



Implementation Evaluation of Integrated Community Case Management
of Common Childhood Illness (ICCM) Program in Soro Woreda,
Hadiya Zone Southern Ethiopia 2017

Evaluation Thesis submitted to: Institute of Health, Public Health
Faculty, Department of Health Economics, Management and Policy,
Health monitoring and Evaluation Post Graduate Unit

Principal evaluator: Sidamo Dunalo (BSc)

Jimma, Ethiopia

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Abstract

Background: *Integrated community case management of childhood illness (ICCM) is one of the important intervention to decrease the under-five morbidity and mortality at community level. Ethiopia is one of the country with highest under five mortality rate, 2016 Ethiopian Demographic and Health Survey key indicators report show that the under five children mortality rates are 67deaths per 1000 live births in 2016.*

Evaluation Objective: *To evaluate the implementation of ICCM program in soro woreda in 2017.*

Methods and Materials: *Case study design with quantitative and qualitative data collection employed with all selected health posts in soro woreda from March 01/2017 to March 28/2017. The evaluation dimensions were availability, compliance, and Acceptability. Data were collected with structured and semi -structured questionnaire. Quantitative data was entered in to epi-data and exported to SPSS version-20 and Bivariate and multivariate logistic regressions were done to determine the predictor of caregiver satisfaction. The qualitative data was analyzed manually using thematic analysis.*

Results: *All health posts have trained health extension workers, Guideline and both registration books had available. However essential drugs stock out were still main issue in majority health posts. In the case of compliance from those observed 69 cases 50(72.5%) were checked for general danger signs and 46(66.7%), 48(69.6%), 26(37.7%) and 59(85.5%) was correctly classified for pneumonia, diarrhea, malaria and malnutrition status according to national guidelines respectively. The overall judgment score of caregiver satisfaction fallen under category of GOOD in score of 70.95%.*

Conclusion and Recommendations: *the overall implementation of integrated community case management in selected health post was GOOD with the overall achievement in three dimensions' score was 74.54%. It is also recommended that, the woreda health office integrate with zonal health department and other partners timely solve essential drug shortage and Its also Woreda health office and health centers conduct only program specific regular supportive supervision and performance review meeting and health extension workers also improve chart booklet using habits for any assessment, classification, treatment and follow-up of sick under five children.*

Key word: *Integrated community case management, Health Extension Workers,*

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Acronyms and Abbreviations

CBNC	Community Based Newborn Care
CCM	Community Case Management of Common Childhood Illnesses
EDHS	Ethiopian Demographic and Health Survey
EA	Evaluability Assessment
EFY	Ethiopia Fiscal Years
FMOH	Federal Ministry of Health
HC	Health Centers
HEP	Health Extension Program
HEWs	Health Extension Workers
HP	Health Post
ICCM	Integrated Community Case Management of Common Childhood Illnesses
IMNCI	Integrated Management of Neonatal and Childhood Illness
IFHP	Integrated Family Health Program
ISS	Integrated Supportive Supervision
L10K	Last 10 Kilometers
MCH	Maternal and Child Health
MUAC	Mid Upper Arm Circumference
NGO	Non-Government Organization
ORS	Oral Rehydration Salts
OTP	Outpatient Therapeutic program
RDT	Rapid Diagnostics Test
RUTF	Ready to Use Therapeutic Foods
SNNPR	South Nation Nationalities People Region.
TOT	Training of Trainers
UNICEF	United Nations International Child Emergency Fund.
WHO World	Health Organization.

Operational Definitions

Availability: the availability of human, drugs, materials and infrastructure that used for ICCM services at health posts.

- ❖ Availability of human resource- Trained Health worker on ICCM program.
- ❖ Availability of materials - materials that used for ICCM services at health posts (family health card, OTP card, Timer; IEC materials and ORT corner materials, reporting and recording materials)

ORT corner: is the place that is used for management of some dehydrated children and it includes all management materials according to guideline.

Compliance: Is the way in which activities are performed and services are delivered to clients that meets the standards of the guidelines.

Correct assessment: Assessment agreed with ICCM guideline assessment algorithm, including asking caregivers, observing, testing for appetite, testing for RDT, checking for pitting edema and measuring for (MUAC, weight, height and temperature).

Correct classification: is the classification of specific common childhood illness (pneumonia, diarrhea, malaria and malnutrition) agreed with assessment of that illness according to guideline.

Correct treatment: Treatments agreed with ICCM guideline treatment algorithm, including correct dose, duration, and frequency.

Correct follow-up care: is provision of care on recommended date of appointment for specific common childhood illness (pneumonia, diarrhea, malaria and malnutrition) according to guideline.

General danger signs: during assessment or classification child shows one of the signs (not able to drink/breastfeed, vomits everything, has/had convulsions, and lethargy or unconscious) that are observed by caregiver and health extension worker.

Caregiver Satisfaction: This is caregiver' opinion/perception about the service readiness to provide, received the ICCM services. In this study the satisfaction level was used to measure the level of caregiver satisfaction on availability, compliance and acceptability.

Report timeliness: health post to health center ICCM reporting period. (between the day of months 20-26). **Report completeness:** From HP to HC reported data include all parts ICCM or each part of formal ICCM report form completed.

Chapter One

Introduction

1.1: Background

Integrated community case management (ICCM) is one of the global action to decrease the under-five mortality rate by two-thirds between 1990 and 2015, from 90/1000 death to 43/1000 death and reducing the rate by 53% percent in the world. It's also improve access to treatment of childhood illness and decrease the under-five morbidity and mortality at community level. This intervention also implemented by the World health organizations and different partners in world, aimed to improve implementation status of ICCM and reduce under-five morbidity and mortality among all under five children. (1, 2,3).

In Africa, ICCM as a key public health strategy to increase coverage of quality treatment services for children. But many countries are still in the early stages of their ICCM programs focusing on some parts of country, or implementation is not at national level. However, a few countries, like Senegal, the Democratic Republic of the Congo, Rwanda, Madagascar, and Niger, have begun to implement the approach on a national level management knowledge and skills.(4).

Integrated community case management of childhood illness (ICCM) is also one of the important intervention in Improve the health status of under five children. It's also promote positive family and community practices. One of the major intervention to improve clinical case of health extension workers to promote improved growth and development among under five children by health extension workers at a community level.(5, 6).

In Ethiopia, small number of conditions continue to account for the majority of deaths in under five children. The major cause of this under five children morbidity and mortality are from preventable or treatable disease, like diarrhea, pneumonia, malaria and malnutrition are commonly continued causes.(3). To address this problem integrated community case management childhood illness program (ICCM) is one of the intervention, which was developed by the World Health Organizations (WHO) and united nations children fund (UNICEF).Currently under the leadership of FMOH and RHBs, and strong partnership with development partners the program is on implementation.(5, 7, 8).

Integrated community case management (iCCM) has been an essential strategy to help for exposed and non-exposed children and it chances of receiving appropriate care when sick with main causes of children mortality like pneumonia, diarrhea malaria, malnutrition. It also integrates with different preventive interventions particularly immunization, community based nutrition, vitamin A and de-worming.(9, 10).

1.2: Statement of the problem

In the world malaria, pneumonia, diarrhea and malnutrition's remains a major under five health burden in many countries. In 1990s and before this years in the world under five mortality rates are higher than 90 deaths per 1000 live births. To address this problem the world health organization(WHO) and united nations children fund (UNICEF) have promoted the integrated community case management of childhood illness (ICCM) intervention in low and middle – income countries to effectively manage the most common causes of the under-five child morbidity and mortality an integrated manner at community levels.(2, 11).

Global, progress show that under five children mortality have dropped by two -thirds between 1900 and 2015.According to report from UNICE, in 2015, up to 99% of the global burden of common childhood illness like (pneumonia, diarrhea, malaria and malnutrition) mortality and morbidity occurs in developing countries. But still every day about 16,000 under five children continue to die in the world. It also showed that in sub Saharan Africa under five mortality rate are still high and reduced to86 deaths per 1000 live births in 2015. But trends are still not sufficiently to meet the target in sub Saharan Africa.(12-14).

Ethiopia is one of the country with highest under five mortality rate, United nation inters agency child mortality report, although shows Ethiopian under five mortality rate in 2013 reduced to 64 deaths per 1000 live births. Also from 2016 Ethiopian Demographic Health Survey (EDHS) key indicators report show that the mortality of under five children decreased from 88 death per 1000 live births in 2011 to 67deaths per 1000 live births in 2016.(13, 15).

Even though there is some improvement in under-five children mortality, the level of reduction differs by household income category, level of mother's education and place of residence. Evidences show that newborn condition, pneumonia, diarrhea and malaria with underlying under nutrition still kill 205,000 under five children each year in Ethiopia.(16).

In some HPs of Ethiopia, stock out of some drugs in health posts, supplies were not available according to the ICCM protocol, limited opening hours of health posts are some of the challenge in ICCM implementation. And a larger number of caregivers did not fully trust that a visit to the health post would not incur some direct costs for treatment. Due to this problems ICCM services used by community is low.(17-19).

The other challenges of ICCM implementation in Ethiopia was poor assessed of sick children for all general danger sign, common childhood illness not classified according to ICCM protocol and some HEWs have poor chart booklet using habit. In our country, only 34% of children with severe illness were correctly managed, 39% children receive correct treatment for diarrhea, 30% of children with suspected pneumonia receive an antibiotic and less than 20% of children with fever. It's also another study reports show that, only 2% of children were assessed for all general danger signs,56% children not assessed for any danger signs,75% for diarrhea and 88% for fever assessed and only 20% for caregivers return to HPs.(2, 18, 20).

Although the dissatisfaction of ICCM services in the country in general and SNNPR region in particular related to: lack of continuous and sufficient supplies of essential medicines at HPs, HEW doesn't give good treatment for under five children and they received medicines that were perceived as inappropriate are some sources of the HPs services dissatisfaction. It's also perceived negative interactions between HEWs and community, caregivers, children and not perceived quality services for sever case are factors that leading the appropriateness of health post services to low degree of trust and satisfaction. socioeconomic nature of the care givers especially maternal education and income level were factors for client's satisfaction. It's also poor integrated supportive supervision and performance review meeting on only ICCM program.(21, 22).

In soro woreda 2016 annual report show that, low coverage of ICCM services on common childhood illness like pneumonia, diarrhea and malaria which are 26%, 34% and 39% respectively. The reports also show that high number of malnutrition cases in woreda. The reason for these is poor linkage between HPs, HC and woreda health office, some Drug stock outs from health post, Weak referral linkage, some HEWs are gaps in skills and not conducted program specific supportive supervision are some reasons.(23).This implies that poor servicers in ICCM program.

The ICCM program implemented for long time but still, the resource status of ICCM services, the compliance of HEWs and satisfaction level of caregivers not yet known on ICCM implementation status in soro woreda. Based on this gap evaluating the program and identifying gap on program implementation is very important to provide information on program implementation limitation. Therefore, this study identified the possible problems of ICCM implementation, to identify implementation status of the program.

1.3: Significance of the study

The finding of this evaluation will be contributing on the improvement of ICCM program in soro woreda by identifying strength and weakness of the program implementation with how to sustain good achievement and how to address the weakness of ICCM services. The study finding also gives input information for program planner and implementers. On the other way, a learning media for a stakeholder on some aspect of evaluation process of ICCM services. It will also serve as a baseline for further studies. Finally, the findings of the study will be used by soro woreda health office to inform the health care providers in the woreda to improve the ICCM service delivery to the community.

Chapter Two: Program Description

Integrated Community Case Management (iCCM) is also one of the intervention used by trained HEWs to assess, classify, treat, counsel, and refer children with signs of infection. It has facilitated access and coverage by bringing services closer to the household, rather than waiting for caregivers to bring sick children to a health post. (7).

ICCM is one of the most powerful interventions to reduce morbidity and mortality of under five children by using appropriate treatment drugs like ORS and zinc, oral antibiotics, coarthem, chloroquine, RUTF, co-trimoxazole, Amoxicillin and paracetamol for common childhood like pneumonia, diarrhea, malaria and malnutrition at community level. (11).

2.1: Program stakeholders

Stakeholders are defined as “individuals, groups, or organizations that can affect or are affected by an evaluation process or its findings.” Key stakeholders are a subset of this group, but who is key, always be a judgment call and a matter for negotiation. Active involvement of stakeholders help to ensure the evaluation process goes more smoothly and ensures the evaluation findings to be used effectively. On the other hand, lack of active involvement of key program stakeholder’s results lack of cooperation in evaluation process and ignorance of evaluation findings.

Different stakeholders were actively involved in the implementation of integrated community case management of common childhood illness program in soro woreda. The Evaluability assessment conducted on ICCM tried to identify different stakeholders involved in implementation of ICCM.

Further stakeholder’s role in the program, perspectives in evaluation, role in evaluation and their level of importance were identified as presented in **Annex I**. The level of importance was decided based on the formal power of the program stakeholder.

2.2: Expected program goal and objectives

2.2.1: Program goal

- ❖ To contribute for the reduction of under-five children morbidity and mortality due to childhood illness in soro woreda.

2.2.2: Objective of ICCM program in soro woreda.

- ❖ To increase appropriate treatment for pneumonia, diarrhea, malaria and malnutrition from 26% ,34%,39% and 83 % to 83.6%. 84.5%, 86.2 and 91% respectively in under-five children in soro woreda.2016/2017.
- ❖ To ensure 90% of children with severe malaria, pneumonia and diarrhea, severely complicated malnutrition and newborns are promptly referred by HEWs to health center in soro woreda in 2016/2017.
- ❖ To achieve 90% reduction in morbidity in the common childhood diseases (malaria, pneumonia, diarrhea and malnutrition) in soro woreda in 2016/2017.
- ❖ To achieve 50% of reduction in mortality in the common childhood diseases (malaria, pneumonia diarrhea and malnutrition) in soro woreda in 2016/2017.
- ❖ To avail all necessary integrated community case management program resources consistently to all ICCM services provided health posts by the end of 2017.
- ❖ To increase access to case management of common childhood illnesses to 100% at the community level in soro woreda in 2016/2017.

2.3: Major strategies

The ICCM strategy includes three main components, which focuses on improving management skills of healthcare providers, the health system and family/community health practices.

To improve case management skills of healthcare providers (HEWs)

- Enhanced skill of the staff (woreda MCH, health extension worker and health center under five focal person) on ICCM procedures for under five children at the health post level.

- Promoting the accurate identification of childhood illnesses by on job training, ISS,
- Ensuring appropriate combined treatment of all major illnesses in HPs.
- Giving responsibility for trained health care providers on management childhood illness.

To Improving the health systems.

- Ensuring continuous and sustainable availability of the supply.
- Checking of the availability of supplies according to the national ICCM protocol in each health post.
- strengthens the counselling of caregivers.
- Ensuring quickly referral system for severely ill children.
- Ensuring availability of health extension workers at all health posts.
- Build continuous supportive supervision at each level.
- Make clear supervision findings quickly as much as possible by focusing on weakness side which will improved for the next visit
- Developing experience sharing among each health post.

Improving family and community health practices.

- Counseling of care givers and families as part of management of the sick child when they are brought to health post.
- Promoting healthy behaviors such as breastfeeding, illness recognition, early case seeking.
- Creating awareness among communities on their role through IEC materials distribution.
- Visiting home to provide an opportunity for identification of sickness and focused BCC for improving newborn and child care practices.
- Promoting appropriate care-seeking behaviors and
- Supporting the correct implementation of prescribed care.

2.4: Program activities and resources

2.4.1: Program components

Input

These are resources used in the program, it includes human, money, and information needed usually from outside the program to mount program activities effectively. The inputs for the implementation of ICCM program includes:

- ✚ Skilled health care provider
- ✚ Finance resource (budget)
- ✚ Medical equipment's (functional Ambu-bag, MUAC measuring tape, Thermometer, weighing scales and height measurement, functional timer)
- ✚ Infrastructure (health post, clean water and clean latrine)
- ✚ drugs (Amoxicillin, anti-malaria with RDT, folic acid, vitamin A, Deworming, zinc, ORS and plump nut).
- ✚ Guidelines, manuals, recording and reporting formats
- ✚ IEC/BCC materials

Activities of the program

These are the actions mounted by the program and its staff to achieve the desired outcomes in the target groups. The activities of the ICCM program includes: -

- ✚ Training for health care providers
- ✚ Giving health information for caregivers
- ✚ Assessing and classifying under-five years' children
- ✚ Testing RDT for febrile children
- ✚ Providing treatment for sick child
- ✚ Counseling care givers /mothers for food, fluid and when to return
- ✚ Establishing ORT corner
- ✚ Measuring weight and MUAC

- ✚ Admitting and discharging malnutrition child to/from OTP program based on pre-established criteria.
- ✚ Referring complicated cases to next level.
- ✚ Recording and reporting each activity.
- ✚ Conducting supportive supervision.
- ✚ Conducting review meeting.

Output of the program

Outputs are the direct products of activities, usually some sort of tangible deliverable. Outputs can be viewed as activities redefined in tangible or countable terms. They are usually the immediate results of using the program resources. The output of the ICCM program includes:

- ✚ Number of trained health care providers.
- ✚ Number of people received health information
- ✚ Number of children assessed and classified and treated
- ✚ Number of children tested for malaria
- ✚ Number of children received follow up.
- ✚ Number of children checked for Vitamin A, deworming and immunization status.
- ✚ No. of caregivers counseled for food, fluid and when to return back for follow-up
- ✚ Number of health post with functional ORT corner.
- ✚ Number of children with complication case who are referred.
- ✚ Number of HP participated in review meeting
- ✚ Number of HP received ISS
- ✚ Number of HPs sent on time reports to next responsible body

Outcome of the program

Outcomes are the changes in someone (other than the program and its staff) that you hope will result from your program's activities. It is the effect of the program on the target beneficiaries. The outcome of the ICCM includes:

- ✚ Increase health seeking behavior
- ✚ Improve quality of health services
- ✚ Increase utilization of services
- ✚ Improved data quality and information use
- ✚ Improve child health condition

Impact of the program

Impact of the program is usually long term effect of the program. The impact of the ICCM program includes:

To contribute for the reduction of morbidity and mortality of under five children

2.5: program logic model

Statement of the problem: Common Childhood illness like pneumonia, diarrhea, malaria and malnutrition are still under five child mortality problem in Ethiopia. ICCM is one of interventions in the country, however, poor management of supplies, incomplete availability of all supplies according to the ICCM protocol, poor management of sick children and interruption of supply delivery to the HP were the main encountered operational problems.

GOAL: To contribute for reducing under five children mortality and morbidity due to major causes of diseases in soro woreda by 2017.

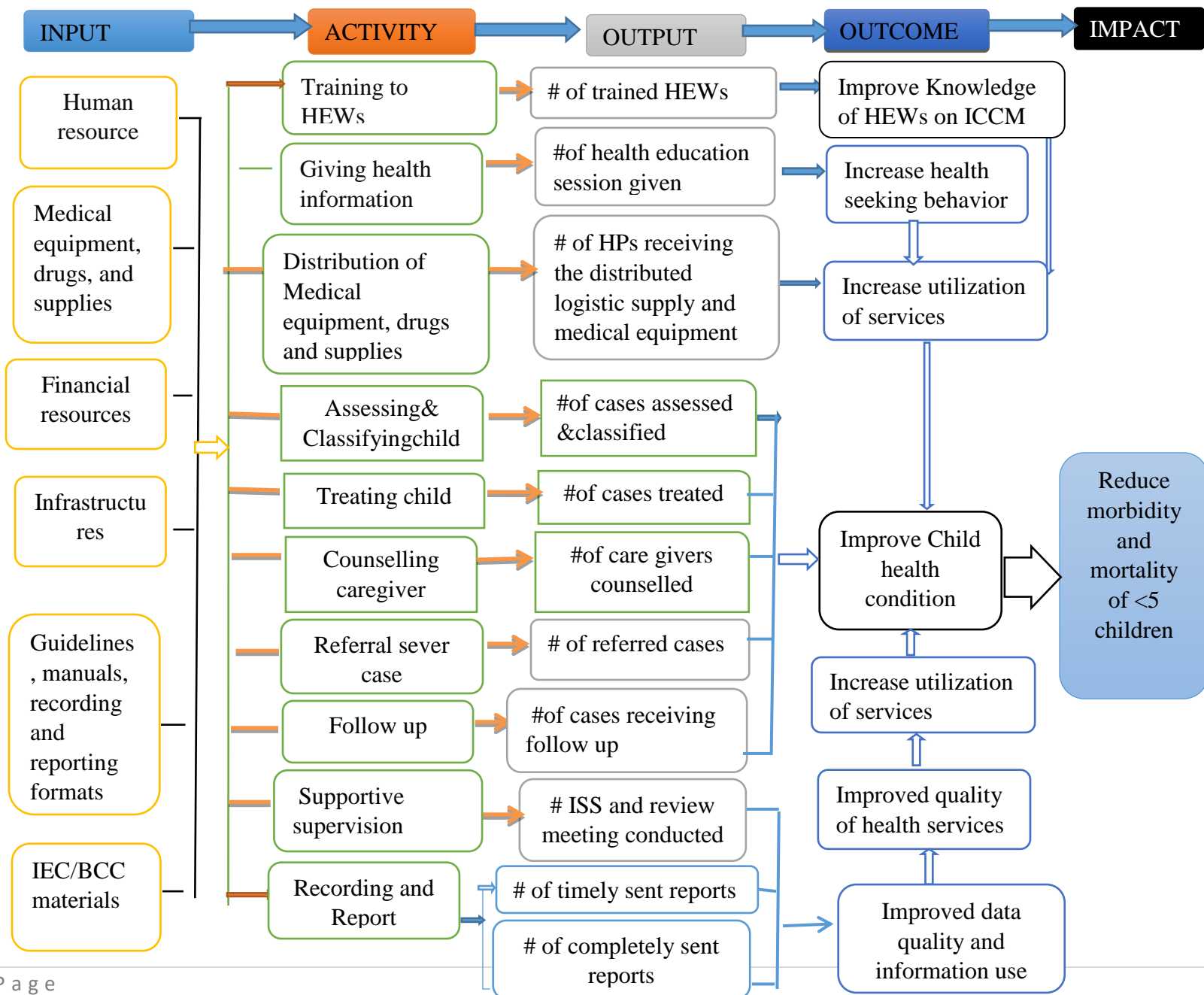


Figure 1::Integrated community case management of childhood illness program logic model in soro woreda health posts in 2017.

2.6. Stage of program development

The integrated community case management of childhood illness (ICCM) intervention established in 1990s by world health organization(WHO) and united nations children fund (UNICEF) for effective management of the causes of under-five child morbidity and mortality at community levels. Expands to different low and middle – income countries, for sustained reduction of child mortality.(2, 10).

In Ethiopia health extension program was introduced in 2004 mainly focused on preventive and promotive parts of HEPs, and a limited number of high-impact curative interventions. In order to address the main causes of child morbidity and mortality Ethiopia was planning to expand curative interventions by integrating to HEPs. ICCM was one of planned curative intervention at nationally level and officially launched In February 23, 2010.(5, 6).

SNNPR regional health bureau collaborate with different developmental partners started ICCM implementation in Shebedino woredas (sidama zone) and Lanfero woredas (silte zone). After mid-term evaluation expand to all zones and special woredas by giving TOT to all zone and special woredas. Hadiya zone started ICCM training for woreda health office expertise, health institutions professionals, health extension supervisors and HEWs step by step in February 2011.(19). After training Soro woreda health office in collaboration with Integrated Family Health Program (IFHP) started the implementation of ICCM program in July 2011. Currently in all 46-rural health posts of soro woreda the ICCM program is at implementation stage.

Chapter Three: Review of Related Literatures

The Integrated community case management of Childhood Illness (ICCM) is one of the interventions to provide clinical care for common childhood illness in community and reduce under-five morbidity and mortality. It was officially launched at the First IMCI Global Review and Coordination Meeting in September 1997. It is also supported by WHO, UNICEF, others different partners for training different health workers, supporting drugs and supplies and to implement program specially in sub-Saharan Africa. (1, 2).

Evaluation conducted in developing country indicates that lack of trained man power, incomplete availability of essential drugs and supplies and some child are not correctly assessed, classification, treated of children, counselling of caregivers and follow up child for childhood illness. Additionally, the study by Hamer DH. in sub-Saharan Africa shows that weak relationship between HEWs and community, health workers (HEWs) and child, not perceived quality drugs, limited absence of health workers from work place and the distance of health facilities some of the negative view for inappropriateness of ICCM services at rural health facility. (24, 25).

Availability of ICCM program resources

The institutional assessment conducted by Ethiopian public health institute in all regions and two administrative cities of Ethiopia, the survey indicates that 60% of HPs had children scale, 39% HPs had also infant scale, 76% of HPs had thermometer, 91% of HPs had Timer and 74% of HPs had Tape for measuring MUAC were available in rural health posts. Also, the study shows as the essential medicines and supplies were not available according to the ICCM protocol and the availability of ORS, Amoxicillin, Paracetamol, Vitamin A, Mebendazole/Albendazole and zinc were 91%, 23%, 16%, 70%, 66% and 37% respectively. (20).

The study conducted in Ethiopia on implementation of ICCM shows that the supply of ICCM medicines are a major concern in the country. It's also low level of product availability at the health post level for products like Zinc salts, Cotrimoxazole and amoxicillin tablet and incomplete availability of anti-malarial drugs and RDTs at health posts level. (26, 27).

Another survey conducted in the country level at health facility, equipment, supplies and medicines available assessed in community based new born care. The survey report shows that 90% HPs had ICCM registration books, 65% of HPs had also chart booklet, 80% of HPs had family folders, 68% HPs had a digital thermometer, only 35% HPs had a clock and only 13% had piped water. (28).

The study conducted in SNNPR for Enhancing Ethiopia's health extension workers package shows that more than 80% HPs had supplies of ICCM (like height scale, thermometers, weight scale, timer, ORT corner to administer ORS, ICCM registration, guidelines and reference manuals for giving ICCM services. Its also 84% HPs had ICCM trained Hews, 91% HPs had zinc, all HPs had ORS and Chloroquine and only 18% HPs are ACTs during the study periods. (19).

Similar study conducted on three zone (Gurage, Sidama and Woliyta zone) of SNNPR selected health posts on the community based new born implementation. The survey reports show as 14%HPs had pure water, 81% HPs Family health cards, 95% HPs are 0-2 months, 95% HPs also 2-59 months ICCM registration book and 81% HPs Chart booklet available. It is also 67% HPs Thermometer and 57% HPs clocks available. From the Medicine 91%, 12% 45% 50% and 53% HPs had Iron, Amoxicillin tab, TTC eye ointment, Vitamin A 200,000 IU and Vitamin A 100,000 IU drug availability at survey conducted HPs.(28).

The study that was done in three regions of Ethiopia (Amhara, Tigray and SNNPR) on the ICCM implementation indicated that nearly all HEWs received training, in 87% of health posts received at least one supervision visit related to iCCM in the previous 3months and 85% HPs had two or more HEWs and 82% of HEWs are contacted home in the last three months. (29).

Compliance of HEWs

According to WHO/UNICEF joint statement on ICCM implementation, the current treatment levels of under five children are very low in developing country: only 30% of children with suspected pneumonia receive an antibiotic, only 39% of children receive correct treatment for diarrhea and less than 20% of children with fever in sub-Saharan Africa testing for malaria checkup.(2).

The study conducted by Ethiopian public health institute in all regions and two administrative cities of Ethiopia on institutional assessment survey show that, only 2% of children were assessed for all general danger signs, 20% for inability to eat or drink or breastfeed, 40% for vomiting everything, 2% the sick children for convulsions assessed and 56% children not assessed for any danger signs during observed conducted in health posts. In this study the observation results for assessment of main symptom shows that 84% children cough or difficulty breathing, 75% for diarrhea and 88% for fever assessed. It's also 18% for giving extra fluids child, 36% for continue feeding of child and 20% for caregivers return to HPs advice.(20).

The study conducted to assess the implementation strength and quality of care of ICCM program in Ethiopia indicates that 81% of children was assessed for the presence of cough, diarrhea, fever, and malnutrition, 62% children were assessed for all four general danger signs and 72% of children for pneumonia,79% of children for diarrhea, and 59% of children for malnutrition are correctly managed respectively. Only 34% of children for severe illness are received correct managed by HEWs according to protocol and 54% of children needing referral to a health center.(26).

Under the ICCM, according to the guideline, children need to correctly assess, classify, treat medicine and follow up together with counseling of care givers. The study that was done to assess the implementation status of ICCM program in Jimma and west Hararghe zone, Oromia region shows that 36% of sick children were not received correct treatment for all ICCM illnesses, many children needing a routine vitamin A supplement or Mebendazole receiving, most care givers were not told about danger signs.(30).

Acceptability /satisfaction of caregiver/

From study conducted in rural Ethiopia on the scale up of ICCM service shows that, the perceived negative interactions between HEWs and caregivers and not perceived quality drugs and services for sever case are factors that leading the appropriateness of health post services to low degree of trust and satisfaction. Additionally, the study showed that the majority of caregivers interviewed had not satisfied or negative views; due to HEWs sometimes absences from health posts and doesn't give good treatment for under five children and they received medicines that were perceived as inappropriate are some sources of the HPs services dissatisfaction. (21).

According to institutional survey conducted by Ethiopian public health institute in all regions and two administrative cities of Ethiopia caregivers exit interview in rural health posts indicates that 9% of caregivers were not satisfied on explanation of child's illness, unavailability of medicines, waiting time and discuss with provider and only 2% of caregivers not satisfied on health post openings time. (20).

From study conducted on implementation of ICCM program in Amhara, SNNP, and Tigray regions indicates that most of care givers know for iCCM services exist their kebele, 80% of them know that health posts provide treatment for febrile conditions, 64% of them know HEWs treated diarrhea, and 55% know HEWs treated ARI symptoms. Only 9% and 2.3% of respondents know that weight loss and skin rash conditions, respectively, were treated at the health post.(29).

The study conducted on care seeking for common childhood illness in the management context of ICCM scale up in rural Ethiopia indicates that 20.7% of health post not opened at work times, 18.7% of caregivers said that drugs were not available at health posts for child and 15% of caregivers from interviewed said that poor services by HEWs of ICCM services.(21).

A study conducted to assess Client satisfaction with integrated community case management program in Wakiso District, Uganda indicated that overall, 80% care givers of children were satisfied with integrated community case management. In wakiso district at multivariable level primary educational level was statistically significant with client satisfactions at AOR=2.8, 95% CI= 1.124, 6.804 p-value 0.02.(31).

Regarding to the study conducted on community case management of malaria and pneumonia in children by the department of public health services, division of global health shows as 88.9% children administered drugs based on the test results, from this 72.5% of children in Ghana, 86.5% in Burkina Faso and 98.3% in Uganda were administered with antibiotics for a high respiratory rates. In this study from interviewed caregivers 60% of them said that the services given by community health worker were better and 90% of caregiver who visit health facility with afebrile illness child in three months administered based on the RDT test. (32).

The study conducted on satisfaction and associated factors in Wolayita shows as 64.3% of clients were satisfied on prescribed drugs (AOR= 0.44, CI=0.25,0.76) and 60% of clients were satisfied on waiting area. Regarding to consultation or examination room privacy 85.5% of respondents

said that adequate privacy during consultation time (AOR=4.08, CI=2.08,8.01) and 68.7% providers told illness of clients. (33).

The study conducted on availability of medicines for the management of childhood illnesses in central uganda the overall findings of the study shows as 33% of the health facility not effectively ICCM drugs treated or prscribed /not all ICCM drugs/ AOR=3.32, 95%,CI=1.33, 8.32. (34).

Another study conducted on prscription of drugs in uganda indicates that 50% of caregivers were satisfied with the availability of drugs/prscription of drugs on ICCM services, (AOR=1.052, 95%, CI= 0.733, 1.513). (35).

Conceptual framework shows that association between dependent variable of caregiver satisfaction on ICCM service with different independent variables which associate with caregiver satisfaction. In this study ICCM service improvement which have direct association with caregiver satisfaction was not studied.

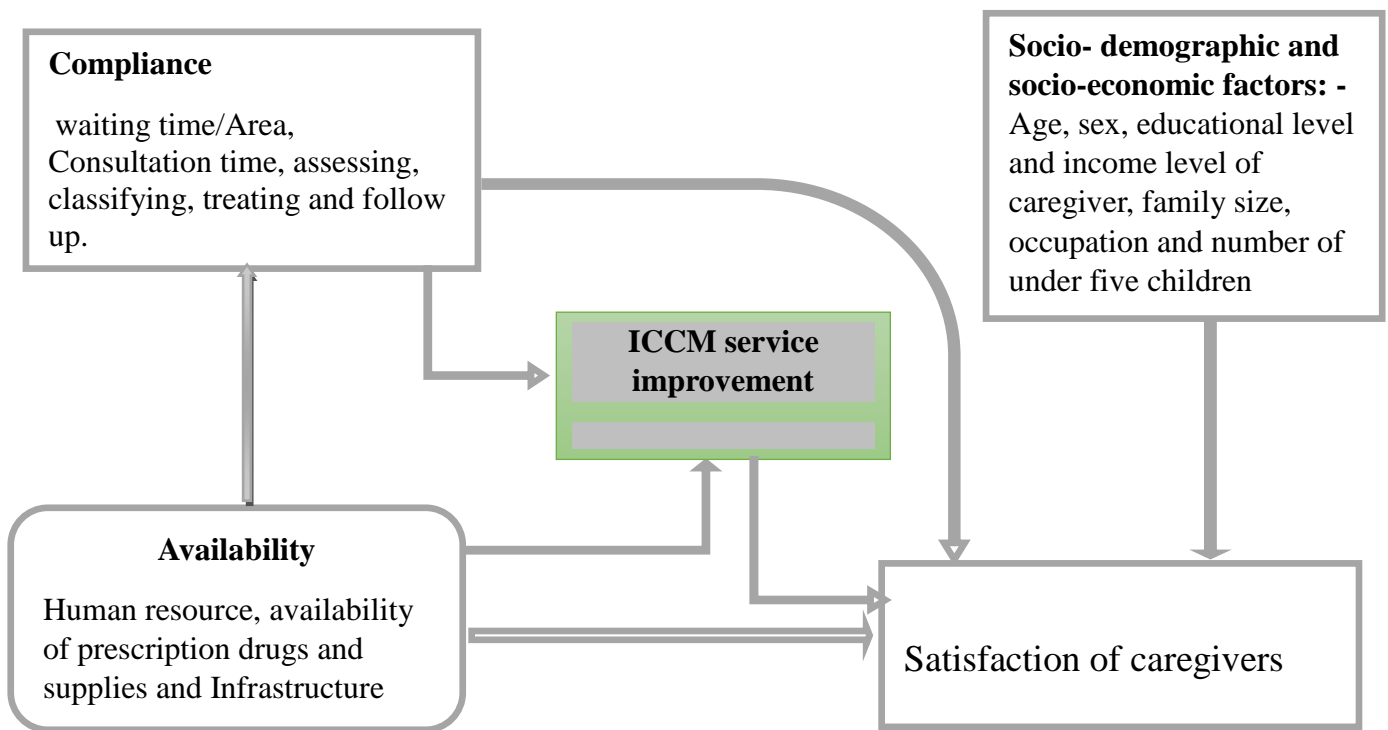


Figure 2: Conceptual framework to evaluate ICCM implementation at selected health posts of soro woreda, 2017. adapted from (29, 36,45).

Chapter Four: Evaluation Question and objectives

4.1: Evaluation Questions

General evaluation Questions

Are ICCM services implemented as intended? If no, why?

Specific evaluation Questions

- Are all necessary program resources needed for the implementation of ICCM service available? If no, why?
- Is the program implemented with congruence to the national ICCM implementation guideline? If not, why?
- Are caregivers satisfied with ICCM service provided?

4.2: Evaluation objectives

4.2.1: General objective

- To evaluate the implementation of ICCM program in soro woreda, 2017.

4.2.2: Specific objectives

- To assess the availability of resources needed for implementation of ICCM program in Soro Woreda.
- To assess the compliance of HEWs with the national ICCM implementation guideline in soro woreda.
- To determine the level of caregiver's satisfaction on ICCM services provided in soro woreda.
- To identify factors that affect caregivers 'satisfaction with ICCM services.

5.2: Evaluation approach

Formative Evaluation approach is process oriented and involves a systematic collection of information to assist decision-makers during planning or implementation stages of a program and often it begins during program development and continues throughout the life of the program. It uses evaluation methods to improve the way a program was delivered. ICCM program in soroworeda was ongoing and implementation stage. So, for this study formative evaluation approach was used to provide the program managers for program improvement in order to achieve their goal.

5.3: Evaluation design

Single Case study design using both quantitative and qualitative data was conducted. The reason for choosing a case study is that, this evaluation was used to get deep understanding, extensive and explorative reports of what has happened over time with in the program and it exploratory quality of the implementation of the program under evaluation. So, this can be better being answered with a case study than other designs. Moreover, case studies allow us to build a sound hypothesis about the relationships between interventions and their context. And also; the case study design helps to answer the evaluation questions by digging data retrospectively.(37).

Taking into consideration all above advantages of a case study and the information that we need to get from the program in order to assess the process of the program.

5.4: Focus of evaluation and dimensions

5.4.1: Focus of evaluation

It is a process evaluation focus on ICCM programs' implementation theory components (program inputs, activities, and output, proximal outcome of caregiver satisfaction on ICCM). It also used to assess whether input or resources were allocated or mobilized and whether activities are implemented as planned on ICCM program.

5.4.2: Evaluation Dimensions

This evaluation was assessed the availability, compliance and acceptability dimensions of ICCM program.

Availability: the relationship of the volume and type of existing services to the clients' volume and types of needs. These dimensions were used to assess availability of the supplies, health care providers and service delivering infrastructures for implementation of ICCM program.(38).

Compliance: these dimensions was also assessed the implementation of ICCM program according to the standard or with the best practice or a state of being in accordance with the established guidelines and implementation in caregiver's perspective will be measured.(39).

Acceptability: the state of being satisfied by caregivers in their perspective about the ICCM service they received.(39). It is important to examine how the caregivers views the services so that the immediate outcome of the service was evaluated proximally because the satisfied caregivers are more likely to adhere to the services so that services utilization was increase.

5.5: Indicators and Variables

5.5.1: Indicators of evaluation

A total of 43 indicators was used under 3 dimensions of evaluation from these 17 for availability, 15 for compliance and 11 for satisfaction. The indicator sets were agreed upon by major stakeholders for measuring the implementation of the program and constructing criteria that was used to judge the program's level of implementation during EA. (**Annex II**).

5.5.2: Variables

Dependent Variable

- ↻ Care givers satisfaction

Independent Variable

- ↻ Age of care givers
- ↻ Sex of care givers
- ↻ Religion
- ↻ Consultation time
- ↻ Waiting time
- ↻ Educational status
- ↻ income level
- ↻ family size
- ↻ number of children
- ↻ occupation/role
- ↻ telling child illness
- ↻ Availability of prescription drugs

5.6: Population and sampling

5.6.1: Source population

All under five children treated for childhood illness, all HP providing ICCM Services, caregiver for treated children, HEW who provide the service in health posts, all health center heads and maternal and child health coordinator in the woreda and woreda health office heads.

5.6.2: Study population

Selected health posts providing ICCM services in soro woreda, Health extension workers in selected Health posts in the woreda, Sampled caregivers in selected health posts in soro woreda. Selected heads of health centers in the woreda, MCH coordinators in Woreda health offices, woreda health office head and ICCM registration book in selected health posts.

5.6.3: Sampling units

Selected health posts, health center, woreda health offices and caregivers who come with sick under five children was a sampling units.

5.6.4: Study units

ICCM registration and caregivers for sick children, selected health extension worker's, health center heads, woreda health office MCH coordinator and woreda health offices head.

5.6.4: Sample size determination

In soro woreda, there are nine health centers and these health centers encompass 46 rural health posts. WHO rule of thumb recommended for the determination of the sample size should also be taken into consideration.(40). For this evaluation from total 46 HPs 50% of total HPs or 23 HPs were selected by simple random sampling of lottery method.

Sample size for document review

All under- five children registered on ICCM register and reports in selected health posts from June 01/2016 to Dec. 30/2016 were included in the evaluation due to resource shortage and limited time.

Sample size determination for direct observation

From selected health posts Five ICCM cases per HEWs were observed to evaluate compliance dimension by checking the guidelines.(41). During observation, the first Two cases was dropped to protect or minimize Hawthorne effect. So, a total of 115 direct observation of ICCM cases were observed.

Sample size determination for exit interview

Single population proportion formula was used to compute the sample size for exit interview, by taking prevalence of satisfaction of ICCM service implementation $p=50\%$ because there was no previously similar study done on satisfaction of care givers on ICCM and standard error was considered to be $d=0.05$ at 95% confidence interval. So, the sample size was used.

$$n = (Z\alpha/2)^2 p (1-p)/d^2$$

$$n = (1.96)^2 0.5 (0.5)/ (0.05)^2$$

$n = 3.84 * 0.5 * 0.5 / 0.0025$ $n = 0.96 / 0.0025 = 384$, by adding 10% contingency 423 sample size were allocated. So, in this evaluation totally, 384 exit interview was conducted.

Key informant interview

Respondents were selected purposively from woreda health office, selected health center heads, and from selected health posts one health extension workers were interviewed. So, totally, 30 key informants were interviewed.

5.6.5: Sampling Procedure/technique

Sampling procedure for exit interview with caregivers

After including all Selected health posts in the sampling process, 423 samples were allocated for each HPs based on 2016 Six-month client flow from ICCM reports. Conveniently the first client was selected and the data collection process continued until end of required sample size attained.

Table 1::Sampling procedure of selecting caregiver for exit interview on ICCM at soro woreda 2017.

s. no	Selected Health Post	Total population	Under five children	Total ICCM cases treated in HP from June - Dec.2016	Allocated sample size
1	Sigeda	4170	650	134	17
2	1 st Hankota	3938	614	142	18
3	Harche	6380	995	186	23
4	1 st odda	5118	798	141	17
5	1 st Banara	5008	781	156	19
6	Bambo	4553	710	128	16
7	Wosheba	7058	1101	163	20
8	Hanged	6413	1000	154	19
9	Danatora	6889	1074	192	24
10	Kecha	8471	1321	205	25
11	1 st Jajura	4494	701	156	19
12	2 nd Jajura	3552	554	132	16
13	Sundusa	5511	860	141	17
14	1 st akama	5705	890	112	14
15	Eile	4867	759	172	22
16	Gegana	3870	604	144	18
17	Shera	6542	1020	168	21
18	Jocho PA	2519	393	92	11
19	k/buya	4325	675	164	20
20	Chacho	4327	675	152	19
21	Bona	2708	422	140	17
22	Hahora	4926	768	121	15
23	Sibiya	5931	925	124	16
Total		117275	18295	3419	423

Sampling for direct observation

An observation was assessed the compliance of health extension workers through observing 115 sick under-five children while HEWs provide ICCM services. Five ICCM cases per HEWs attending selected health posts during data collection period were observed. During observation, the first Two cases were dropped to protect or minimize Hawthorne effect. HEWs selected conveniently who available and provide services during data collection period.

Sampling procedure for document review

All under- five children registered on ICCM register and report in selected health posts from June 01/2016 to Dec. 30/2016 was reviewed in the evaluation due to shortage of resources and limited times.

Sampling procedure for Resource inventory

All randomly selected health posts were included to assess availability of program resources (test kits, drugs, guidelines, bin cars, stock cars, reports and supplies) and infrastructures like water supply availability by using resource inventory check list.

Key informant interview

Woreda health office, each selected HC heads, and HEWs who assigned as coordinator of HPs was selected purposively to collect sufficient and relevant information which is related to ICCM program.

5.6.6: Inclusion and Exclusion criteria

Inclusion criteria

- Key informants who worked in the program at least one year, to get sufficient information about the program.

Exclusion criteria

- Care givers of less than 18 years
- seriously ill children during study period was excluded.

5.7. Data collection

5.7.1. Development of data collection tools

A structured and semi- structured Tools were developed by reviewing national ICCM guideline, standard ICCM tools, national ICCM evaluation indicators and check lists; it was comprising of the following components:

Document review template: - semi-structured checklist was developed by referring ICCM registration and different national guidelines. The template comprised of components such as general information, information during classification, information on treatment, follow up, and information during referral.

Resource inventory checklist: - structured resource inventory checklist was developed by referring the resources that was listed in national ICCM guideline. It is an inventory tool containing four Parts- Infrastructure, human resource, ICCM drugs and supplies and logistics (guidelines, recording and reporting tools).

An observation checklist: - structured observation checklist was used to assess the compliance of health extension worker while delivering ICCM service. The check list was developed from national ICCM guideline and ICCM evaluation tools and checklist.

Key informant interview- semi-structured guide line was used comprised of components such as background characteristics of the respondent; training and preparation; service organization and delivery; barriers to availability of program resources from the perspective of health care managers and health extension workers and recommended solutions. The tool was developed from different literatures and guideline related to ICCM program.

Exit interview questionnaire: -Structured questionnaire were developed by referring different literatures and standard ICCM tool, it was comprising of the following components: Socio-demographic characteristics of care givers and children, institutional factors, satisfaction of care givers on different components of service. The questionnaire for the client exit interview was translated into Amharic language.

5.7.2. Data collectors

Data collectors were selected from health professionals who have trained on ICCM/IMNCI program and with previous experience in data collection. For document review a total of three clinical diploma nurses, for direct observation Three BSc nurses and for exit interview a total of Seven diploma nurses were selected from out of the evaluation area to avoid inter observer bias. In-depth interview and Resource inventory were conducted in all selected HPs by principal evaluators. Finally, for overall supervision Three BSc were selected.

5.7.3: data collection field work

Document Review: - In the data collection periods from March 01/2017 to march 28/2017 ICCM registers and reports were reviewed by data collectors. The registers were reviewed consecutively from March 01/2016 to February 30/2017.

Exit interview; - It was conducted after each child received ICCM services at health posts i.e.in their exit from service.

Direct observation: -The observations were conducted during health extension workers deliver ICCM services. Before conducting the observation, the data collectors were received consent from both the health extension worker and care providers.

Resource inventory: -This was conducted by principal evaluators by communicating the convenient time to HEWs. During inventory standards of listed resources was crosschecked with the developed checklist for the period of three months.

Key informant interview: -principal evaluators were communicating the convenient time to the respondents. The interview was conducted at health facilities (Woreda health offices, Health centers and Health posts).

5.7.4: Data quality control

Quality assurance techniques for quantitative data

Quality control prior to data collection

Training was given to the data collectors. This also included holding discussion about different sections of the questionnaire, using question by question description of the questionnaire. Data was collected by data collectors after reaching the understanding on the questionnaire. The questioners of exit interview were pre-tested in 5%(in 21 caregivers) of sample size were used for pretest in outside the study area (in Orcha, 2ndselfe and shano HPs).

For qualitative data assurance member checked and peer examination conducted.

Quality control during data collection

During data collection filled questionnaires was checked for completeness and consistency of information by the supervisor on daily basis and typing errors was manually edited. Supervision and technical support for data collectors.

Data quality control techniques for qualitative data

Before data collection training was given to the data collectors. During data collection data collectors, were tells them the purpose of interview and getting permission. Before data collection confidentiality issues, were discussed with all interviewers

5.8: Data management and analysis

5.8.1: data entry

The questionnaires were checked for consistency and completeness after data collection by principal evaluator together with data collectors and supervisors; Quantitative data were entered every day night with Epi-data version 3.1 and finally export to SPSS version 20 for analysis.

5.8.2: Data cleaning

The data cleaning was done by principal investigator at field level and after entry to check for coding error and missing values. Some errors which occurred during data collection was removed and the completeness of data checked daily. Additionally, the data was cleaned by visualizing, calculating frequencies and sorting. The questionnaires and the soft copy of the data with multiple backups were kept in proper places.

5.8.3: Data analysis

Descriptive statistics (univariate analysis) was used to determine frequency, mean and proportions of variables. Binary logistic regression was used to identify candidate variable for multivariable analysis and those variables which showed statistical significant value (P -value <0.25) was taken to Multivariable analysis. Multivariate analysis was employed to identify predictors of outcome of interest for the program. In all cases, statistical significant value was considered at cut-off point of 0.05 within 95% Confidence interval.

To check reliability of the satisfaction tool using data obtained from pre-test which has internally reliable (Cronbach's Alpha based on items was 0.848). Satisfaction was rated by 11 items each having five point Likert scale from strongly Dissatisfied (1) to strongly satisfied (5) for analysis, each satisfaction item that was analyzed for their frequency (univariate). Caregivers was categorized as not satisfied (if they score below the mean) or satisfied (if they score \geq to the

mean satisfaction score). The Mean cut point was calculated by using mean score formula. (by adding five point Likert scale/five) or $(1+2+3+4+5)/5 = 3$ mean of each item,(42). In this evaluation level of satisfaction of caregiver total score of each respondent was measured by 11 satisfaction items, the cutoff point was 33, which is obtained by multiplying the total items with mean of the score (i.e. $11 \times 3 = 33$); and sum of satisfaction was dichotomized based on the cutoff point.

Qualitative responses were written with field notes and analyzed manually. The responses that obtained from interviews were coded thematized and, categories each response.

Finally, findings of quantitative data were presented using tables and diagrams, whereas qualitative data were described in narrative form using text.

5.9: Matrix of analysis and judgment

The overall Matrix of analysis and judgement, presented under table2, shows the standards, weight of indicator and evaluation rate, set by stakeholders from woreda health office (health office heads, MCH coordinator, ICCM focal), Save the children focal person at soro woreda and ICCM trained HC heads after the draft on the indicators and dimensions are set by principal investigator from ICCM guideline, each dimension is weighted by the stakeholders by nominal group technique method to reach an agreement for implementation of ICCM services in soro woreda public health posts.

Table 2: The overall judgment and weight given for each evaluation dimension used for evaluation of Implementation of ICCM program in soro woreda 2017.

Dimensions	Weight given	Observed value %	Score	Values	Implementation level	Findings
Availability	35%			[90 –100]	Very good	
				[71 – 89]	Good	
				[56-70]	Fair	
				[< =55]	Poor	
Compliance	40%			[85 –100]	Very good	
				[70 – 84]	Good	
				[55-69]	Fair	
				[< =54]	Poor	
Acceptability	25%			[80 –100]	Very good	
				[65 – 79]	Good	
				[51-64]	Fair	
				[< =50]	Poor	
Overall judgment	100%			[85 –100]	Very good	
				[70 – 84]	Good	
				[55-69]	Fair	
				[< =54]	Poor	

5.10: Ethical clearance

Ethical clearance was obtained from Jimma University Institute of Health, Ethical Review committee. Permission letter was received from soro woreda health office by introducing the importance of evaluation to the woreda make it full sentence. Finally, the objective of the evaluation was discussed with health centre heads, health extension workers including, data collectors, and time of data collection and period of data collection. Confidentiality of the information given was maintained throughout the process of data collection. Evaluation were designed to assist the organization, to address and effectively serve the need of full range of targeted participants.

All data collection was conducted after receiving oral consent from participants and health extension workers.

5.11: Evaluation finding dissemination plan

Dissemination of findings is important step in the evaluation process because stakeholders should use the evaluation findings timely to take corrective action. The final evaluation report will be presented to Jimma University. The evaluation findings will be communicated on one day discussion with program managers, health extension worker and different stakeholders. In addition, hard and electronic copies of the final report will be disseminated to stakeholders. Finally, effort will be made to present in various seminars and workshops and for publication in national or international journals

Chapter Six: Results

6.1. Background characteristics of the study population

The data for this evaluation was collected through both quantitative and qualitative data collection methods aimed to answer the evaluation question and objective of the study. From 384 planned study participants or caregivers in all the selected health posts, all caregivers were interviewed. Out of these 115 were observed for the assessment of compliance during the HEWs providing services accordance to guideline. In addition, resource inventory/audit were carried out in all study HPs and key informant interviews were conducted to supplement the quantitative result.

6.2: Availability of resource to provide ICCM services

6.2.1: Availability of Human Resource

In majority of health posts 20(91.3%) were two health extension workers and only 3HPs have one HEWs. From those who two HEWs available HPs at the time of study in sundusa, 1stHankota, Danatora and 1stBanara health posts only one health extensions were on the working area other were on the school because of upgrading to diploma level. Among this health extension workers only 9 of them were upgraded their education level to diploma and the rest of 29 health extensions were at certificate level. All HEWs were trained for 6-days on ICCM to manage under five common child illness at community level.

6.2.2: Guideline, Reporting and Recording Tool

A facilities audit (inventory) was conducted in all health post to assess the availability of basic guideline, Recording and Reporting materials. The finding show that all HPs 23(100%) have ICCM guideline and ICCM both registration books and 19(82.6%)HPs have ICCM Monthly report format with no stock out for the last three months and the remaining 4(17.4%)HPs have ICCM monthly report format stock out for last two month.

According to guideline, report format and recording tool most of the key informant finding showed that, in all HPs there is no shortage of guideline and recording tool. But agreed on report format problem in some HPs for last two months.

A 31 years old health extension worker said that “...in this two-month reporting format was not available, due to this monthly report were not sent to next level”

6.2.3: Availability of medical equipment’s and infrastructure

All of the HPs had functional Thermometer, weighting scale and MUAC (measure mid arm of the children). However, only 87% HPs had Timer. Also from those observed HPs 91.3% of them had ORT corner available (at least 1 a measuring jug, 2cups, spoon and clean water and 8.7% HPs have nonfunctional ORT corner. Regarding to the infrastructure from 23 HPs only 2 of them have with pipe water supply in their compound, but the rest have no.

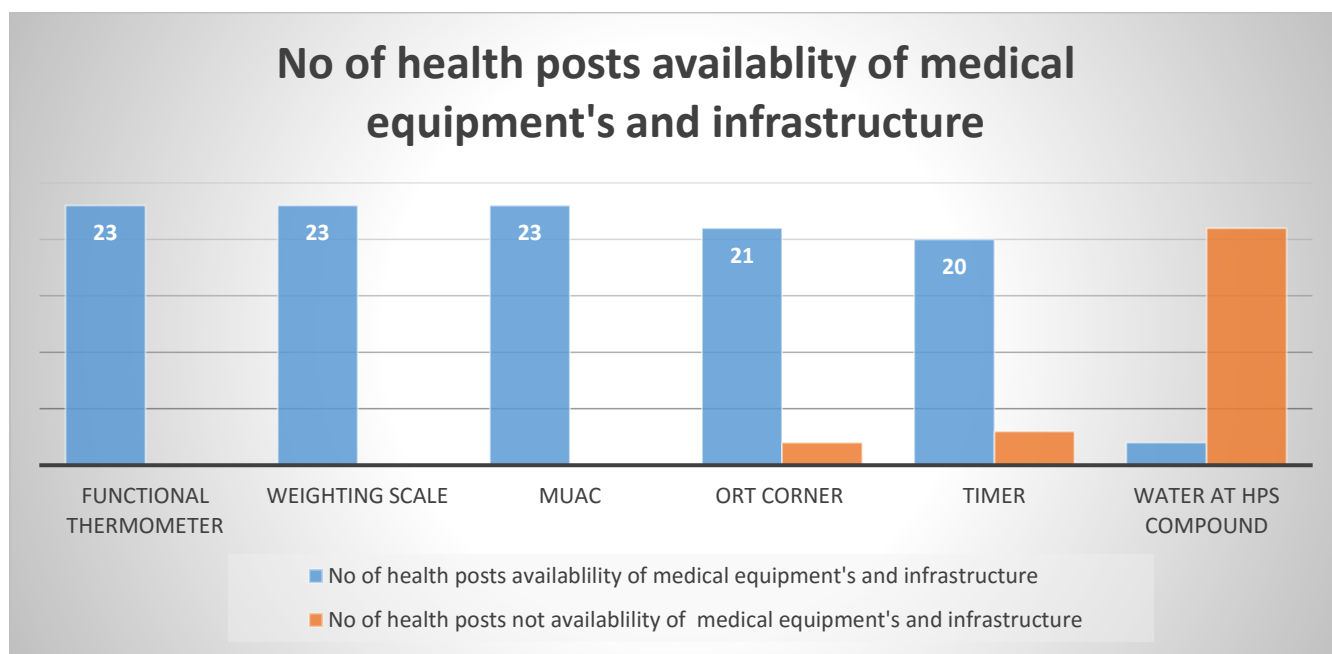


Figure 4: Availability of medical equipment and infrastructure in the HPs during evaluation of ICCM program in soro woreda 2017 (n=23).

6.2.4: Availability of essential drugs

All HPs were observed to have essential drugs for stock of three months. From 23 HPs, vitamin A capsules and zinc tablets were available at all (100%) of HPs; Amoxicillin and Deworming had available at 21 (91.3%) and 19(82.6%) of HPs respectively; and Cotrimoxazole and TTC eye ointment were available at 10(43.5%); RUTF, ORS, Folic acid and paracetamol had available at 19(82.6%), 18(78.3%), 14(60.9%) and 16(69.6%) of HPs respectively and Anti- malaria with RDT were available at 9(39.1%) of HPs. [Figure 5](#) below shows availability of essential drugs at HPs levels.

The majority of Key-informant interview showed that the availability of some essential drugs was stock out for two months. Poor linkage between HPs, HCs, woreda health office, zonal health department and different NGOs were the reason for this stock out of drugs and inappropriate drugs balance management, irregular supply and not timely requesting, resupplying, and reporting system was another reason.

One of the Health extension workers 29 years old mentioned that “... before one year all essential drugs are interrupted many times, but the problem was solved by woreda health office and different partners. RUTF, cotrimoxazole and anti-malaria drugs were stock out. Even though we asked one month stock out, but still the problem was existing. for examples, there was not cotrimoxazole and anti-malaria drugs in my stock for two months. The reason for stock out was the drugs not resupplied timely.”

A 28-year-old male health center head said that “... shortage of essential ICCM drugs had still our main problem in the program. The health posts were not regularly supplied with ICCM drugs on time and with enough amount considering of case load, even if, most of the time there was not ICCM drugs supplied for more than Two months. On other hands the reason for stock out of drugs were poor linkage between health posts and health centers and inappropriate drugs balance management and not timely requesting, resupplying and reporting system.”

Another 35-year-old male woreda health office key informant mentioned that “... shortage of essential ICCM drugs had our main problem in the program. But now most essential drugs have been supplied from different partners without other routine drugs. But steel Cotrimoxazole, TTC eye ointments and Anti-malaria drugs are our problems in ICCM program. However, next time we avail the drugs in all HPs as national ICCM protocol integrated with in different partners and woreda budget. The reason for unavailability of ICCM drugs was the poor linkage between health posts and health centers, poor supportive supervision; inappropriate drugs balance management and not timely requesting, resupplying and reporting system.”

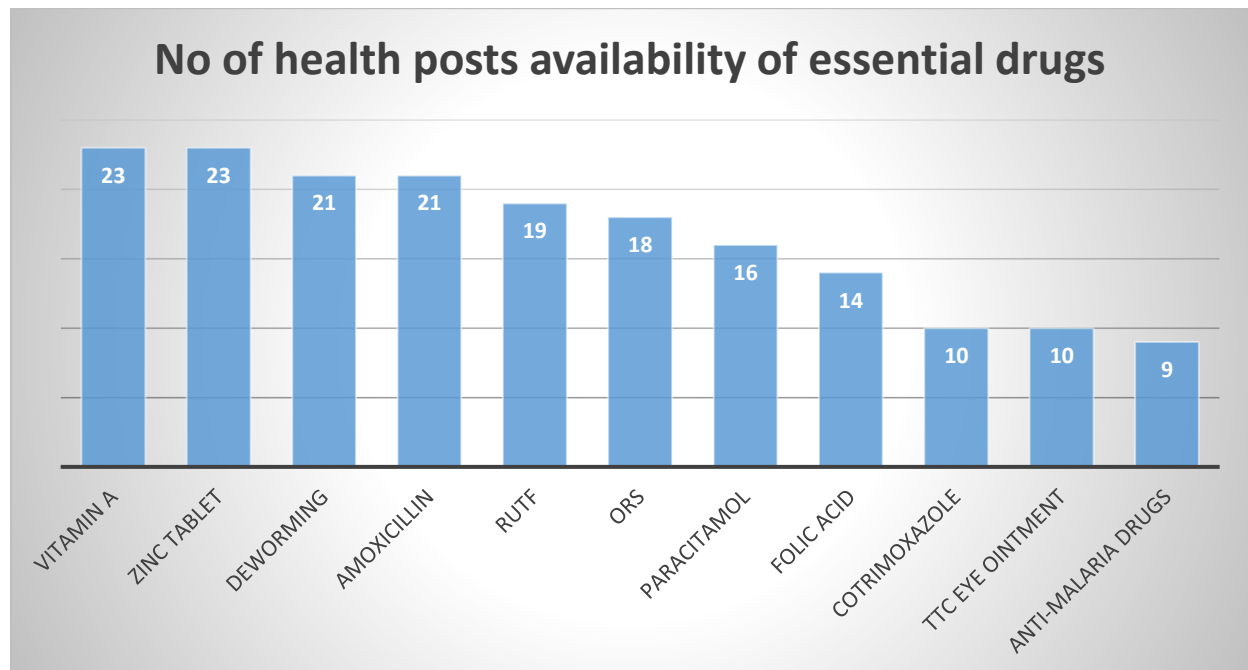


Figure 5: Availability of Essential drugs in the HPs during evaluation of ICCM program in soro woreda 2017 (n=23).

Table 3: Judgment matrix for availability dimension to evaluate ICCM program in Hadiya Zone, soro woreda 2017

Indicators	Weight given	Observed value	Score (Observed value*100)/Weight	Agreed criteria	Parameter	Judgment criteria
Number of health posts with trained health extension worker on ICCM.	10	10	100	[90 –100] [71 – 89] [56-70] [< =55]	V. good	
					Good	
					Fair	
					Poor	
Number of HPs with amoxicillin no stock out in the last three months.	6	5.48	91.3		V. good	
					Good	
					Fair	
					Poor	
Number of HPs with no stock out of anti-malaria drugs in last three months.	6	2	39.1		V. good	
					Good	
					Fair	
					Poor	
Number of HPs with no stock out of Zinc in last three months	6	6	100	V. good		
				Good		
				Fair		
				Poor		
Number of HPs with no stock out of ORS in last three months.	6	4.7	78.3	V. good		
				Good		
				Fair		
				Poor		
Number of HP with no stock out deworming in the last three month.	6	4.96	82.6	V. good		
				Good		
				Fair		
				Poor		
Number of HPs with no stock out Vitamin A in last three months.	6	6	100	V. good		
				Good		
				Fair		
				Poor		
Number of HPs with no stock out RUTF in the last three month.	7	5.78	82.6	[90 –100]	V. good	
				[71 – 89]	Good	
				[56-70]	Fair	
					Poor	
Number of HPs with MUAC.	4	3.8	95.7		V. good	

				[< =55]	Good	
					Fair	
					Poor	
Number of HPs with functional thermometer.	6	6	100		V. good	
				Good		
				Fair		
				Poor		
Number of HPs with functional weight scale.	6	6	100	V. good		
				Good		
				Fair		
				Poor		
Number of HPs with ICCM guide line.	7	7	100	V. good		
				Good		
				Fair		
				Poor		
Number of HPs having ICCM registration book.	5	5	100	V. good		
				Good		
				Fair		
				Poor		
Number of HPs with monthly ICCM reporting format.	3	2.48	82.6	[90 –100]	V. good	
				[71 – 89]	Good	
				[56-70]	Fair	
				[< =55]	Poor	
Number of HPS with functional ORT corner.	7	5.17	73.9	V. good		
				Good		
				Fair		
				Poor		
Number of HPS with Cotrimoxazole.	6	2.6	43.5	V. good		
				Good		
				Fair		
				Poor		
Number of HPs with functional timer.	5	4.35	87	V. good		
				Good		
				Fair		
				Poor		
Over all Availability dimension	100		87.32	[90 –100]	V. good	Good
				[71 – 89]	Good	
				[56-70]	Fair	
				[< =55]	Poor	

6.3: compliance to the ICCM program

6.3.1: Direct observation of HEWs while delivering the ICCM service

Direct observation was conducted in 23 HEWs on 115 sick under-five children during Health extension ICCM service delivery, the evaluation assessed Five ICCM cases per HEWs with national ICCM guideline assessment. And out of that Five cases during the observation the first two cases were dropped to protect or minimize Hawthorne effect. From total observation, to dropped 46 cases, after dropping those cases for this evaluation used 69 observed cases.

From 69 observed cases 51(73.9%) of them were ask by Hews for general condition of Childs, 61(88.4%) caregivers were greeted, 58(84.1%) of children were measured the body Temperature, and 61(88.4%) of sick children were measured weight and appropriately measured. Also from those observed 69 ICCM cases 19(27.5%) of them were not checked for general danger signs, 14(20.3%) of children not checked for de-worming status and 67(97.1%), 65(94.2%) and 55(79.7%) children checked for Immunization, vitamin-A status and HIV- status.

From total observed ICCM cases 46(66.7%) were correctly classified for pneumonia, 48(69.6%) of sick children was correctly classified for diarrhea, 26(37.7%) of sick children were correctly classified for malaria and 59(85.5%) of sick children were correctly classified for malnutrition status according to national ICCM guidelines. Also from those observed ICCM cases 52.2% of children were correctly treated for pneumonia, 47.8% of children was correctly treated for diarrhea, only 24.6% of children were correctly treated for malaria and 50.7 % of children were correctly treated for malnutrition according to national ICCM guidelines.

During observation time 58 (84.1%) of caregivers were counseled by HEWs on food, fluid and when to return back and 56(81.2%) children were appointment given for next was-up visit.

6.3.2: Document review

Document review results shows as from total HPs, supportive supervision and performance review meeting were conducted at 18(78.3%) HPs; and sending report timely to next supervisory body 20(86.9%) health posts.

Table 4: Direct observation results during implementation of HEWs in evaluation of ICCM program in soro woreda, 2017.

Observed Variables Category		Frequency (n=69)	Percent
No of caregiver greeted	Yes	61	88.4
	No	8	11.6
No of children checked for danger sign	Yes	50	72.5
	No	19	27.5
No of children checked for De-worming	Yes	55	79.7
	No	14	20.3
No of children checked for immunization status	Yes	67	97.1
	No	2	2.9
No of children checked for Vit.A	Yes	65	94.2
	No	4	5.8
No of children correctly classified for Pneumonia	Yes	46	66.7
	No	23	33.3
No of children correctly classified for diarrhea	Yes	48	69.6
	No	21	30.4
No of children correctly classified for malaria	Yes	26	37.7
	No	43	62.3
No of children correctly classified for malnutrition	Yes	59	85.5
	No	10	14.5
No of caregivers counseled by HEWs	Yes	58	84.1
	No	11	15.9

Most of the key informant's interview findings showed that supportive supervision was conducted different time integrated with another program in each three month by using standard format, but it is not regular. It's also only ICCM specific supportive supervision and review meeting were not conducted by HC or Woreda health office.

One of the health extension workers whose 32 years old mentioned that “...*Many Supportive Supervision team were come to our health post in different time from health center, woreda health office, Zonal health department and different non-governmental organizations. The problem is that we do not know when they come and their schedule properly. In addition to this the supervision was conducted for all program not only focused on ICCM.*”

One of the Health center head mentioned that “...*we conducted supportive supervision at different time in each three month, but still there was not regular Supportive supervision and Performance review meeting conducted. In addition to this the supervision and review meeting was conducted for all program not only focused on ICCM program. Most of the time not used standard format during supportive supervision.*”

Woreda health office MCH Coordinator said that “Supportive supervision and performance review meeting conducted for all programs within each three month, but not addressed all HPs. Supportive supervision and performance review meeting conducted by woreda health office is not focused only on ICCM. Some the supervision and review meeting conducted by integration with different partners also focused only on ICCM program.”

Table 5: Judgment Matrix for compliance dimension to evaluate ICCM program in Hadiya Zone, soro woreda in 2017.

Indicators	Weight given	Observed value	Score	Agreed criteria	Parameter	Judgment criteria
Proportion of sick children who those history taking.	4	2.96	73.9	[85 –100] [70 – 84] [55-69] [< =54]	V. good	
					Good	
					Fair	
					Poor	
Proportion of Hews ask greeting for the client.	3	2.65	88.4		V. good	
					Good	
					Fair	
					Poor	
Proportion of sick children with assessment of pneumonia who are correctly classified according to ICCM guideline.	6	4	66.7		V. good	
					Good	
					Fair	
					Poor	
Proportion of sick children with assessment of diarrhea who are correctly classified according to ICCM guideline.	6	4.2	69.6		V. good	
					Good	
					Fair	
					Poor	
Proportion of sick children with assessment of malaria who are correctly classified according to ICCM guideline.	6	2.26	37.7		V. good	
					Good	
					Fair	
					Poor	
Proportion of sick children with assessment of malnutrition who are correctly classified according to	6	5.1	85.5	V. good		
				Good		

ICCM guideline.					Fair	
					Poor	
Proportion of sick children with classifications of pneumonia who are correctly treated according to ICCM guideline.	5	2.8	55.2		V. good	
					Good	
					Fair	
					Poor	
Proportion of sick children with classifications of diarrhea who are correctly treated according to ICCM guideline.	5	2.4	47.8		V. good	
					Good	
					Fair	
					Poor	
Proportion of sick children with classifications of malaria who are correctly treated according to ICCM guideline.	5	1.23	24.6	[85 –100] [70 – 84] [55-69] [< =54]	V. good	
					Good	
					Fair	
					Poor	
Proportion of sick children with classifications of malnutrition who are correctly treated according to ICCM guideline.	5	2.54	50.7		V. good	
					Good	
					Fair	
					Poor	
Proportion care givers counseled about food, fluids, home care and when to return according to ICCM guideline.	4	3.4	84.1		V. good	
					Good	
					Fair	
					Poor	
Proportion of sick children with classifications of pneumonia who had followed up according to ICCM guideline.	4	2.67	66.7		V. good	
					Good	
					Fair	
					Poor	
Proportion of sick children with classifications of diarrhea who had	4	2.78	69.6		V. good	
					Good	

followed up according to ICCM guideline.					Fair	
					Poor	
Proportion of sick children with classifications of malaria who had followed up according to ICCM guideline.	4	1.5	37.7		V. good	
					Good	
					Fair	
					Poor	
Proportion of sick children with classifications of malnutrition who had follow up according to ICCM guideline.	4	3.4	85.5		V. good	
					Good	
					Fair	
					Poor	
Proportion sick children checked for danger signs according to ICCM guideline.	4	2.9	72.5	[85 –100] [70 – 84] [55-69] [< =54]	V. good	
					Good	
					Fair	
					Poor	
Proportion mother and child children checked for HIV/AIDS status according to ICCM guideline.	3	2.4	79.7		V. good	
					Good	
					Fair	
					Poor	
Proportion sick children checked for immunization status according to ICCM guideline.	3	2.9	97.1		V. good	
					Good	
					Fair	
					Poor	
Proportion sick children checked for vitamin A supplementation status according to ICCM guideline.	3	2.83	94.2		V. good	
					Good	
					Fair	
					Poor	
Proportion sick children checked	3	2.3	76.8		V. good	

for de-worming status according to ICCM guideline.					Good		
					Fair		
					Poor		
Proportion of complicated cases referred to HC according to ICCM implementation guide line.	5	1.7	33.3		V. good		
					Good		
					Fair		
Proportion of HP supervised by WorHO in last quarter with standard check list.	3	2.4	79.8		Poor		
					V. good		
					Good		
Number of HP sent report during reporting period.	2	1.56	78.26		Fair		
					V. good		
					Good		
Proportion of HEWs attended ICCM performance review meeting.	3	2.4	79.8		Poor		
					V. good		
					Good		
Over all compliance dimension	100	65.28	65.6	[85 –100]	V. good	Fair	
					[70 – 84]		Good
					[55-69]		Fair
					[< =54]		Poor

6.4: Acceptability Dimension/ caregiver exit interview result on caregiver's satisfaction of ICCM service.

6.4.1. Socio demographic characteristics of the caregiver exit interview respondents

Caregiver exit interview data were collected from 384 respondents from twenty-three (23) ICCM service delivering health posts in soro woreda. The mean age of exit interviewed caregiver were 28 year with standard deviation of SD=4. 406. From total (384) caregivers with age group 26 -30 years was highest frequency of 169 (51%), 21-25 age group was 75(19.5%) and 31-35 years' age group was 67(17.4%)frequency. Out of 384 caregivers 318(82.8%)were married, 48(12.5%)were not married (single), the rest were widowed and divorced.

In this study, the majority of the caregivers 148(38.5%) were illiterates (unable to read & write) and 71(18.5%) were read and write and 121(31.5%) were primary, 27(7%) were high school completed and 17(4.4%) are college and above. More than half of the care givers 221 (57.6%) were house wife's, 50(13%) were trader/merchants, 41(10.7%) were farmers, 20(5.2%) were government employ and 33(8.6%) were others. More than 88% of caregivers were females.

Table 6: Socio demographic characteristics during ICCM program evaluation in soro woreda in selected HPs, 2017.

Characteristics of caregivers (n=384)		Frequency (n=384)	Percent
Age of the caregivers	18 to 20	23	6
	21 to 25	75	19.5
	26 to 30	196	51
	31 to 35	67	17.4
	More than 35	23	6
Marital status	Married	318	82.8
	Single	48	12.5
	Widowed	13	3.4
	divorce	5	1.3
Educational status	illiterate	148	38.5
	read and write	71	18.5
	primary school	121	31.5
	secondary school	27	7.0
	college and above	17	4.4
Occupational status	Government employee	20	5.2
	Farmers	41	10.7
	Trader/Merchants	50	13
	Housewife	221	57.6
	Daily labor	19	4.9
	Others	33	8.6
Number of under five children	One	204	53.1
	Two	165	43
	Three	15	3.9

Caregivers satisfaction level on ICCM service in Soro woreda.

Satisfaction of caregivers on ICCM services was measured by 11 items each having Lickert scale value 1-5 from 1 strongly not satisfied to 5 strongly satisfied. Finally, to categorized caregivers in to satisfied and not satisfied, by using mean of score of 33 and the values below and value above the mean score were considered not satisfied and satisfied respectively.

Out of the total respondent 310(80.7%)of caregivers were satisfied on availability of HEWs at working time. It's also 268(69.8%) of caregivers were satisfied on the way of communication with HEWs, 281(73.2%) of care givers satisfied on child health status explanation and 264(68.8%) of care givers satisfied on the health extension worker respect.

In acceptability of ICCM program only 220(57.3%) of caregivers satisfied on cleanliness of health post, but in the privacy maintained during examination room 269(70.1%) of care givers satisfied. Also242(63%) of care givers satisfied on the waiting area is appropriate size and comfortable chair to wait for service. In the time management 270(70.3%) of care givers satisfied on the consultation time is appropriate for them, 273(71.1%) of care givers satisfied on the waiting time is reasonable, 316(82.3%) of caregivers are satisfied on the recommend the service for other family or friend and 284(74%) of care givers satisfied on the return back to the same facility to receive service.

Table 7: Caregiver satisfaction level on ICCM service availability at soro woreda, 2017.

S. N	Satisfaction items	Strongly not satisfied	Not satisfied	Neutral	Satisfied	Strongly satisfied
		No.(%)	No.(%)	No.(%)	No.(%)	No.(%)
1	Availability of provider at working time.	1(0.3%)	22(5.7%)	51(13.3%)	196(51%)	114(29.7%)
2	The way of communication with HEWs.	0(0%)	25(6.5%)	91(23%)	195(50.8%)	73(19%)
3	Cleanliness of health post	0(0%)	56(14.6%)	108(28.1%)	163(42.8%)	137(36%)
4	HEWs explain the health status of child very well	3(0.8%)	38(9.9%)	62(16.1%)	171(44.5%)	110(28.6%)
5	The privacy was maintained during examination.	0(0%)	35(9.1%)	80(20.8%)	177(46.1%)	92(24%)
6	Waiting area is appropriate size and comfortable chair to wait for service.	0(0%)	29(7.6%)	113(29.4%)	164(42.7%)	78(20.3%)
7	The health extension worker showed respect for them.	2(0.5%)	42(11.7%)	73(19%)	164(42.7%)	100(26%)
8	consultation time is appropriate for them.	0(0%)	58(15.1%)	56(14.6%)	213(55.5%)	57(14.8%)
9	The waiting time is reasonable.	1(0.3%)	38(9.9%)	72(18.8%)	228(59.4%)	45(11.7%)
10	Recommend the service for other family or friend.	0(0%)	21(5.5%)	47(12.2%)	226(58.9%)	90(23.4%)
11	Agree that they will return back to the same facility to receive service.	0(0%)	25(6.5%)	75(19.5%)	164(42.2%)	122(31.8%)

Factors associated with caregiver satisfaction on ICCM services availability

To assessing factors related with caregiver satisfaction on ICCM service availability. So, binary logistic regression analysis was done to identify variables having association with caregiver satisfaction on ICCM service. In this analysis, independent variables like age, sex, religion, marital status, educational status, occupational status, income level, total under five, total family, caregivers bring child to HPs, hews tell child illness availability of prescribed drugs, waiting and consultation time were tested.

From this in the bivariate analysis, independent variables like Sex, Educational status, total under five, hews tell child illness, availability of prescribe drugs and waiting time were taken as candidate variables for multivariable analysis at P-value of 0.25.

Multivariable analysis of candidate variables associated with ICCM program caregiver satisfaction.

During backward LR method multivariable analysis variables like; educational status of caregivers, Availability of prescribed drug and waiting time were found to be associated with caregiver satisfaction of the program whose p-value is less than 0.05 and at 95 % CI.

Caregivers who illiterate were 4 time more likely satisfied on ICCM services compared to caregiver who learned College and above. (AOR = 4.125 95% CI=1.232, 13.811), P-value 0.022. In addition to this a care gives those who read and write 7 times more satisfied on ICCM service than caregiver who learned College and above. (AOR=7.326 95% CI= 1.741, 30.837) and p-value 0.007

Caregivers those who received prescribe drugs were 2 times more likely satisfied on ICCM services compared to those not received prescribe drug (AOR=2.013 95% CI= 1.025, 3.955) and p-value 0.042.

Caregivers those less than 30 minutes' service waited caregivers were 3 times more satisfied on ICCM services compared to more than 30 minutes 'service waited caregivers (AOR=3.079, 95% CI=1.378,6.878) and p-value 0.006

Table 8:Multivariate candidate and predictor variables for caregiver satisfaction in evaluation of ICCM program in soro woreda.2017.

Variables	Categories	Satisfaction		COR	(95% CI)		AOR	(95% CI)	
		Satisfied	Not Satisfied		Lower	Upper		Lower	Upper
Sex	Male	34	10				1		
	Female	340	32	0.353	0.160	0.781	0.819	0.143	4.698
Educational status	Illiterate	132	16	3.438	1.072	11.022	4.125*	1.232	13.811
	Read & write	66	5	5.500	1.378	21.945	7.326	1.741	30.837
	Primary	106	15	2.944	.909	9.535	3.721	1.097	12.63
	Secondary	26	1	10.83	1.138	103.12	14.16	1.434	39.813
	College & above	12	5				1		
Total under five children	One	181	23	2.862	0.842	9.730	2.339	0.588	9.312
	Two	150	15	3.636	1.030	12.839	2.862	0.700	11.705
	Three	11	4				1		
Received prescribed drug	Yes	237	22	2.052	1.074	3.921	2.013*	1.025	3.955
	No	105	20				1		
HEWs tell child illness	Yes	241	24	1.790	1.031	3.441	1.158	0.319	4.210
	No	101	18				1		
Waiting time	< 30 minutes	306	31	3.016	1.397	6.512	3.079*	1.378	6.878
	>30 minutes	36	11				1		

Variable at P-value <0.05(*) in multivariate analysis shows predictor for caregiver satisfaction on ICCM service and 1(one) shows as a reference group.

Table 9: Judgment Matrix for acceptability dimension to evaluate ICCM program in Hadiya Zone, soro woreda in 2017.

Indicators	Weight given	Observed value	Score	Agreed criteria	Parameter	Judgment criteria
Number of caregiver satisfied with availability of provider at working time.	10	8.05	80.5		V. good	
					Good	
					Fair	
					Poor	
Number of caregiver satisfied on the way of communication with HEWs.	10	6.99	69.9		V. good	
					Good	
					Fair	
					Poor	
Number of care givers satisfied on cleanliness of health post.	8	4.59	57.4		V. good	
					Good	
					Fair	
					Poor	
Number of care givers who perceived the HEWs explain the health status of child very well	9	6.57	73		V. good	
					Good	
					Fair	
					Poor	
Number of care givers who perceived that privacy was maintained during examination.	10	6.99	69.9		V. good	
					Good	
					Fair	
					Poor	
Number of care givers who perceived that the waiting area is	9	5.66	62.9		V. good	
					Good	

appropriate size and comfortable chair to wait for service.					Fair	
					Poor	
Number of care givers who perceived that the health extension worker showed respect for them.	10	6.86	68.6	[80 –100] [65 – 79] [51-64] [< =50]	V. good	
					Good	
					Fair	
					Poor	
Number of care givers who perceive that the consultation time is appropriate for them.	8	5.6	70.1		V. good	
					Good	
					Fair	
					Poor	
Number of care givers who perceived that the waiting time is reasonable.	9	6.4	71.2		V. good	
					Good	
					Fair	
					Poor	
Number of care givers who promised to recommend the service for other family or friend.	8	6.58	82.3		V. good	
					Good	
					Fair	
					Poor	
Number of care givers who agree that they will return back to the same facility to receive service.	9	6.66	74		V. good	
					Good	
					Fair	
					Poor	
Over all acceptability dimension	100	70.95	70.95	[80 –100] [65 – 79] [51-64] [< =50]	V. good	
					Good	
					Fair	
					Poor	

Overall Judgment matrix for Implementation evaluation of ICCM Program

Average value of an overall evaluation of Implementation of ICCM program dimensions was recorded as 73.43% as shown in the table below.

Table 10:An overall judgment matrix used for evaluation of Implementation of ICCM program in soro woreda 2017.

Dimensions	Weight given	Observed value %	Score	Values	Implementation level	Findings
Availability	35%	87.32	30.56	[90 –100]	Very good	Good
				[71 – 89]	Good	
				[56-70]	Fair	
				[< =55]	Poor	
Compliance	40%	65.6	26.24	[85 –100]	Very good	Fair
				[70 – 84]	Good	
				[55-69]	Fair	
				[< =54]	Poor	
Acceptability	25%	70.95	17.74	[80 –100]	Very good	Good
				[65 – 79]	Good	
				[51-64]	Fair	
				[< =50]	Poor	
Total score	100%		74.5	[85 –100]	Very good	Good
				[70 – 84]	Good	
				[55-69]	Fair	
				[< =54]	Poor	

Chapter Seven: Discussion

Availability Dimension

To Implement the ICCM intervention availability of resources as national guide line was very important. In the study area, an availability of resource was evaluated in different perspectives. In Soro woreda health posts, though most of the resources needed for implementation of the program were filled, Number of trained human resources was one of the perspectives; it is required to implement planned activities and to achieve planned ICCM program.

In the study area, the result showed that in observed HPs all health extension workers were trained on ICCM program for 6-days and 87% of health posts had two or more HEWs. This was in line with the standard of national ICCM guideline which recommended that all HEWs in health post must train at least one times in the program. (45).

This might be due to good communication strategy of the woreda health office with different governmental organization and non-governmental organization to given the training. In all HPs trained HEWs availability was one of the need to achieve planned ICCM program and increase compliance of HEWs.

For ICCM implementation recording materials and guideline lines are others very important resources to achieve program. In this study, all HPs had ICCM registration book and guideline. This was in line with the standard of national ICCM guideline which recommended that in all HPs registration book and guidelines were found as per national guideline. (45).

This similarity might be due to proper distribution and management of logistics. The availability of guideline and registration books was very important for correctly assessment, classification, treatment and follow up conducted by HEWs during ICCM services or increase compliance of HEWs.

The national ICCM guideline recommended that ICCM essential drugs was appropriate for sick children treatment in the program. The findings of this evaluation showed that availability of essential drugs were not comparable with the standard treatment guide line and woreda health office plan. Amoxicillin and De-worming had available at 91.3% Health posts, Cotrimoxazole

and TTC eye ointment had available at 43.5% HPs, folic acid had available at 60.9% HPs and anti-malaria had available only 39.1 HPs. Shortage of this drugs it's also affect sick child treatment and caregiver satisfaction level.

This was also in line with the study conducted on three zone in SNNPR (Gurage, Sidama and Woliyta zone) on selected health posts which indicates TTC eye ointment was available at 45%HPs, paracetamol was available at 69.6% HPs and anti- malaria with RDT was available at only 39.1% HPs.(28).

This low availability of some essential drugs availability might be due to the interruption of drugs at woreda health office or zonal health department store and irregular supplies of essential drugs, inappropriate management of health extension workers, and poor supply management of drug from woreda to health post. Due to this sick child was not treated according to the national ICCM protocol and caregiver's satisfaction level was it might be affected and the program not implemented as a planned.

The result of key –informant interview with HEWs indicated that, this condition might be happened due to giving of low attention and irregular supply of ICCM essential drugs at zonal health department, woreda health offices and health centers level. In addition to this the result of the availability of essential drugs in HPs showed that it is not in line with the woreda plan and national ICCM guide line. The woredas plan and ICCM guideline showed that each HP have all essential drug in their store without any stock out.

Resource inventory findings showed that all health posts had functional thermometers, weighting scales and MUAC and 87% HPs had Timer available, 91.3% health posts had ORT Corner available. The finding of this evaluation was similar with the study conducted in SNNPR, indicates that more than 80% of health posts are ICCM supplies like Thermometers, weight scales, Timer and ORT corners to administer ORS.(19).

The reason for this similarity might be due to proper distribution of resources from zonal health department, woreda health office and health center to HPs. This resource availability was essential for good implementation of ICCM program. The availability of this medical equipment was used for compliance of HEWs or for giving services with national guideline.

Water supply was important to deliver an ICCM services, but the study indicated that only (8.7%) have water supply in HPs compound. This finding comparable with the study conducted in Southern Region of Ethiopia indicated that 15% of health posts had clean and safe water. This

might be due poor coverage of functional pipe water in the kebeles and the installation was not set at the beginning of health post construction as reported from one of the woreda coordinators of ICCM program coordinator. This it's also affect timely case management during plan B-dehydrated child treatment, appetite test for malnourished children, for HPs equipment cleaning.

Compliance Dimension

Observation findings of ICCM materials availability showed that the protocol for management of common child hood illness was available in the all health posts; Even though some health extension workers use it regularly and others use it when they face problems. The ICCM quick reference guideline was also available in all HPs but habit of using the quick reference guideline during any assessment, classification, treatment and follow up session is poor among majority of HEWs.

According to judgment matrix of compliance dimension over all compliance of health extension workers with national ICCM guide line was fair with scoring of 65.6%. Direct observation finding of this evaluation shows that 72.7% of observed children were checked for general danger sign. The finding of the evaluation was compared to the study conducted to assess quality of ICCM program in Beneshangul-Gumuz region which indicate that 86% of sick under-five children were checked for danger sign.

This difference might be due to HEWs not used chart booklet regularly and irregular supportive supervision from the HC and woreda health office and interruption of meeting with HEWs to discuss about ICCM services. Due to This gaps children who sick were not appropriately treat as per national guideline and ICCM program were not implemented as planned.

The finding of this study show as88.4% caregivers were asked greeting and 97% were checked for Immunization status. This study was similar to the study conducted to assess quality of ICCM program in Beneshangul-Gumuz region which indicate that89.9% care givers were greeted and 95% of sick children checked for immunization.(43).

This similarity might be due to HEWs give respect for caregivers and giving attention on immunization services. Due to this satisfaction level of care giver was increased. It also used for defaulter tracing mechanism.

The other observation findings of the ICCM program delivery systems indicates that 66.7%, 69.6%, 37.7% and 85.5% of children were correctly classified for Pneumonia, diarrhea, malaria

and malnutrition respectively. This study was compared to the study done to assess quality and use of ICCM program in three regions of Ethiopia indicates that 88% of children correctly classified for Pneumonia, 92% of children correctly classified for diarrhea and 93% of children correctly classified for malaria. (44).

The reason for this difference may be absence of malaria measurement kit/RDT for malaria, poor utilization of chart booklet by HEWs and lack only ICCM focused supportive supervision and performance review meeting by HC and Woreda health office. This poor classification of ICCM case affect appropriate treatment of sick children, follow up and not reduce morbidity of that child and ICCM services not implemented as planned.

The finding of this evaluation on treatment of child indicates that 52.2% of children were correctly treated for pneumonia, 47.8% of children were correctly treated for diarrhea, only 24.6% of children were correctly treated for malaria and 50.7 % of children were correctly treated for malnutrition according to national ICCM guidelines. The finding of this evaluation compared to the study done to assess the implementation strength and quality of care In Ethiopia indicates that 72% of children for Pneumonia, 79% of children for diarrhea and 59% of children for malnutrition were correctly treated according to national ICCM guidelines.(26).

This difference might be due to poor utilization of chart booklet, stock out and irregular supplies of ICCM essential drugs, absence of refreshment training and inappropriate management of health extension workers due to weak integrated supportive supervision, performance review meeting and inappropriate supply management of drug from woreda to health post and absence of only ICCM focused Supportive supervision. Due to this the sick child morbidity not reduced timely or sick child were not improved and care giver were not satisfied on ICCM services and the program not implemented as a planned.

By this evaluation supportive supervision and performance review meeting was conducted at 18(78.3%) HPs; and sending report timely to next body 20(86.9%) health posts.

This was compared to the study conducted in three regions of Ethiopia (Amhara, Tigray and SNNPR) on the ICCM implementation indicated that 87% of health posts received at least one supervision visit related to ICCM in the previous 3months. (29). This difference might be due to

three region study was large study and include many health posts. Due to this ICCM implementation problems not solved timely and the program not implemented as planned.

Acceptability Dimension /satisfaction of caregivers/

In this study, the result showed that the overall satisfaction of care giver on ICCM service was 70.95%. However, 70.95% of satisfaction of care giver was lower than compare to similar studies conducted in Wakiso district, Uganda showed that the overall care giver satisfied with in ICCM services was 80%. (31). The reason for this difference might be due to stock out of essential drugs and poor case management by HEWs and poor communication between HEWs

and Caregivers. Due to this number of services users were decreased and implementation of ICCM program was poor or not implemented as a planned.

In this evaluation Caregivers who illiterate were 4 time more likely satisfied on ICCM services compared to caregiver who learned College and above. (AOR = 4.125 95% CI=1.232, 13.811), P-value 0.022. In addition to this a care gives those who read and write 7 times more satisfied on ICCM service than caregiver who learned College and above. (AOR=7.326 95% CI1.741, 30.837) and p-value 0.007.

The finding of this study was compared to the study conducted in wakiso district in Uganda indicates that the primary education has statistically significant compared to caregiver satisfaction who have no educated/illiterate/ within (AOR=2.8, 95%, CI=1.12, 6.80). (31).This might be due to the difference in educational level and contextual difference in caregivers. Due to this ICCM service users or cases flow was decreased.

This evaluation results shows as 19.5% of caregivers were not satisfied with availability of HEWs/ HPs not open at work times. This study was compared to the study conducted on rural Ethiopia on care seeking for common childhood illness in the management conteext of ICCM scale up indicated that 20.7% of caregivers are said that or not sasisfied on health posts opning at work time.(21).

In this study 21.1% of caregivers also not satisfied on the way of communication with HEWs/provider not able to discuss with care giver/and 28.8% of caregivers were not satisfied on

waiting time. The finding of this study was compared to the survey conducted by Ethiopian public health institute in all regions and two administrative cities of Ethiopia caregivers exit interview in rural health posts indicates that 9% long waiting time and provider not able to discuss with care giver or not satisfied. (20). In this evaluation Caregivers those less than 30 minutes' service waited caregivers were 3 times more satisfied on ICCM services compared to more than 30 minutes' service waited caregivers (AOR=3.079, 95% CI=1.378, 6.878) and p-value 0.006.

This variation might be due to Ethiopian public health institute study was large or a country level study. Due to this number of services users were decreased and care give choice other private health facility.

According to the waiting area, the finding of this study indicates that 62.9 of caregivers satisfied on cleanness, availability of chair at waiting area. This finding is also compared to the study conducted on patient satisfaction and associated factors in wolayita shows as 60% cilants are satisfied with waiting area. In this evaluation 69.9% of caregivers were satisfied with the privacy of examination/consultation room. This evalotion show poor consultation room privacy compared to the study conducted patient satisfaction and associated factors among outpatient departement of wolayita report shows as 85.5% of clients satisfied. (33).

The reason for this difference might be due to HEWs carelessness during services, consultation room appropriateness problem. Due to this the case flow was decreased and the service users choice another private health facility.

In this evaluation 89% of caregivers are satisfied with received prescription drugs at health posts. In the present study, Caregivers those who received prescribe drugs were 2 times more likely satisfied on ICCM services compared to those not received prescribe drug (AOR=2.013 95% CI= 1.025, 3.955) and p-value 0.042. Another finding conducted on factor influences availability of medicines for the community management of childhood illnesses in central uganda indicates that 33% of the health facility not effectively ICCM drugs treated or prscribed /not all ICCM drugs/ (AOR=3.32, 95%,CI=1.33, 8.32). (34).

The present finding more prescribed than the study conducted in Uganda indicates that Caregivers those who received prescribe drugs were similar to satisfied on ICCM services compared to those not received prescribe drug, (AOR=1.052, 95%, CI= 0.733, 1.513).(35). This difference might be due to the country ICCM ipmlementation satus, irregural supply of ICCM essential drugs,poor

linkage between HPs, HC and woreda health office and inappropriate supply management. This also affects the satisfaction of caregivers, increases morbidity of sick child health, ICCM program service users were decreased and caregivers' choice of other private health facilities for services was increased.

Limitations of these evaluations

Subjective responses of caregiver satisfaction were affected by social or personal problems that might affect overall satisfaction.

It is recognized that a limitation that may arise from providers who had shown their best behavioral response during observation of client-provider interaction (Hawthorne effect).

Recall bias might affect the information obtained from caregivers.

Chapter Eight: Conclusion and Recommendation

8.1: Conclusion

This evaluation identifies some gap on implementation of Integrated community case management program in soro woreda. The overall result of this evaluation on implementation of integrated community case management in selected health post of soro woreda was GOOD as per-sated judgment criteria.

In general, for implementation of ICCM program soro woreda availability of trained human resources (HEWs) and availability of adequate recording materials and availability of medical equipment's in each health post with in adequate amount were very important to implement planed objective of program. However, Stock out (unavailability) of some essential drugs and kits, absence of formal referral formats in some health posts reporting formats and inaccessibility of clean water supply almost in all health posts were still problem to achieve the intended objective of ICCM program in soro woreda.

According to the finding of this evaluation Compliance of the health extension workers with the national ICCM guideline the overall the judgment was FAIR. Using the Chart booklet habit during any assessment, classification, treatment and follow up session was less among majority of HEWs. Regular and continues supportive supervision and performance review meeting problem and absence of only ICCM focused supportive supervision and performance review meeting at HC and Woreda levels.

In this evaluation satisfaction of caregiver on ICCM program was 70.95% which judged as GOOD with respect to settled criteria. In this evaluation, educational status, prescription drugs availability and waiting times were as a predictor of caregiver satisfaction on ICCM services.

8.2: Recommendation

The major results or findings of this evaluation have important implications for program improvement, demand generation and service provision. The overall implementation of ICCM services was GOOD, but stock out of essential drugs and kit, absence of reporting and referral format, absence of water supply at HPs compounds, refreshment training problem, poor chart booklet using habit and lack of Regular and continues supportive supervision and performance review meeting are main problems. Based on this gaps, the following recommendation were forward to strengthen the ICCM program in soro woreda.

Plan it for providing refreshment training. It's also strength on timely, regularly and continuous supply of essential drugs and kit. Strength specifically only ICCM focused regular supportive supervision and review meetings will be expected from Zonal health department.

Soro woreda health office will be expected to timely, regularly and continuous distribute stock out essential drugs to health centers and strength supply chain management. It's also Integrated and only ICCM program specific regular follow-up, supportive supervision and review meetings conducted integration with different partners and communicate with different sectors and NGOs on water problem solving will be expected for program better performance.

From Health centers conducting its regular and continuous Supportive supervision and review meeting at catchment level and Strength referral linkages between health center and health posts will be expected and timely solve referral and reporting format problems. It's also based on under five child loads timely distribute supplied ICCM essential drugs. They have to strengthen supply chain management, integrated pharmaceutical logistics system and ask woreda health office by letter for different resource shortages immediately will be expected from HCs.

From Health extension workers, the following recommendation will be expected, during services provision to follow ICCM chart booklet during any assessment, classification, treatment and follow up session of sick under five children. For complicated case referring use formal referral formats and for monthly report uses formal reporting formats. During service provision health extension workers give attention to caregivers and children. It's also to strengthen supply chain management, integrated pharmaceutical logistics system.

Chapter 9: Meta Evaluation

Meta-evaluation can be used to assess the quality of a single study or a set of studies in different ways. Literature identifies two types of meta-evaluations. First, formative meta-evaluations assist evaluators to plan, conduct, improve, interpret, and report their evaluation studies. Second, summative meta-evaluations – conducted following an evaluation – help audiences see an evaluation’s strengths and weaknesses, and judge its value.

This paper is focus on formative meta evaluation on evaluation of Implementation evaluation of ICCM in SNNPR, Hadiya zone of soro Woreda by considering program Evaluation standard, guiding principles of evaluators and Fundamental ethical principles.

The evaluation was conducted after performing all the procedure to synthesis the final report of this evaluation. By using standardized checklist adopted from American Joint committee of Evaluation. (46) With 4 standards:

6.1: Utility standards

To enhance use of the finding this evaluation was fully participatory from the starting to the end the key stakeholders are identified at the beginning and participate throughout the evaluation process. The judgment criteria for the evaluation of ICCM service for this evaluation was set by stakeholders and the indicators are also commented by them.

The evaluation process was conducted with a standard way by consulting advisors and different stakeholders the evaluation questions are the needs of stakeholders and the finding at the end will be disseminated timely according to the interest of the stakeholders. This all was assure the evaluation finding by the target beneficiary.

6.2: Feasibility standards

To ensure the practicality of ICCM evaluation was costs less than 10% of the program cost and the time also one months and keep the stakeholders involve, all the points upon which planning agreements were made put into activity and as much as possible measures to reduce wastage of resource was sought through a clear communication with those early identified stakeholders.

6.3: Propriety standards

All data collection tools are designed consider the ethical, legal issues to the rights and welfare of study participant are considered. Ethical clearance planned to be taken and permission of the study subjects is given due emphasis.

There is no procedure that affects privacy, dignity, confidentiality, and rights of participants. The data collection is complete and optimal in assessing the ICCM. Stakeholders agreed and consensus reached to do this Implementation evaluation before starting the evaluation and Conflict of interest was dealt with openly and honestly.

6.4: Accuracy standards

The accuracy standards ensure that an evaluation produces and disseminate valid and adequate information. detail description of the program and its level of implementation was set during discussion with key stakeholders and direct observation during services given. Data for the evaluation were collected by trained data collectors and the principal investigator using a pre-tested questionnaire.

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Annex I: Stakeholder Identification and Analysis Matrix

Table 11: Stakeholder Identification and Analysis Matrix in soro Woreda in 2016 G.C

Stakeholder	Role in the Program	Stakeholder interest in evaluation	Role in The Evaluation	Communication Strategy	Level of Importance
SNNPR health bureau ((MCH)	Distribution of protocol, guidelines supply and equipment's Providing supportive supervision.	Use the evaluation finding as an input for program improvement, Decision making, resource allocation	finding users	Letter	M
Hadiya Zone Health Department	Resource Allocation Capacity building, conduct ISS and review meeting.	Use the evaluation finding as an input for program improvement, Decision making, resource allocation	finding users, Source of data, and disseminating information	Face to Face Letter	H
Soro Woreda Health Office	Plan, implementation, Provide Technical Support and Facilitate Management Activities, Record and report, Monitoring, budget allocation, training of health care providers, ISS and conduct review meeting	Use evaluation findings for program improvement and effectiveness	Formulation of Evaluation Question, set judgment criteria, serving as sources of data, finding users, Describing program activities, context, priorities and goal	Face to Face Tell phone Letter	H

Soro Woreda administration	Community mobilization, Resource allocation Budget allocation	Use evaluation finding for resource allocation and decision making	Finding users	Face to face Letter	M
Health center	monitoring and follow up, ISS, Recording and reporting	Use the findings for program improvement	Formulation of Evaluation Question, set judgment criteria Serving as sources of data	Face to Face Tell phone Letter	H
Health post	Plan, Implementation, monitor, follow up, recording and reporting	Use the findings for program implementation improvement	Source of information, Formulation of Evaluation Question, set judgment criteria Serving as sources of data Interpreting findings	Face to face Tell phone Letter	H
Care givers	beneficiary	Program Improvement	Data sources	Face to face	M
Kebele administration	Community mobilization, Strengthen of HDA, approval of program plan and achievement	collaboration in program implementation	Transferring information Use the findings for client mobilization	Face to face Letter	L
Health Development Army(HDA)	Community mobilization Support and facilitate implementation	collaboration in program implementation	Serving as sources of data during the evaluation	Face to face	L
NGOs (IFHP, save the children)	Capacity Building Providing drugs, Support Resource and Supportive supervision	Program improvement	Finding users, Formulation of Evaluation Question, set judgment criteria	Face to face Tell phone letter	M

Annex II: Indicators definition for evaluation of ICCM program

Table 12: Indicators definition for evaluation of ICCM program in soro woreda, in 2017.

Dimensions	Indicator	Numerator	Denominator
Availability	Number of health posts with trained health extension worker on ICCM.	Number of health posts with trained health extension worker on ICCM.	Total number of health posts
	Number of HPs with amoxicillin no stock out in the last three months	Number of HPs with amoxicillin no stock out in the last three months	Total number of health posts
	Number of HPs with no stock out of anti-malaria drugs in last three months	Number of HPs with no stock out of anti-malaria drugs in last three months	Total number of health posts
	Number of HPs with no stock out of zinc in last three months	Number of HPs with no stock out of zinc in last three months	Total number of health posts
	Number of HPs with no stock out of ORS in last three months	Number of HPs with no stock out of ORS in last three months	Total number of health posts
	Number of HP with no stock out deworming in the last three month	Number of HP with no stock out deworming in the last three month	Total number of health posts
	Number of HP with no stock out Vitamin A in	Number of HP with no stock out Vitamin A in	Total number of health posts

	last three months	last three months	
	Number of HP with no stock out RUTF in the last three month	Number of HP with no stock out RUTF in the last three month	Total number of health posts
	Number of HP with MUAC	Number of HP with MUAC	Total number of health posts
	Number of HP with functional thermometer	Number of HP with functional thermometer	Total number of health posts
	Number of HPS with functional weight scale	Number of HPS with functional weight scale	Total number of health posts
	Number of HPs with ICCM guide line.	Number of HPs with ICCM guide line.	Total number of health posts
	Number of HPs having ICCM registration book.	Number of HPs having ICCM registration book.	Total number of health posts
	Number of HPS with functional ORT corner.	Number of HPS with functional ORT corner.	Total number of health posts
	Number of HPS with Cotrimoxazole no stock out in the last three months.	Number of HPS with Cotrimoxazole.	Total number of health posts
	Number of HPs with functional timer.	Number of HPs with functional timer.	Total number of health posts
	Proportion of sick children who those history taking.	Number of sick children who those history taking	Total number of under five children for all cases
	Proportion of caregivers satisfied by providers greeting.	Number of caregivers satisfied by providers	Total number of under five children

compliance		greeting.	caregivers
	Proportion of children who are correctly assessed and classified for pneumonia, diarrhea, malaria and malnutrition according to ICCM guideline	Number of children who are correctly assessed and classified for pneumonia, diarrhea, malaria and malnutrition according to ICCM guideline	Total number of children with assessment of pneumonia, diarrhea, malaria and malnutrition
	Proportion of sick children with classifications of pneumonia, diarrhea, malaria and malnutrition who are correctly treated according to ICCM guideline	Number of sick children with classifications of pneumonia, diarrhea, malaria and malnutrition who are correctly treated according to ICCM guideline	Total number of children with classification of pneumonia, diarrhea, malaria and malnutrition
	Proportion of care givers counseled about food, fluids, home care and when to return according to ICCM guideline.	Number of care givers counseled about food, fluids, home care and when to return according to ICCM guideline.	Total number of care givers who brings sick children
	Proportion of sick children with classifications of pneumonia, diarrhea, malaria and malnutrition who had followed up according to ICCM guideline.	Number of sick children with classifications of pneumonia, diarrhea, malaria and malnutrition who had followed up according to ICCM guideline.	Total number of children with classification of pneumonia, diarrhea, malaria and malnutrition
	Proportion of sick children checked for danger signs according to ICCM guideline.	Number of sick children checked for danger signs according to ICCM guideline	Total number of sick children

Proportion mother and child children checked for HIV/AIDS status according to ICCM guideline.	Number of child children checked for HIV/AIDS status according to ICCM guideline.	Total number of sick children
Proportion of sick children checked for immunization status according to ICCM guideline	Number of sick children checked for immunization status according to ICCM guideline	Total number of sick children
Proportion sick children checked for vitamin A supplementation status according to ICCM guideline.	Number of sick children checked for vitamin A supplementation status according to ICCM guideline.	Total number of sick children
Proportion sick children checked for de-worming status according to ICCM guideline.	Number of sick children checked for de-worming status according to ICCM guideline.	Total number of sick children
Proportion of complicated cases referred to HC according to ICCM implementation guide line	Number of complicated cases referred to HC according to ICCM implementation guide line	Total number of children referred
Proportion of HP supervised by WorHO in last quarter with standard check list	Number of HP supervised by WorHO in last quarter with standard check list	Total number of health posts
Number of HP sent report during reporting period.	Number of HP sent report during reporting period.	Total number of health post
Proportion of HEWs attended ICCM	Number of HEWs attended ICCM performance	Total number of health posts

	performance review meeting.	review meeting.	
acceptability	Number of caregiver satisfied with availability of provider at working time.	Number of caregiver satisfied with availability of provider at working time.	Total number of caregivers
	Number of caregiver satisfied on the way of communication with HEWs.	Number of caregiver satisfied on the way of communication with HEWs.	Total number of caregivers
	Number of care givers who perceived that the waiting area is appropriate size and comfortable chair to wait for service.	Number of care givers who perceived that the waiting area is appropriate size and comfortable chair to wait for service.	Total number of caregivers
	Number of care givers satisfied on cleanliness of health post.	Number of care givers satisfied on cleanliness of health post.	Total number of caregivers
	Number of care givers who perceive that the consultation time is appropriate for them.	Number of care givers who perceive that the consultation time is appropriate for them.	Total number of caregivers
	Number of care givers who perceived that privacy was maintained during examination.	Number of care givers who perceived that privacy was maintained during examination.	Total number of caregivers
	Number of care givers who perceived that the health extension worker showed respect for them.	Number of care givers who perceived that the health extension worker showed respect for them.	Total number of caregivers

	Number of care givers who perceived that the waiting time is reasonable.	Number of care givers who perceived that the waiting time is reasonable.	Total number of caregivers
	Number of care givers who promised to recommend the service for other family or friend.	Number of care givers who promised to recommend the service for other family or friend.	Total number of caregivers
	Number of care givers who agree that they will return back to the same facility to receive service.	Number of care givers who agree that they will return back to the same facility to receive service.	Total number of caregivers
	Number of caregivers who satisfied on the HEWs explain the health status of child very well.	Number of caregivers who satisfied on the HEWs explain the health status of child very well.	Total number of caregivers

Annexes III: Measuring tools and information matrix of indicators

Table 13: Information matrix for indicators used for process evaluation of ICCM program in soro woreda, 2017

Evaluation question	Indicators	Source of information	Data collection method	Data collection tool
Are all necessary program resources needed for the implementation of ICCM service available? If yes, how? If no, why?	<p>Number of health posts with trained health extension worker on ICCM.</p> <p>Number of HPs with amoxicillin no stock out in the last three months</p> <p>Number of HPs with no stock out of anti-malaria drugs in last three months</p> <p>Number of HPs with no stock out of zinc in last three months</p> <p>Number of HPs with no stock out of ORS in last three months</p> <p>Number of HP with no stock out deworming in the last three month</p> <p>Number of HP with no stock out Vitamin A in last three months</p> <p>Number of HP with no stock out RUTF in the last three month</p> <p>Number of HP with MUAC</p> <p>Number of HP with functional thermometer</p> <p>Number of HPS with functional weight scale</p> <p>Number of HPs with ICCM guide line.</p> <p>Number of HPs having ICCM registration book.</p> <p>Number of HPS with functional ORT corner.</p> <p>Number of HPS with functional Ambu-bag.</p> <p>Number of HPs with functional timer.</p>	<p>Facility Records (like Bin car, stock card and In-service training registration book Report of request and resupply)</p> <p>Health extension worker</p>	Resource audit	Resource audit checklist

	<p>implementation guide line</p> <p>Proportion of HP supervised by WorHO in last quarter with standard check list</p> <p>Number of HP sent report during reporting period.</p> <p>Proportion of HEWs attended ICCM performance review meeting.</p>			
<p>Are caregivers satisfied with ICCM service provided? If yes, how? If no, why?</p>	<p>Number of caregiver satisfied with availability of provider at working time.</p> <p>Number of caregiver satisfied on the way of communication with HEWs.</p> <p>Number of care givers who perceived that the waiting area is appropriate size and comfortable chair to wait for service.</p> <p>Number of care givers satisfied on cleanliness of health post.</p> <p>Number of care givers who perceive that the consultation time is appropriate for them.</p> <p>Number of caregivers who perceived the HEWs explain the health status of child very well.</p> <p>Number of care givers who perceived that privacy was maintained during examination.</p> <p>Number of care givers who perceived that the health extension worker showed respect for them.</p> <p>Number of care givers who perceived that the waiting time is reasonable.</p> <p>Number of care givers who promised to recommend the service for other family or friend.</p> <p>Number of care givers who agree that they will return back to the same facility to receive service.</p>	Care giver	Exit inter view	Structured questionnaire

Relevance matrix of indicators used for evaluation of FANC service in Hawassa town public health centers 2017.

S.no	Indicators	Dimension		
		Availability	Compliance	Acceptability (Satisfaction)
1	Number of health posts with trained health extension worker on ICCM.	RRR	RRR	RR
2	Number of HPs with amoxicillin no stock out in the last three months	RRR	R	RR
3	Number of HPs with no stock out of anti-malaria drugs in last three months	RRR	R	RR
4	Number of HPs with no stock out of zinc in last three months	RRR	R	RR
5	Number of HPs with no stock out of ORS in last three months	RRR	R	RR
6	Number of HP with no stock out deworming in the last three month	RRR	R	RR
7	Number of HP with no stock out Vitamin A in last three months	RRR	R	RR
8	Number of HP with no stock out RUTF in the last three month	RRR	R	RR
9	Number of HP with MUAC	RRR	RRR	RR

10	Number of HP with functional thermometer	RRR	RRR	RR
11	Number of HPS with functional weight scale	RRR	RRR	RR
12	Number of HPs with ICCM guide line.	RRR	RRR	R
13	Number of HPs having ICCM registration book.	RRR	RRR	R
14	Number of HPS with functional ORT corner.	RRR	RRR	R
15	Number of HPS with Cotrimoxazole no stock out in the last three months.	RRR	R	RR
16	Number of HPs with functional timer.	RRR	RRR	RR
17	Proportion of sick children who those history taking.		RRR	RRR
18	Proportion of caregivers satisfied by providers greeting.		RRR	RRR
19	Proportion of children who are correctly assessed and classified for pneumonia, diarrhea, malaria and malnutrition according to ICCM guideline		RRR	RR
20	Proportion of sick children with classifications of pneumonia, diarrhea, malaria and malnutrition who are correctly treated according to ICCM guideline		RRR	RR
21	Proportion of care givers counseled about food, fluids, home care and when to return according to ICCM guideline.		RRR	RRR
22	Proportion of sick children with classifications of pneumonia, diarrhea, malaria and malnutrition who had followed up according to ICCM guideline.		RRR	RR

23	Proportion of sick children checked for danger signs according to ICCM guideline.		RRR	RR
24	Proportion mother and child children checked for HIV/AIDS status according to ICCM guideline.		RRR	R
25	Proportion of sick children checked for immunization status according to ICCM guideline		RRR	RR
26	Proportion sick children checked for vitamin A supplementation status according to ICCM guideline.		RRR	RR
27	Proportion sick children checked for de-worming status according to ICCM guideline.		RRR	RR
28	Proportion of complicated cases referred to HC according to ICCM implementation guide line		RRR	R
29	Proportion of HP supervised by WorHO in last quarter with standard check list		RRR	
30	Number of HP sent report during reporting period.		RRR	
31	Proportion of HEWs attended ICCM performance review meeting.		RRR	
32	Number of caregiver satisfied with availability of provider at working time.			RRR
33	Number of caregiver satisfied on the way of communication with HEWs.			RRR
34	Number of care givers who perceived that the waiting area is appropriate size and comfortable chair to wait			RRR

	for service.			
35	Number of care givers satisfied on cleanliness of health post.			RRR
36	Number of care givers who perceive that the consultation time is appropriate for them.			RRR
37	Number of care givers who perceived that privacy was maintained during examination.			RRR
38	Number of care givers who perceived that the health extension worker showed respect for them.			RRR
39	Number of care givers who perceived that the waiting time is reasonable.			RRR
40	Number of care givers who promised to recommend the service for other family or friend.			RRR
41	Number of care givers who agree that they will return back to the same facility to receive service.			RRR
42	Number of caregivers who satisfied on the HEWs explain the health status of child very well.			RRR

KEY RRR = very relevant RR = relevant R = poorly relevant

Annexes IV: Data collection Tools for ICCM program

Jimma University school of Health sciences Department of Health Economics, Management and Policy; Health Monitoring and Evaluation Program unit

Title: A data collection tool developed for process evaluation of integrated community case management childhood illness program (ICCM) in selected health posts of soro woreda, Hadiya zone, southern Ethiopia 2016.

Questionnaire I: Tool for collection of data from care giver to evaluate implementation of the ICCM program (at health post after services).

Letter of permission from Health facility

I am _____, BSc/MSc student from Jimma University and I am one of the research team working as a research assistant entitled as: Process Evaluation of ICCM program in under five children in Soro Woreda, Hadiya zone, SNNPR. The purpose of the evaluation will be to evaluate the Intended process of ICCM program in order to capture lessons that can be used in future to improve the implementation of ICCM program in Hadiya zone Soro woreda in 2016. The interview should take less than 30 minutes/an hour. All responses will be kept confidential and your willingness for participation will be respected. This means that your interview responses will only be shared with research team members and we will ensure that any information we include in our report does not identify you as the respondent. Remember, you don't have to talk about anything you don't want to and you may end the interview at any time.

Are you willing to participate in this interview? Yes___ No___

Thanking you for the anticipated favorable response. Yours faithfully,

Instruction: This questionnaire will be used to conduct exit interview/care giver/ in order to assess the ICCM implementation during the study period of at selected health posts in the woreda.

I Identification and background of the respondent (care givers)

- 01 Name of HPs_____
- 02 Age of caregiver _____
- 03 Sex of caregiver_____
- 04 Religion of caregiver _____
- 05 Marital status 1. Married 2, single 3, widowed 4, Divorced/separated
- 06 What is your Educational status of caregiver? 1. Illiterate 2. Read and write 3. Primary education 4. Secondary education 5. College and above
- 07 Occupational status. 1. Government employee 2. Farmer 3. Trader/Merchant 4. House wife 5. Daily laborer 6. Other, specify_____
- 08 Income level per months 1. <500 2. 501- 1000 3. 1001- 2500 4. 2501-3500 5. >3500
- 09 How many under five years' children did you have currently? 1. One 2. Two 3. Three
- 10 What is your total family number currently? 1. < 4 2. 4-8 3. 8-12 4. > 12

II Information on child health care practice

- 11 Is the child given other foods (all other than breast) within the first six months? 1.Yes 2. No
- 12 When was, complementary diet started?
1. <6 months 2. At six months 3. > 6 months
- 13 How many times did you bring your child health post? -----times
- 14. Have you vaccinated your child? 1. Yes 2. No
- 15 If yes for Q 12 did your child fully immunized or updated based on age 1. Yes 2. No
- 16 Have you de-wormed your child every six month after 24months of age 1. Yes 2. No
- 17 Have you supplied your child with vitamin A every six month after 6 months of age?
1. Yes 2. No

III INFORMATION ON FOLLOW UP CARE

- 18 Did health extension worker tell you your child's illness?
1. Yes 2. No 3. Don't know

19 Did the health extension worker prescribe any medication for your child (drugs are available)?

1. Yes 2. No

20 How many times do you give this medicine to your child? Time in number _____

21 For how many days? Days in numbers _____

22. Was the ORS prescribed or given to your Childs? 1. Yes 2. No

23. If yes for Q 20, What quantity of water are used to mix with a sachet of ORS? _____in liter.

24 What quantity of ORS are you going to give to the child every time? _____ in Cup.

25 How long did you wait between the time you first arrived to the HPs and gets service?

1. < 30 minutes 2. > 30 minutes

26. How long time the consultation time of the service provider by HEWs?

1. <15 minutes 2. 15-30 minutes 3. >30 minutes

27 Did the health extension worker give a specific appointment when to come back at the HP?

1. Yes 2. No

IV Answer the following satisfaction level assessment questions as strongly agree, agree, neutral, disagree and strongly disagree when I ask you respective questions.

28. You are satisfied with availability of HEWs at working time.

Strongly agree 2. Agree 3. Neutral 4. Disagree and 5. Strongly disagree

29. You are satisfied with on the way of communication with HEWs.

1 Strongly agree 2. Agree 3. Neutral 4. Disagree and 5. Strongly disagree

30. You are satisfied with on cleanliness of health post.

1 Strongly agree 2. Agree 3. Neutral 4. Disagree and 5. Strongly disagree

31. You are satisfied with the HEWs explain the health status of child very well.

1 Strongly agree 2. Agree 3. Neutral 4. Disagree and 5. Strongly disagree

32. You are satisfied with perceived of the examination rooms cleanliness.

1 Strongly agree 2. Agree 3. Neutral 4. Disagree and 5. Strongly disagree

33. You are satisfied with the waiting area is appropriate size and comfortable chair to wait for service.

1 Strongly agree 2. Agree 3. Neutral 4. Disagree and 5. Strongly disagree

34. You are satisfied with the health extension worker showed respect for them.

1 Strongly agree 2. Agree 3. Neutral 4. Disagree and 5. Strongly disagree

35. You are satisfied with the consultation time provided by HEW.

1 Strongly agree 2. Agree 3. Neutral 4. Disagree and 5. Strongly disagree

36. Do you agree with the waiting time is reasonable.

1 Strongly agree 2. Agree 3. Neutral 4. Disagree and 5. Strongly disagree

37. Do you agree to recommend the service for other family or friend.

1 Strongly agree 2. Agree 3. Neutral 4. Disagree and 5. Strongly disagree

38. Do you interest will return back to the same facility to receive service.

1 Strongly agree 2. Agree 3. Neutral 4. Disagree and 5. Strongly disagree

Thank you!!

Data collector name: _____ Date of data collection: _____ Signature: _____

supervisor's name: _____ Checked date _____ Signature: _____

Questionnaire II : - Protocol for collection of data from ICCM registration book and report format (health post document review).

Informed Consent form

My name is _____ from Jimma University and I am one of the research team working as a research assistant entitled: as we will review ICCM registration book and reports in order to capture information related to implementation of ICCM program in soro woreda in 2016.

The purpose of the evaluation will be to evaluate the Proposed process evaluation of ICCM program in Hadiya zone Soro woreda in 2016. The information that will be generating from this study will be used to understand the compliance of the program. The research approach involves collecting data from information in the health post ICCM registers book and report format while the client was under the care of health post during the time period of July 01/2016 to January 30/2016. I have already submitted a request for clearance from University of Jimma and will not undertake any part of this research until such clearance is received. I promise that if granted such permission.

May I continue to review the ICCM reports & registration book? 1. Yes 2. No

Thanking you for the anticipated favorable response. Yours faithfully,

Instruction: This questionnaire will be used to conduct document review in order to assess the ICCM services received by the under five children in soro woreda, 2016

The data will be collected from ICCM registration book from each selected health posts.

Code	Questions that will be obtained from ICCM registration	code			Remark
	General information	Yes (1)	No(2)	NA(3)	
001	Name of HP _____				
002	Date of data collection(dd/mm/yy) ___/___/_____				
003	HMIS code of HP _____				
004	Age of child (month) _____				
005	Sex of child 1=male, 2= Female				
006	Weight of child _____				

007	Temperature of child _____				
008	Distance to home(min.) _____				
Information checked for danger signs					
009	Checked for danger sign? 1=yes 2=No				
	If Q 009, yes checked all below danger signs				
	Can't drink 1= Yes 2=No				
	Vomits all that he eats (everything) 1=Yes				
	Had convulsions 1=Yes 2=No 3=NA				
	Checked if the child is lethargic or unconscious				
Information about assessing cough or difficult of breathing					
010	Does the child have cough or difficult of breathing? 1= Yes 2=No 3 =NA				
011	If Q 010, yes, correctly classify Childs for pneumonia?				
012	HEWs classification of cough or difficult of breathing (circle one of the classification listed below) 1. Severe pneumonia 2. Pneumonia 3. Cough or cold				
Information about assessing diarrhea					
013	Does the child have diarrhea? 1= Yes 2=No 3= NA				
014	If Q013 yes, child correctly classify for the diarrhea?				
015	HEWs classification of diarrhea (circle one or more of the classification listed below) 1. Severe dehydration 2. Some dehydration 3. No dehydration 4. Sever persistent diarrhea 5. Persistent diarrhea 6. Dysentery				
Information about assessing fever					
016	Does the child have fever? 1=Yes 2=No 3= NA				
017	If Q016 yes, Child correctly classify about for the fever?				
018	HEWs classification of fever (circle one of the classification listed below)				

	1. Very severe febrile disease 2. Malaria 3. Fever –malaria unlikely 4. Severe complicated measles 5. Measles with eye or mouth complications 6. Measles				
Information about Malnutrition checking in the Child					
019	Child correctly classify about malnutrition?				
020	Is this child less than six months of age?				
021	If Q 020 yes, Visible severe wasting in infants less than six months of age				
022	If Q 019 yes, measure mid upper arm circumference (MUAC) for greater than or equals to six months' child?				
023	If Q 019 yes, Look and feel for edema of both feet				
024	Check for feeding problem of sick infant				
025	Testing appetite for severe acute malnutrition for greater than six months				
026	HEWs classification of malnutrition (circle one of the classification listed below) 1. Severe complicated malnutrition 2. Severe uncomplicated malnutrition 3. Moderate acute malnutrition 4. No acute malnutrition				
Information checking about HIV/ADIS, Immunization, De-worming, Vitamin A and Anemia					
027	Have the child checked for anemia				
028	Have the mother and child Checked for HIV/AIDS status				
039	Have the child checked for Immunization status				
030	Have the child checked for de-worming status				
031	Have the child checked for vitamin supplementation status				

Information about treatment of cough or difficult of breathing					
032	Hews Correctly prescribe the pre-referral treatment for severe pneumonia or very severe disease				
033	Hews Correctly prescribed for pneumonia (Cotrimoxazole or amoxicillin with correct DSD)				
034	By hews No treatment is given for no pneumonia classification				
035	Correctly stated the follow-up date for pneumonia				
Information about treatment of diarrhea					
036	HEWs Correctly prescribe the pre-referral treatment for severe dehydration, severe persistent diarrhea and dysentery				
037	HEWs Correctly prescribed for some dehydration (ORS according to plan B with correct DSD)				
038	HEWs Correctly prescribed for no dehydration (ORS according to plan A with correct DSD)				
039	HEWs correctly prescribe zinc sulphate for some dehydration and no dehydration with DSD				
040	HEWs Correctly stated the follow-up date for diarrhea				
Information about treatment of fever					
041	HEWs Correctly prescribe the pre-referral treatment for very severe febrile disease or severe malaria with paracetamol				
042	HEWs Correctly prescribed for malaria (coarthem if mixed or Plasmodium falciparum; chloroquine if Plasmodium vivax with correct DSD)				
043	By HEWs No treatment is given for fever (no malaria) classification				
044	HEWs Correctly stated the follow-up date for malaria				
045	HEWs Correctly prescribed for measles with eye or				

	mouth complication and measles (vitamin A)				
Information about treatment of malnutrition					
046	HEWs Correctly prescribe the pre-referral treatment for severe complication malnutrition with vitamin A if no edema				
047	Correctly prescribed for severe uncomplicated malnutrition with plumpy nut, amoxicillin, folic acid and vitamin A if no edema)				
048	Hews Correctly stated the follow-up date for malnutrition				
Information about communication and counseling					
049	Hews Counsel care givers about food, fluid and when to return to the health posts for next appointment				
Information about result of treatment (It is confirmed during follow up care appointment date)					
050	Sick child improved after treatment				
051	Sick child the same after treatment				
052	Sick child worsens after treatment				
053	Sick child die after treatment				
Information about referral , ISS and Reports					
054	Did the sick child need Referral? To next level				
055	If yes for Q054 was the sick child referred to next level facility?				
056	Did health post supervised in the last quarter by woreda Health office?				
057	Did the HP send report during reporting period to next body?				
058	Did HEWs attended performance review meeting				

Thank you!!

Data collector name: _____ Date of document review: _____ Signature: ____
supervisor's name: _____ Checked date _____ Signature: ____

Questionnaire III : Direct observation check-list (Guide)

Instruction: This checklist will be used to conduct direct observation of health extension worker at health post while assessing, classifying, treating and counseling and providing follow-up services.

An observation checklist used to assess the compliance of health extension worker in ICCM service delivery at health post.

Consent form between health extension worker and data collector

I want to thank you for taking time to meet with me today. My name is _____ from Jimma University and I am hereby to observe the ICCM service at this unit. This is part of the overall program evaluation and it will help to improve the implementation of ICCM program services delivered at this health post. The observation will be conducted during you provide the services and all findings of the observation will be kept confidential. Further we will ensure that any information we include in our report does not identify you as the respondent. Remember, everything will be undertaken with your agreement and your willingness will be respected.

Are you willing to participate in this interview?

Interviewee

observer

Date

Consent form between health care provider and care givers

Thank you for visiting our health post for receiving services. Today I will provide you services. He is a data collector for evaluation of ICCM services in health post hereby to observe the clinical process and provide additional support which will help me to provide you better services. During the overall process your information will be kept confidential as previous and no one will identify you as part of the observation or respondent. Remember, everything will be undertaken based on your will.

Are there any questions about what I have just explained?

Are you willing to participate in this interview?

Interviewee

observer

Date

Code	Activities	Yes (1)	No(2)	NA(3)	Remark
Part I Client provider interaction					
	ICCM initial visit				
101	Do the HEWs show respect for the client (Greeting and offer seat)?				
102	Do the HEWs ask the age of the sick child				
103	Do the HEWs measure the weight of the sick child				
104	Do the HEWs measure the temperature of the sick child				
105	Do the HEWs ask the main problem of sick child from care givers				
106	Do the HEWs ask if the sick child had convulsions				
107	Do the HEWs observe if the sick child is convulsing now				
108	Do the HEWs ask If the sick is unable to breastfeed/drinking				
109	Do the HEWs ask If the sick child is the child vomits everything				
110	Do the HEWs ask If the sick child is lethargic or unconscious				
111	Do the HEWs check the child for general danger signs				
112	Do the HEWs count the number of breathing per/minute				
113	Do the HEWs look for chest in-drawing				
114	Do the HEWs look or listen for a stridor?				
115	Do the HEWs correctly classified for pneumonia				
116	Do the HEWs ask if Is there blood in the stool				

117	Do the HEWs look at the child's general condition				
118	Do the HEWs look for sunken				
119	Do the HEWs offer the child fluid				
120	Do the HEWs Pinch the skin of the abdomen				
121	Do the HEWs correctly classified for Diarrhea				
122	Do the HEWs decide Malaria risk				
123	If "low or no" malaria risk, then ask: has the child travelled outside this area within 7 days				
124	If for Q123 yes, has been travel to a malarias area				
125	Do the HEWs look or feel for stiff neck				
126	Do the HEWs look for runny nose				
127	Do the HEWs look for signs of Measles: generalized rash and one of these: Cough runny nose or red eyes.				
128	Do the HEWs Do RDT test				
129	Do the HEWs correctly classify for fever				
130	Do the HEWs look for visible severe wasting				
131	Do the HEWs check for pitting edema of both feet.				
132	Do the HEWs Measure MUAC for age 6-59 month				
133	Do the HEWs Check Complications: Pneumonia, watery diarrhea/dysentery, fever and measles				
134	If there is MUAC <11cm or pitting edema and no medical complication do appetite test: fail/ pass				
135	Do the HEWs look for palmar pallor: Severe pallor/ Some pallor				
136	Do the HEWs correctly classify for malnutrition				
137	Do the HEWs check for HIV status				
138	Do the HEWs check for immunization status				
139	Do the HEWs check for vitamin-A status				
140	Do the HEWs check for de-worming status				

141	Do the HEWs ask for other health problem				
142	Do the HEWs classified all problem of sick child				
143	Do the HEWs correctly prescribe for pneumonia				
144	Do the HEWs correctly prescribe for diarrhea				
145	Do the HEWs correctly prescribe for malaria				
146	Do the HEWs correctly prescribe for malnutrition				
147	Do the HEWs refer to the next level for severe classification				
148	Do the HEWs counsel the care giver on food, fluid and when return back				
149	Do the HEWs give appointment for follow-up visit				
	ICCM follow-up visit				
150	Do the HEWs check the child for general danger signs				
151	Do the HEWs assess the child for appointed classification				
152	Do the HEWs ask is the child breathing lower				
152	Do the HEWs ask is the child less fever				
153	Do the HEWs ask is child eat better				
154	Do the HEWs assess for new problem				
155	Do the HEWs treat the child based on follow-up assessment				

Closing: Thanks, the HEWs as well as the client parents and then finish your observation!!

Observer's name _____ Observation Date: _____ Signature: _____

Checked by/supervisors name: _____ Checked date: _____ Signature: _____

Questionnaire IV: - ICCM Resource Inveniter check-list

Instruction: This checklist will be used to conduct Resource audit (inventory) in order to assess Infrastructure, human resource, ICCM drugs and supplies in all selected HP.

Name of Health post-----

Total population -----

Total number of under five children -----

Number of HEWs -----

Complete the following table by asking the health extension worker or by observing story and bin card.

Code	Items	Standard on ICCM guideline	Available and use it (Put a √ mark)		If the item was stock out		Remark
			Yes	No	Day of stock out	Reason of stock out	
Recording & Reporting Tool							
1	ICCM guide line						
2	ICCM Registration Book for 2-59 months of age children						
3	ICCM Registration Book for 0- 2 months of age children						
4	Family health card						
5	OTP card						
6	Monthly Reporting Format						
7	Referral formats						
medical equipment and Infrastructure							

Code	Items	Standard on ICCM guideline	Available and functional		If not available and functional	Remark
			Yes	No	Reason for it	
8	Thermometer					
9	Newborn Ambu-bag					
10	Timer					
11	MUAC measuring tape					
12	Weighing scale					
13	Thermometer					
14	ORT corner functional (ORS solution given according to Plan B-registered)					
15	ORT corner available (at least; a measuring jug, 2 cups, spoon, clean water, ORS)					
16	Clean drinking water					

Essential Drugs and supplies

Code	Items	Standard on ICCM guideline	Available and use it		If the item was stock out		Remark
			Yes	No	Day of stock out	Reason of stock out	
17	Albendazole (deworming)						

18	Anti-malaria with RDT						
19	Coarthem tablets						
20	Chloroquine syrup bottles						
21	Cotrimoxazole tablets						
22	Amoxicillin/antibiotics/						
23	Vitamin A capsule						
24	RUTF						
25	ORS						
26	Zinc tablets						
27	Paracetamol tablets						
28	Vitamin K ampoules						
29	Folic acid						
30	TTC eye ointment tubes						
31	2cc syringe and needle						
32	Examination gloves cartoon						

Thank you!!

Data collector name----- Date of data collection: ----- Signature: --

supervisor's name: ----- Checked date----- Signature: -----

Questionnaire VI: Interview Guide for Key Informants

Instruction: This questionnaire/tool will be used to assess the ICCM program service delivery, program context, resources sustainability, monitoring strategy and the strength and weakness of the implementing the program.

Consent form

I want to thank you for taking time to meet with me today. My name is _____ from Jimma University and I would like to talk to you about your experiences participating in the ICCM program.

Specifically, as one components of our overall program evaluation we are assessing program implementation in order to capture lessons that can be used in future to improve the program. The interview should take 30 -45 minutes. All responses will be kept confidential. This means that your interview responses will only be shared with research team members and we will ensure that any information we include in our report does not identify you as the respondent. Remember, you don't have to talk about anything you don't want to and you may end the interview at any time.

Are there any questions about what I have just explained?

Are you willing to participate in this interview?

The information about the proposed research study and consent has been explained by

Name of data collector _____ signature _____

Statement of consent.

I have fully understood the nature of this study, so I am agreed to participate.

Signature of participant _____ date _____

I. Guiding question to Health Extension Workers

Identification of HEW:

Name of HP _____ Name of Cluster HC _____

Qualification of HEW:

- 10+1 _____ Level IV _____

Training status: Trained _____ Untrained _____

Service year (Year started): _____

1. Are the all program resources in place to deliver ICCM services at this health post? If yes check it, if no what is the problems?

2. Had the ICCM service been interrupted due to unavailability of supplies, drugs and human power? If yes specify

3. Did you ever receive supportive supervision related to ICCM service? Yes, No

4. If yes from whom woreda health office? HC? NGOs? _____

5. If yes; when did, last supervision received? (dd/mm/yy) ____/____/____

6. How often the support provided? _____

7. Do you have any suggestions that you think are solutions to improve the implementation ICCM program at your health post? If yes, describe them

Thank you!!

Name of data collector _____

Date of data collection _____

Signature _____

Checked by/supervisors Name _____

Checked date _____ Signature _____

II. Guiding question for Health center heads in the selected HC

Identification of health center.

Name of HC _____

Qualification of HC head: Diploma in ----- BSc in ----- Master in -----

Training status: Trained _____ Untrained _____ Service year (Year started):

1. Could you tell me ICCM services follow up mechanism in the health post?

2. frequency of supervision conducted? Do you use ISS format?

3. Could you tell me about complicated case referral mechanism from HPs to HCs?

4. Is there regular performance review meeting with health extension workers in this health center? yes/no _____ If yes, how often? -----

If not for Q20, why? -----

5. What is the challenges and opportunity regarding to implement the ICCM program in health posts?

Thank you!!

Name of data collector _____ Date of data collection _____ Signature _____

Checked by/supervisors Name _____ Checked date _____ Signature _____

III. Guiding question for Woreda health office.

Name of the health institution: _____

Qualification: Diploma in -----BSc in ----- Master in -----

Training status: Trained _____ Untrained _____ Service year (Year started): _____

1. Does the health office and all the health centers have specific plan document for ICCM?
If not, why? -----

2. Could you tell me ICCM implementation follow up mechanism in the health post?

3. how to manage stock out of ICCM program implementation resources and drugs at health posts? -----

4. Capacity building and retention mechanism of health extension workers? -----

5. Has any trained professionals turn over within the last two years? If yes, what do you think the reason -----

6. What action did you take to solve all the above problems of ICCM services? -----

7. Is there support system (ISS) for HEWs? Yes/ no ----- If yes, how Often-----

8. If not for Q7 why? -----

9. Is there performance review meeting in the woreda? Yes/no ----- If yes, how frequently conducted? -----

10. If not for Q9, why? -----

11. What is the challenges and opportunity regarding to implement the ICCM program in health posts? -----

Thank you!!

Name of data collector _____ Date of data collection _____ Signature _____

አጠቃላይ መረጃ

- 01. የጤናኬላሰም -----02. የተንከባካቢዕድሜ -----
- 03. የተንከባካቢዎታ-----04. የተንከባካቢኃይማኖት-----
- 05. የተንከባካቢጋብቻሁኔታ: 1. ያገባች 2. ያላገባች 3. ቧላየሞተባት 4. የተፈታች
- 06. የተንከባካቢየትምህርትደረጃ: 1. መደበኛትምህርትየሌላት 2. ሁለተኛደረጃ
3. ማንበብናመፃፍየምትችል 4. ሦስተኛደረጃየመጀመሪያደረጃት/ት
- 07. የሥራሁኔታ:1. የመንግስትሠራተኛ: 2. ገበሬ 3. ነጋዴ 4. የቤትእመቤት 5. የቀንሠራተኛ 6. ሌላ
- 08. ወርሃዊየገቢሁኔታ: 1. <500 2. 500- 1000 3. 1001 -2500 4. 2501 – 3500 5. >3500
- 09. ከአመስትዓመትበታችአሁንያሉህፃናትብዛት? 1. አንድ 2. ሁለት 3. ሶስት
- 10. አሁንበዚህጊዜያለዉአጠቃላይየቤተሰብብዛት1. < 4 2. 4-8 3. 8-12 4. > 12

በሕፃኑጤናአተገባበርላይያለዉመረጃ

- 11. በመጀመሪያዎቹስድስትወራትለሕፃናትከጡትዉጭሌላምግብይሰጣሉ? 1.አዎ 2. አይደለም
- 12. ተጨማሪምግብመችነዉምጀመረዉ? 1. ከስድስትወርበፍት 2. በስድስትወር 3. ከስድስትወርበኋላ
- 13. ወደጤናኬላህጻናትንስንትጊዜአምጥተዋል? -----ጊዜ
- 14. ሕፃኑተከትቧል 1. አዎ 2. አይደለም
- 15. ጥያቄቁጥር12አዎከሆነሕፃኑሁሉንምክትባትወስዶጨርሶል? 1. አዎ 2. አይደለም
- 16. የህፃኑዕድሜ 24 ወርከሞላቧኃላበየ 6 ወሩየአንጀትጥገኛትላትልመድኃኒትይወስዳል ? 1. አዎ 2. አይደለም

17. የሕፃናት ልማት 6 ወር ከሞላ ለሰዓት 6 ወር ስለሚታዩ ንጹህ መድኃኒት ይወስዳል ?

1.

አዎ 2. አይደለም

በክትትል ዘመን ለሥራ ለማድረግ

18. ለእርሶጤና ኤክስቴንሽን ሥራ ተገኝቶ ለሕፃናት ስለሚታዩ ለሥራ ለማድረግ ? 1. አዎ 2. አይደለም 3. አላውቁም

19. የጤና ኤክስቴንሽን ሥራ ተገኝቶ ለሕፃናት ስለሚታዩ ለሥራ ለማድረግ ? 1. አዎ 2. አይደለም

20. መድኃኒት ለሕፃናት ስለሚታዩ ለሥራ ለማድረግ ? ጊዜ በቁጥር

21. ለምን ያክል ቀን ? ቀን በቁጥር

22. አ. ረ. ኤስ ለሕፃናት ስለሚታዩ ለሥራ ለማድረግ ? 1. አዎ 2. አይደለም

23. ጥያቄ ጥርጣሬ 20 አዎ ከሆነ ለአንድ ሰዓት አ. አር. ኤስ ስለሚታዩ ለሥራ ለማድረግ ? ----- በሊትር

24. ከተጠበቀ ጠባቢ ለሕፃናት ስለሚታዩ ለሥራ ለማድረግ ? ሲኒ

25. አገልግሎት ከማገኛቸው በፊት ምን ያክል ጊዜ ቆይተዋል ? 1. ከ 30 ደቂቃ በታች 2. ከ 30 ደቂቃ በላይ

26. ከጤና ኤክስቴንሽን ሥራ ተገኝቶ ለሕፃናት ስለሚታዩ ለሥራ ለማድረግ ?

1. ከ 15 ደቂቃ በታች 2. ከ 15-30 ደቂቃ 3. ከ 30 ደቂቃ በላይ

27. ጤና ኤክስቴንሽን ሥራ ተገኝቶ ለሕፃናት ስለሚታዩ ለሥራ ለማድረግ ? 1. አዎ 2. አይደለም

በአገልግሎት ለሥራ ለማድረግ የተከባከቧ ዎች እርካታ

28. ጤና ኤክስቴንሽን ሥራ ተገኝቶ ለሕፃናት ስለሚታዩ ለሥራ ለማድረግ ?

1. በጣም ተስማምቶኛል 2. ተስማምቶኛል 3. ምንም አይልም 4. አልተስማማኝም 5. በጣም አልተስማማኝም

29. ከጤና ኤክስቴንሽን ሥራ ተገኝቶ ለሕፃናት ስለሚታዩ ለሥራ ለማድረግ ?

1. በጣም ተስማምቶኛል 2. ተስማምቶኛል 3. ምንም አይልም 4. አልተስማማኝም 5. በጣም አልተስማማኝም

30. በጤና ኤክስቴንሽን ሥራ ተገኝቶ ለሕፃናት ስለሚታዩ ለሥራ ለማድረግ ?

1. በጣምተስማምቶኛል 2. ተስማምቶኛል 3. ምንምአይልም 4. አልተስማማኝም 5. በጣምአልተስማማኝም

31. የጤናኤክስቴንሽንንሠራተኛዋስለልጆየጤናሁኔታበገለፀችዉደስተኛኖትን?

1. በጣምተስማምቶኛል 2. ተስማምቶኛል 3. ምንምአይልም 4. አልተስማማኝም 5. በጣምአልተስማማኝም

32. በምርመራክፍልኒዲህናደስተኛኖትዉይ?

1. በጣምተስማምቶኛል 2. ተስማምቶኛል 3. ምንምአይልም 4. አልተስማማኝም 5. በጣምአልተስማማኝም

33. አገልግሎትለማገኘትበምጡብቁትወንበርእናቧታደስተኛኖትዉይ?

1. በጣምተስማምቶኛል 2. ተስማምቶኛል 3. ምንምአይልም 4. አልተስማማኝም 5. በጣምአልተስማማኝም

34. ጤናኤክስቴንሽንሠራተኛዋበምትሰጠዉክብርደስተኛኖትዉይ?

1. በጣምተስማምቶኛል 2. ተስማምቶኛል 3. ምንምአይልም 4. አልተስማማኝም 5. በጣምአልተስማማኝም

35. ከጤናኤክስቴንሽንሠራተኛዋጋሪበነበረዉይይት /ምክርየፈጀበትጊዜደስተኛኖት?

1. በጣምተስማምቶኛል 2. ተስማምቶኛል 3. ምንምአይልም 4. አልተስማማኝም 5. በጣምአልተስማማኝም

36. የጤናኤክስቴንሽንሠራተኛዋከማግኘትዎበፊትበጠበቁትወረፋደስተኛኖት?

1. በጣምተስማምቶኛል 2. ተስማምቶኛል 3. ምንምአይልም 4. አልተስማማኝም 5. በጣምአልተስማማኝም

37. አገልግሎቱንለሌሎችቤተሰቦች/ጎዴኞችለማስተዋወቅፍቃደኛኖት?

1. በጣምተስማምቶኛል 2. ተስማምቶኛል 3. ምንምአይልም 4. አልተስማማኝም 5. በጣምአልተስማማኝም

38. በቀጣይሕፃናትንበዚህጤትጤናኤክስቴንሽንተመልሰዉለማሳካምፍላጎትአሉት ?

1. በጣምተስማምቶኛል 2. ተስማምቶኛል 3. ምንምአይልም 4. አልተስማማኝም 5. በጣምአልተስማማኝም

የመረጃሰብሳቢዉስምናፊርማ _____

የሱፐርቫይዘርስምናፊርማ __ ቀን _____