recommendations:** The neonatal technical component of the CS-23 has made the least progress; assisted delivery and newborn care seeking are unfortunately low due to a myriad of factors (see utilization section below), including cultural and health systems barriers. Management of sick newborns, ENC and post-natal care messages are included for one day in the IMNCI training packages, although treatment of the sick newborn is not allowed at the HP level. However there seems to be hope that this will change, although it will take some time. It is anticipated that the conclusion of SNL’s sepsis management research will provide further evidence to reinforce advocacy efforts so that HEWs will be allowed to treat sick newborn babies with antibiotics.

Another strategy that the government is embarking on is the upgrading of HEWs to Level III which would allow them to treat sick newborns. It is reported that so far about 5000 have been trained, but the process is slow due to a lack of available resources. Another potential challenge of this process is that unless well managed, it will contribute to further ‘attrition’ of HEWs as they will be absent from the already over-burdened HPs for a long time. In the meantime, care for newborn babies should be improved through strengthening home visits and referral by
vCHWs to HPs. The government should also explore diversifying the use of the ambulance to transport referred sick newborns.

**d. Contribution toward objectives**

**IR-2: Quality of child health services increased**

This section details different attributes that either influenced quality or demonstrated the quality of services provided in the project. Within each section, we discuss the challenges and recommendations to improve health systems support and quality of services.

**Supervision to ensure quality of services at HPs and HCs**

Supervision: The final KPC showed that supervision was very effective. Nearly all (100%) health workers and HEWs reported to have been supervised at least once in the three months prior to the survey. The CS-23 team and FMOH partners identified supervision as a large challenge within the implementation of IMNCI. Therefore, a detailed assessment of the supervision system for the IMNCI services was done and detailed in the MTE. The supervision of HEWs and HPs within the HEP system included joint supervision from the DHO, from the HCs and weekly supervision by HEP supervisors. HEP supervisors were supervised monthly by the DHO HEP Coordinator. Save the Children supports and joins many of these supervision visits, and also conduct supervision visits independent of those conducted by the districts.

It is estimated that Save the Children provided over 50% of supervision to HPs. The joint supervision with local health authorities was reported to be a large contribution of the CS-23 project, contributing to high supervision completion rates at HC and HP levels. HCs are also implementing the government policy of being responsible for supervising five HPs. In one interview, we were told that each kebele/HP is allocated a health worker to supervise and to be responsible for its performance. This serves as a great link between HCs and the HPs. During interviews, most respondents identified supervision as one of the major contributors to the observed performance of the project.

Because districts faced constraints in terms of capacity to supervise (lack of functional vehicles/motorcycles and funds for fuel and maintenance), Save the Children assisted with the provision of most of these services or resources. Other challenges included high workloads of government staff that presented challenges to completing scheduled joint supervisions. During the FE field visits, HEWs reported that they were concerned that the ending of the project might mean less supervision, and yet this supervision was a basis for their motivation and improving skills. In both the MTE and the FE, most HEWs from both districts reported that the supervisor checked records, corrected errors, and gave training.

**Challenges and recommendations:**

Supervision was a great success especially towards the end of the project. However, because of the challenges outlined above, it is doubtful whether the frequency and quality of supervision can be maintained or scaled-up in routine district health systems. There are also concerns about whether the HEP supervisors can be motivated enough to continue the work. As scale-up of the project takes place, strengthening integrated support supervision in the districts will be key.
Quality of services at HPs and HCs
The performance of health workers and HEWs was assessed at baseline, mid-term and at endline. It was found that HW performance on assessment was quite poor in both districts. However, they were able to give the right treatment based on the diagnosis or classification made. The main gaps – less commonly observed than at HPs – were checking for general danger signs, chest indrawing or duration of cough. On the other hand, HEWs did well when evaluated on both criteria (assessment and treatment). Thus, it is clear HEWs were able to follow guidelines. During the FE field visits, we found reasonably good quality of registers at HCs, however they lacked completeness especially related to the recording of age and weight. Overall, HP registers were generally complete.

Challenges and recommendations: Health workers are the referral point and supervisors for HEWs. However, their performance is below standard in terms of following the IMNCI guidelines. It is recommended that once trained, supervision should be comprehensive and should emphasize the use of guidelines.

e. Contribution toward objectives
IR-3: Knowledge and acceptance of key child health services and behaviors increased
Overall: The project activities to promote the knowledge of key services and practices were a success for some services but disappointing for others. Communities were aware of the services provided at HCs and HPs, and the work that HEWs and vCHWs were doing in the community. This awareness was attributed mainly by the community mobilization performed by the trained HEWs and the vCHWs. The CS-23 project trained 109 HEWs and 1080 vCHWs in c-IMNCI, and provided job aids and counseling cards to support their community mobilization. To further support the vCHWs and HEWs, the CS-23 project recruited two Save the Children project field staff per district to support the community work and to allow for more intensive follow-up of c-IMNCI activities in communities. Key quantitative indicators of increased knowledge by community members are those of danger sign awareness. According to the KPC findings, the percentage of mothers who knew at least two signs of illness in older children increased from 51% at baseline to 74% at endline; but there was no change in awareness of neonatal danger signs (29% at baseline to 28% at endline). These findings clearly show that more work in improving neonatal care awareness is needed.

Challenges and recommendations: Gaps in awareness still remain especially with regard to newborn care. Future programs at scale should consider a special focus on implementation and monitoring of the newborn component. Possible strategies include additional training of HEWs and vCHWs, having more targeted supervision, and strengthening or expanding the use of pregnant women and mother-to-mother groups.

f. Contribution toward objectives
IR-4: Child health social and policy environment enabled
Save the Children has engaged in policy dialogue and advocacy at the international, national and regional/local levels in order to foster a positive policy environment.

At the international level, Save the Children advocates for CS programming and best practices. Health workers from Shebedino and the CS-23 project team were featured in a US-based
campaign for child and neonatal survival, sponsored by the Ad Council. This campaign aims to garner support and funding for MNCH services. An Italian donor group visited the project in 2010, and based on this successful visit supported Ethiopia’s EveryOne Campaign and implementation of a three-year MNCH project in three remote districts of Southern Ethiopia. Save the Children Korea also provided support to bridge gaps in the CS-23 project. This included renovation and equipping of HPs with delivery care equipment and procurement of furniture, motorbikes, ambulances and essential drugs and medical supplies. The CS-23 project also contributed to the development of the international iCCM benchmarks and indicators of implementation strength.

At the national level, Save the Children is a member of the National Child Survival and CCM Task Forces, and has presented experiences from CS-23 and other related projects. Much of this advocacy has focused on fostering policy change to permit the management of pneumonia with antibiotics at the community (HEW) level. In late 2009, the government of Ethiopia changed the HEP policy to allow pneumonia management with antibiotics in the community. This achievement in the policy environment was likely influenced, in combination with political and contextual factors, by a myriad of advocacy activities by many development partners, including Save the Children’s. This re-emphasizes the well-known fact that policy change takes time. Local evidence (including experience from CS-17 published during CS-23), demonstrates that strong and strategic partnerships, site visits, and persistent multi-channel advocacy collectively has a “big voice to reach big ears.” IMNCI at the HP level (CCM), including treatment of pneumonia, was introduced at-scale in Ethiopia through support from UNICEF. Save the Children was awarded a grant from UNICEF-Ethiopia to implement iCCM with pneumonia treatment in 100 districts in the Oromia [64] and SNNP [36] regions, including Shebedino District.

At the regional and local levels, Save the Children has a strong partnership with the regional and local health authorities and is a member of the Regional Child Survival Task Force. It also facilitated the formation of district-level Child Survival Task Forces. The CS-23 Program Manager and the Save the Children Health Unit Head have played a crucial role in the revision and development of national strategic documents and guidelines plus training materials in nutrition, IMNCI and iCCM.

g. Contribution toward objectives

Strategic Objective: Use of services

Table 2 (page 15 of this report), which is the M&E matrix, summarizes the overall utilization of services. In addition, according to HMIS records, by the end of 2011, 13,035 children under five had been treated with antimalarials (or 211 malaria/fever cases per 1000 under-fives); 8,200 were treated with antibiotics (133 pneumonia cases treated per 1000 U5s); 9,137 were treated with ORS of which 3,712 were treated with ORS + zinc (148 diarrheal cases 1000 under five) at either HCs or at HPs.

Based on the baseline and final KPCs, the following services were doubled during the project period or exceeded the set targets: 1) appropriate hand washing practices (28% to 60%); 2) increased fluid intake during diarrheal disease episode (20 to 59); 3) zinc therapy (7% to 34%); 4) immediate and exclusive breastfeeding of the newborn (62% to 93%); 5) exclusive
breastfeeding of infants 0-5 months old (3% to 29%); and 6) access to immunization (80% to 97%). However, the following services use was not markedly increased or performance was below the set target: 1) increased feeding during diarrheal disease episode (29% to 25%); 2) appropriate care seeking for pneumonia treatment (32 to 45%); 3) ITN use by child (40% to 39%); and 4) postnatal visit in the first three days (4% to 14%, target 30%). Thus, whereas use of some services increased (diarrhea management, breastfeeding, immunization services, others were quite low (pneumonia treatment, malaria prevention by using ITNs and newborn care services). An assessment of how HEW spend their time found that although they spend most of their time (Annex 1, Learning Brief 1) at the HP, they spend little time on CCM (2.7% of HP and 1.6% of total time).

Interpretation and recommendations: CS-23 staff investigated reasons for low utilization in Shebedino (Annex 1, Learning Brief 5) and found the following possible explanations: under-reporting (maltreated children registered in Outpatient Treatment Program but not in IMNCI Register, HEWs treating sick children during household visits without registers, high patient loads, and forgetfulness); Geographic and financial access barriers were common for services at HCs, but not at HPs – sometimes aggravated by seasonal harvest responsibilities and flooding; The technical quality of case management at all health facilities (especially at HCs) was not high: limited demand for evidence-based treatment due to: 1) lack of awareness of illness signs; 2) reliance on a variety of home treatments for multiple syndromes; 3) belief that illness is self-limited; 4) reluctance to bring young infants out of the home, fearing “evil eye” or shame; 5) preference for prayer or traditional healing and resorting to “western” care only if conditions worsened; 6) use of pharmacies or private clinics; and 7) lack of mothers’ autonomy to seek care outside the home if there is a financial implication.

Field visits during the FE in Lanfero found similar reasons. Strengthening both service supply and demand should increase utilization. Studying the behavioral determinants of a selected few recent adopters of prompt evidence-based treatment could help to refine and strengthen the demand strategy. Very few cases of neonatal illness were seen at HCs and few were seen at HPs. This evidence of appallingly low care seeking for newborns is likely related to low rates of assisted delivery and lack of awareness that health services are available for newborns. Lessons from the SNL research now being carried out in SNNPR and Oromiya Region could further inform efforts to scale-up care for sick newborn babies.

1. Contextual Factors
Contextual factors influence the implementation, sustainability and potential impact of the CS-23 project. Many of the implementation-related contextual factors have been discussed above. The contextual factors that might have positively influenced the CS-23 project included: 1) strong policy and program context – the project enhanced an already existing government system; 2) positive synergies with other projects present in Shebedino District, where local NGOs support maternal and neonatal health programming - Lanfero has few complementary health projects; and 3) the policy change to allow pneumonia management also was a timely shift that enabled HEWs to begin treating pneumonia. This motivated both the HEWs, the vCHWs and the communities as antibiotics were now available at HPs.
Contextual factors that might have negatively impacted the project included: 1) The rural nature of the districts, especially Lanfero, meant that access and care seeking were already low, and made program implementation more difficult; 2) Famine and malnutrition are common problems in the districts, especially in Lanfero-these not only affect the risk of childhood illnesses but also influence care seeking as families may be struggling to find food; 3) The lag in approving the pneumonia policy which allowed community pneumonia treatment delayed the introduction of this important intervention in the project areas; 4) Current policy does not allow neonatal sepsis management at the HEW level; this has constrained efforts to promote care for sick newborns. Merely assessing, counseling and referring is not attractive to either the HEWs nor the community members as referral is often impossible; 5) The availability and access to many drug shops and private clinics, especially in Shebedino, could have served as alternative points for accessing treatment. This would be especially helpful when the communities were unsatisfied with the care they were getting at the HPs (e.g. when a care giver preferred a certain treatment or drug that is not available at the HP). Yet these drug shops and HPs are not part of routine HMIS nor are they part of district/FMOH quality improvement projects; 6) The chronic lack of logistical resources for support activities—e.g., neither of the DHOs has a car, but they do have only one or two old motorbikes for all their activities. Unfortunately, the cost of petrol is often not included in the operating budget. These factors threaten the sustainability of progress at the close of project activities, constrain the day-to-day functioning of DHOs, and challenge the CS-23 project coordination with FMOH partners; and 7) Health staff in both districts have many competing demands on their time with many staff frequently absent from their posts to engage in other, sometimes non-health related activities.

2. **Role of Key Partners**
As discussed above, the FMOH at all levels is the main partner in project implementation. Other PVOs and multi-lateral agencies were also partners. The role of each project partner, the results of the collaboration and suggestions for improvements are presented in Table 3 below. As discussed above, the FMOH at all levels is the main partner in project implementation.

<table>
<thead>
<tr>
<th>Partners</th>
<th>Role in Project</th>
<th>Result of Overall Collaboration Activities/Suggestions for Improvements</th>
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| Regional Health Bureau and Zonal Health Offices | • Approval and support for CS-23 activities, particularly with HEWs and communities.  
• Participate in joint planning and progress review.  
• Lead and participate in CS Task Force and TAG meetings.  
• Participate in training activities and provide follow-up on service provision after training.  
• Conduct joint supportive supervision of HEWs periodically.  
• Ensure that HPs have essential supplies and medicines for maternal and child health. | Results:  
• Activities for building the capacity of HEWs and vCHWs have proceeded as planned.  
• Introduction of IMNCI supports and strategies have proceeded as planned.  
• High level of buy-in for IMNCI and CS activities.  
Suggestions for improvements:  
• Increase coordination and frequency of joint supportive supervision suggested.  
• Increase coordination on monitoring data and use of HMIS systems for CS interventions.  
• Develop jointly, a transition plan for the end of project. |
| Lanfero and Shebedino District Health Offices | | |

Table 3. CS-23 Ethiopia Key Partners
| Regional Bureau of Finance and Economic Development | • Appropriate distribution to HPs within the target area of any equipment donated and/or essential medicines. | • Oversee the overall coordination of the project at all levels in cooperation with DPPB, RHB and SC/US.  
• Perform midterm and terminal evaluation of the project according to GO-NGO guideline.  
• Link SC/US to relevant offices and institutions for securing supports needed in program. | • Strong collaboration to monitor the implementation of activities with all partners.  
• SC/US facilitated the midterm evaluation and covered all expenses.  
• Support letter to relevant offices to facilitate the implementation of project activities. |
| Population Services International in Ethiopia | • Provide orientation training for zinc treatment and provide initial stocks of zinc. | | • Introduction of zinc has proceeded as planned; no suggestions for improvement. |
| GOAL-Ethiopia | • Provide assistance for orientation training for zinc treatment.  
• Collaborate in sharing plans and results for CS programming. | | • GOAL staff have readily collaborated with SC, CS-23, sharing available information and experiences. |
| UNICEF | • Support iCCM kit and delivery kit for HPs to implement case management.  
• Monitor the implementation of IMNCI/iCCM in collaboration with FMOH/RHB. | | • iCCM kits and delivery kits supported HPs to deliver quality health services.  
• Integrated supportive supervision to give on-the-job training for HEWs, to improve IMNCI/iCCM services. |
| JSI/IFHP | • Developed IMNCI/iCCM registers and chart booklets in collaboration with FMOH/RHB.  
• Give IMNCI training for HWs and HEWs in collaboration with SC/US, DHO and RHB.  
• TOT training for SC/US CS staff to enable them to give training for HEWs. | | • IMNCI/iCCM registers and chart booklets distributed to all health facilities.  
• All HPs and HCs are implementing IMNCI/iCCM services and child health services improved.  
• CS health staffs able to give training for HEWs and contributed for quality improvement at HPs and HCs.  
• Knowledge and skill of the health workers and HEWs improved to save the life of children. |
| JSI/L10K | • Implementing iCCM activity in collaboration with DHO and CS-23 field staff.  
• Supportive supervision to update the knowledge and skill of HEWs. | | • All HPs and HCs are implementing IMNCI/iCCM activities.  
• Improved knowledge and skills of HEWs to manage cases at HP level. |
| Plan International | • Participated on baseline, midterm and final evaluation debriefing workshop to share experiences and to strengthen our partnership. | | • Participated on all debriefing workshops to adapt lessons learned from CS project to their organization. They have contributed to the generation of ideas during discussion.  
• Strengthened partnership. |
Malaria Consortium

- Participated on baseline, midterm and final evaluation debriefing workshops to share experiences and to strengthen our partnership.
- Participated on all debriefing workshops to adapt lessons learned from CS project to their organization. They have contributed to generate ideas during discussion.
- Strengthened partnership.

3. **Overall Design Factors that Influenced Results**

The CS-23 project’s choice to implement simultaneously all three components of IMNCI (clinical, community and health systems) at HCs and HPs for one of the first times in Ethiopia is commendable. This design serves as a model for future programming in caring for the sick child in the community in Ethiopia and beyond. This design is considered best practice to achieve results in improving access and utilization of sick child services, although it is rarely implemented in practice.

The newborn care technical component received less attention in design and implementation. The CS-23 project planned to train HEWs in management of sepsis and neonatal infections based on results and lessons learnt in an SNL-funded randomized control trial to be carried out in SNNPR and Oromia, but this activity was delayed and did not release its findings within the life of CS-23. Because of this delay and the need for stronger emphasis on the neonate in order to achieve the CS-23’s ultimate goal of impacts on under-five mortality, the project re-worked the original design and strategy for improving neonatal health by trying to strengthen postnatal visitation, recognition of danger signs, assessment at HPs and referral. However, as discussed before, success was limited. It is evident that changing long held cultural briefs, practices take time.

**a. Contribution to Global Learning**

The implementation of IMNCI at the HPs, especially with the addition of pneumonia management, is one of the first in the SNNPR and serves as a learning experience at the regional and national levels. Lanfero and Shebedino Districts are among the first in the country to introduce zinc treatment for management of diarrhea. The project also served as a pilot for developing the global iCCM indicators. CS-23 conducted formative research to assess and propose potential improvements to supervision within the HEP system; a full operational research proposal for HEP supervision strategies is under development. Project staff have also participated and presented the project experiences at international meetings and conferences.

Linking with USAID, MCHIP and ACCESS, strategies tested by MCHIP were further expanded by these projects to four additional districts in Malawi, and technical and training materials were shared and replicated more widely. The project also linked with Save the Children’s SNL global country programs. Experiences with implementation have been used to inform approaches to community-based newborn programming in other SNL countries. Finally, one peer reviewed article was published.

**b. Dissemination and information use**

In addition to the global learning activities described above, information about project activities and research findings have been disseminated using a number of mechanisms, including:

- Latest meetings, workshops, trainings and technical updates;
- Presentations at international and regional conferences and meetings;
• Local exchange study tours – staff visit other districts to observe local practices;
• International exchange study tours. Save the Children staff, the FMOH and partners visited the SEARCH project in India; and
• Program reports, technical documents, training material, facilitators guidelines, and health education materials; all have been available for review and use by the FMOH and other donors and partners.

A full list of project publications and presentations is presented in Annex 2. After the field work of the FE, preliminary findings and recommendations were presented to regional stakeholders in a half-day meeting. The CS-23 FE report will be shared with all stakeholders.

G. CONCLUSIONS AND RECOMMENDATIONS

Overall, the CS-23 project has successfully supported the implementation of the complete package of IMNCI in facilities and the community. Its activities have, and will, serve as a model for implementation of comparable initiatives in Ethiopia. The grant to Save the Children from UNICEF to implement IMNCI/iCCM in the community in 100 districts using a similar approach, is a good measure of the CS-23 project’s success. However, utilization of maternal, child and neonatal services remains a challenge. The project should build on its success in introducing and supporting IMNCI, as well as reinforcing capacity and relationships with the FMOH at all levels, in order to introduce and implement stronger strategies to improve neonatal health. In summary, the primary recommendations at endline include:

1. According to the regional and district partners, it is important to engage traditional and spiritual healers as they are still trusted by the community in the case of certain illnesses;
2. Strengthen the capacity of the districts to sustain regular integrated and clinical supervision for HCs, HPs and community volunteers;
3. Revise and distribute BCC materials to include key IMNCI messages;
4. Strengthen MNC with special focus on skilled and clean births, and care for both the well and sick newborn baby;
5. Strengthen HPs to be able to provide 24-hour services by ensuring that each HP has the recommended two HEWs and other key requirements such as solar/electricity and water;
6. In the long term, strengthen the pharmaceutical supply chain to ensure that HPs are adequately stocked with key commodities for IMNCI;
7. Strengthen both the demand and supply side to be able to effectively increase care seeking and treatment for pneumonia at HPs.
8. Expand iCCM to include treatment of the sick young infant at HP level; and
9. Save the Children should continue fostering a strong partnership at the local, regional and national levels to ensure that lessons learnt are scaled-up all over the country.

CS-23 Ethiopia, Final Evaluation Report, Save the Children, December 2012