International Eye Foundation and Christian Children's Fund

# *PVO Partnership for Child Survival Basonaworena and Debrebirhan Woredas of North Shewa Zone of the Amhara National Regional State*

**Mid-Term Evaluation and Final Report**
**September 16th- September 30th, 2000**

**Child Survival Cycle XII**

Cooperative Agreement No.: FAO-A-00-95-00018-00

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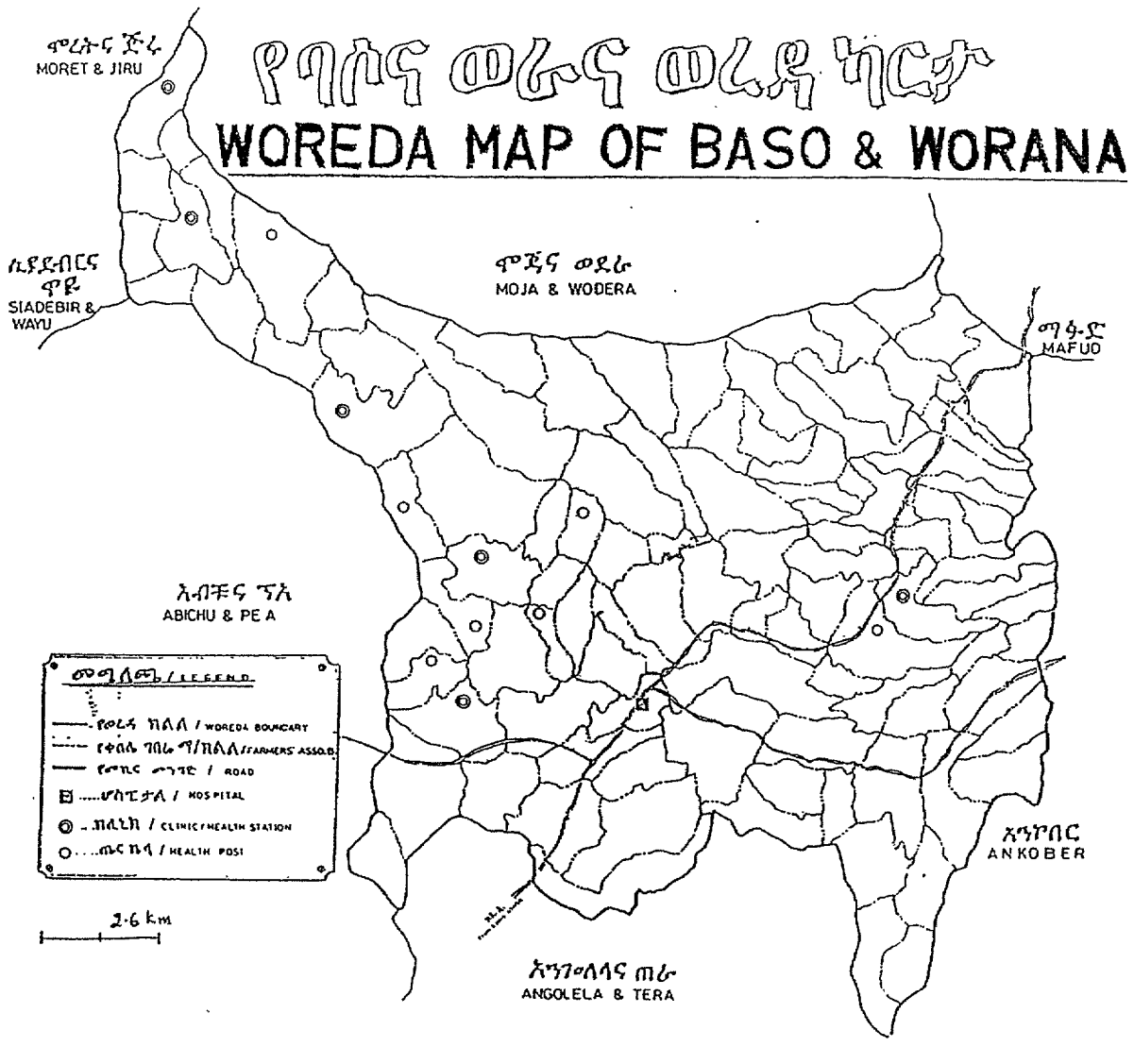
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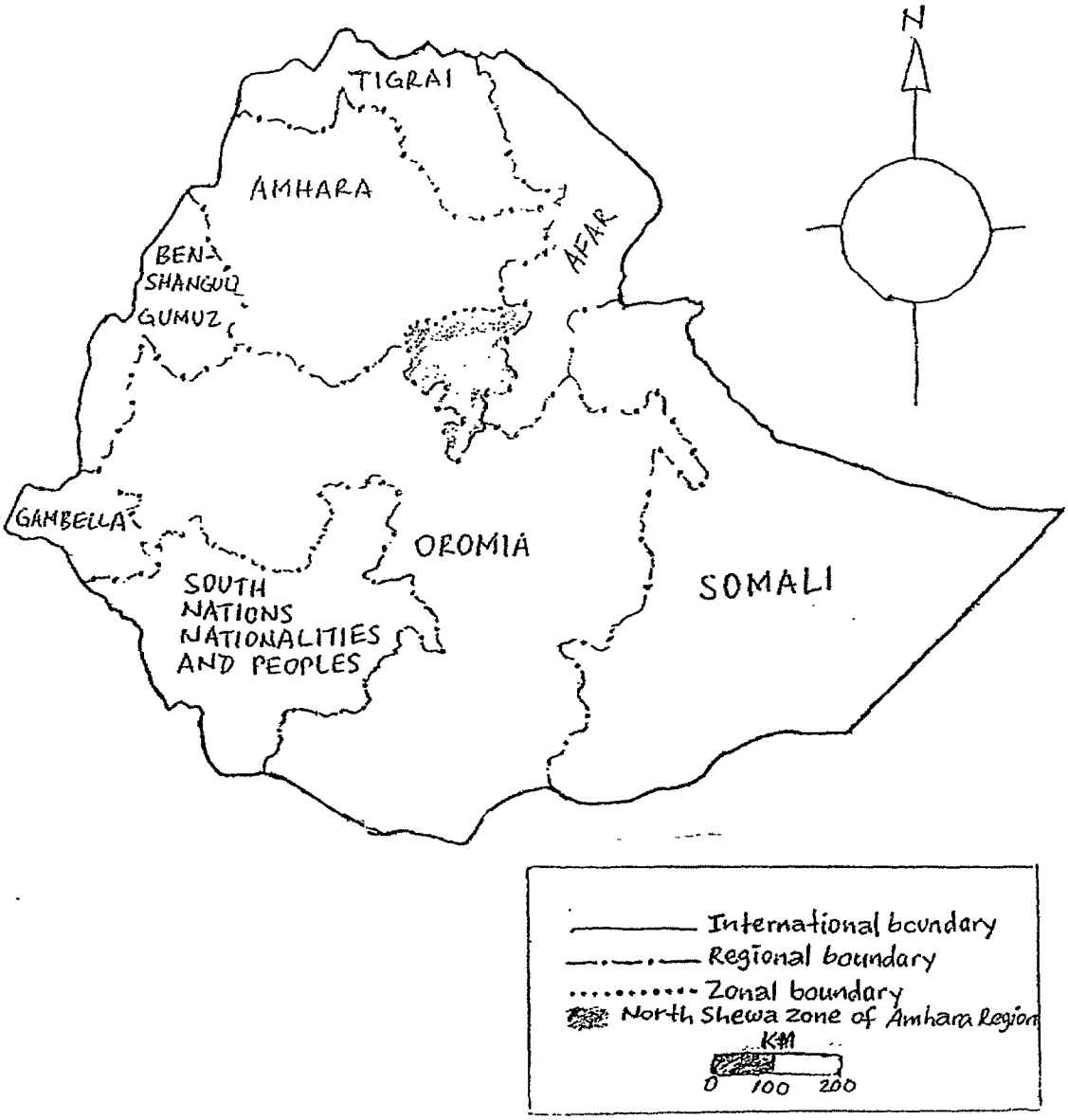
# ETHIOPIA

## Country Map



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## Acronyms

| | |
|---|---|
| BF | Breastfeeding |
| CCF | Christian Children's Fund |
| CHA | Community Health Agent |
| CHW | Community Health Worker |
| CS | Child Survival |
| DCM | Diarrheal Case Management |
| DD | Drug Depot |
| DH | Depot Holders |
| DIP | Detailed Implementation Plan |
| DPPD | Disaster Prevention and Preparedness Department |
| DPT3 | Diphtheria Pertussis Vaccine |
| EPI | Expanded Program on Immunization |
| IEC | Information, Education, and Communication |
| IEF | International Eye Foundation |
| HIS | |
| KPC | Knowledge, Practices, and Coverage |
| LOP | Life of Project |
| Majet | Hearth Model |
| MCH | Maternal Child Health |
| MOH | Ministry of Health |
| NGO | Non-Governmental Organization (see also PVO) |
| ORS | Oral Rehydration Salts (sachets) |
| ORT | Oral Rehydration Therapy |
| PA | Peasant Association |
| PVO | US Private Voluntary Organization (see also NGO) |
| QA | Quality Assurance |
| TA | Technical Assistance |
| TBA | Traditional Birth Attendant |
| TT | Tetanus Toxoid (and TT2) |
| UNICEF | United Nations Children's Fund |
| USAID | United States Agency for International Development |
| VAC | Vitamin A Capsule |
| WHO | World Health Organization |

# I. EXECUTIVE SUMMARY

*Program Overview and Objectives*

The IEF/CCF child survival project PVO Partnership for Child Survival is being implemented in the North Shewa Zone of the Amhara National Regional State, 130 kilometers northeast of capital city, Addis Ababa, the capital of Ethiopia. The population of the *woreda* (subdistrict) is approximately 165,000. The majority of the population is poor, rural, with about 40,000 people living in the main town of Debre Birhan. The area was chosen for the project based on need and on CCF's history of successful programming in the region.

Four primary interventions were selected based upon results of the baseline KPC survey: strengthen expanded program on immunization, diarrheal case management, promote breastfeeding and vitamin A, and improve mother and child nutrition practices (introduction of solids, complementary feeding, feeding during illness, etc.). The project targets 65,000 direct beneficiaries: 30,000 children under five years of age and 35,000 women of childbearing age. CCF has an established relationship with select *kebeles (*group of villages*)* in the woreda because of ongoing child and family health projects. This relationship has helped to establish more activities and develop trust with the kebele leaders and community.

A sub-grant agreement was signed in 1997 between the IEF (International Eye Foundation) —the grantor—and CCF (Christian Children's Fund)—the sub-grantee—to implement the program for the period from January 1997 to September 2000. However, the project agreement between CCF-Ethiopia, the Amhara National Regional Office of Disaster Prevention and Preparedness Commission, and the Regional Health Bureau was not signed until August 1998 due to difficulty meeting the DPPC strict criteria for PVOs in Ethiopia.

The IEF/CCF Child Survival XII project has been operating for 26 months since signing of the country agreement, although the project duration was from January 1, 1997 to September 29, 2000. A no-cost extension was granted to IEF/CCF for three months (until December 31, 2000) to carry out the mid-term evaluation and final report to USAID under this current agreement. A decision not to do a 12- month no-cost extension was made by IEF in February 2000.[1]

The objectives of this evaluation were to assess achievement against project objectives; explore strategies for future program direction; and develop project recommendations. The evaluation team, IEF, and CCF agreed to conduct a mid-term evaluation instead of a final evaluation, based on the timing of the approval of the DIP and lengthy delays in putting the project in place. The project is about half completed, and although the formal agreement with IEF will terminate in December 2000, CCF plans to continue supporting the project until the agreement with the Government of Ethiopia is completed, in April 2002. Alternatives for funding are being explored.

*Main accomplishments*

The project now operates in all of the 34 kebeles (community of villages) existing in the two woredas. The project's particularly noteworthy accomplishments to date include:

Input and output level achievements

- Approved detailed implementation plan and country agreement.
- Established and staffed field office.
- Baseline knowledge, practices, and coverage survey and health facilities survey.

[1] A decision not to request a 12 month no cost extension was made by IEF in February 2000 based on reconsideration of IEF strategic interests and uncertainty on what could be accomplished in another 12 months regarding sustainability.

- Training conducted in 23 rounds for 1,158 people from all levels (zonal, Ministry of Health, and volunteer mothers, covering the four interventions areas— expanded program of immunization, diarrheal case management, nutrition and vitamin A, and breastfeeding promotion.
- Mid-term KPC.
- Successful initiation of the Hearth model (*Majet*) in two kebeles.
- Improved capacities of ten health facilities including the Zonal Hospital in Debre Birhan, to conduct EPI, diarrheal case management, and other health activities.
- Excellent working relationships established with all counterparts in the project.
- Trust and transparency developed with, MOH, kebeles, and all local partners involved with the project.
- Large pool of health cadres selected by the communities themselves have been trained and placed in the communities (CHAs, TBAs, DHs and volunteer mothers).

Impact level achievements

- EPI coverage has significantly increased from 15.5 to 22.6 percent of children fully immunized and from 22.3 to 78.2 percent of mothers immunized with two tetanus toxoid in the two woredas.
- The number of people holding health cards and records of their immunizations has nearly doubled since project implementation.
- All health facilities have an oral rehydration therapy (ORT) corner.
- Vitamin A is reaching significantly more postpartum mothers (from 4.3 to 15.3 percent) and children under five (from 6 to 69.3 percent).

*Overall progress made in achieving program objectives*

Although the project experienced delays in starting, it has made every effort to make up for lost time, even with a thinly stretched staff. The project has made great strides since the actual field implementation began, although the start-up period experienced lengthy delays causing the timing, evaluation and financing of the CS cycle to off schedule. Notable accomplishments are mentioned above. The project is using state-of-the-art techniques, although at times development of these has been at a time cost (delay). Knowledge in some areas of the four interventions has improved, however it is too early to elaborate on behavior change other then the improvement in knowledge of immunization and acting upon it. In the area of developing relationships and trust for ease of project implementation and longer-term project sustainability, the project staff has gone above and beyond the norm.

Areas for improvement include intensifying the supervision and monitoring, by establishing roles for MOH staff, project staff as well as kebele leaders to lessen the burden on the project itself and to build the capacity of their partners. This also includes clearly defining expectations from each level of project staff, putting necessary checklists and tools into their hands and reviewing them on a regular basis. The project also has the opportunity to address the gap in communications between the community health workers and the health posts and stations, including support to each other's work, defining roles and responsibilities (such as assisting with campaigns, monitoring, referrals). Strengthening the diarrheal case management intervention needs particular attention, whereby purchase and provision of sugar and salt at the community level (as well as health posts) should be done without delay. The project has a prime opportunity to help move the cultural shift away from dependence on the unavailable ORS to (more self-reliance) home solutions, which are readily available.

To operate more efficiently and best address the four interventions, the whole evaluation team agreed the project needed more staff, at least two field level positions to cover what is needed at present. While the project is contemplating adding components such as HIV/AIDS and family planning, it would be ill-

advised to do so with out more staff. There should be careful consideration of any other interventions (such as ARI – for reasons discussed in the early project reports), as the staff is simply insufficient even for its current activities. With the planned completion of trainings and expansion of services to cover all areas as planned, and to address the recommendation from this midterm, the present staffing level is insufficient. The complete set of recommendations can be found in Section IV. C.

The principal aim of the project is to reduce infant and child morbidity and mortality through the four interventions mentioned above. The main strategy to achieve these objectives, as well as to create long-lasting sustainability of the interventions, is capacity building. Capacity building is defined as strengthening the partners and partnerships IEF/CCF, CCF/Ethiopia and their partners Ministry of Health such as health facilities, health worker performance, training, and program management (supervision of program staff and technical and administrative support).

*Barriers/Constraints*
A number of typical constraints face this project as face many child survival projects. These have contributed to some of the project shortcomings, such as inefficient monitoring of project activities and lack of change in such behavior indicators (e.g. nutrition and early initiation of breastfeeding). Initially, government resistance to Child Survival programming delayed the onset of the project and its insistence on low overhead caps still hampers the project from getting badly needed staff. There is a lack of sufficient government health facilities, basic infrastructure and supplies, and personnel to meet health needs, coupled with a dispersed and often inaccessible population. Changes in local government policies (particularly in regard to whether or not the project could have and train CHAs delayed their training and the program overall. Finally, the project staff and their partners face deep-rooted cultural beliefs, attitudes, perceptions, values, and practices in the project area rendering behavioral change a challenge.

*Prospects for sustainability*
The project's sustainability strategy was designed to attack the problem of poor child survival from the community level, increasing awareness and demand for services, and from the service delivery level, increasing the capacity of the Ministry to improve the quality and quantity of available services. The project intended to use quality assurance techniques to improve decision making control at the level of work performed and to enable Ministry personnel to overcome existing problems with EPI and continually monitor the process in the future without assistance from the project. To achieve sustainability, the project aims to increase the capacity of the Ministry Of Health and increase community demand for ministry services; improve the peasant associations' ability to organize health care; train community-level health workers based on the ministry curriculum; establish community-level drug depots to increase the availability of drugs; and establish a weaning foods microenterprise. The latter intervention was dropped.

The project has made great strides in most of these goals for laying the groundwork of sustainability. Ministry facilities have been upgraded to enable Ministry personnel to carry out EPI and other activities. MOH services are in greater demand, evidenced by steadily increasing immunization and vitamin A capsule coverage. Training of community-level health workers is in full swing, with more rounds to go, and refresher courses needed to assure sustainability of basic knowledge and skills. The project is succeeding in supporting the MOH in its lead role in health care, with project staff acting as support staff, or "extending arms," of the Ministry. The strategy to address quality in all aspects of the project needs improvement. Quality assurance in monitoring and supervision will be key to project effectiveness.

## II. ASSESSMENT OF RESULTS

### A. Results and Program Impact

#### 1.a. Background

The IEF/CCF child survival project PVO Partnership for Child Survival is being implemented in the North Shewa Zone of the Amhara National Regional State, Ethiopia. The project area is 130 kilometers northeast of capital city, Addis Ababa, the capital *(see Figure 1 Map of CSXII area).*

The project is located in Basona Worena and Debre Birhan *woredas* (subdistricts), about 130 kilometers northeast of the Addis Ababa in the highlands of Ethiopia. The population of the woreda is approximately 165,000. The majority of the population is rural, with about 40,000 people living in the main town of Debre Birhan. Communities are well-organized in 25 Peasant Associations and nine urban kebeles, which consist of 112 Peasant Villages. Peasant Villages range in size from 59 to 601 households in rural areas and from 948 to 1,348 households in the town. Most of the villagers in the rural areas are subsistence farmers of the Amhara ethnic group. The area was chosen for the project based on need and on CCF's history of successful programming in the region.

A sub-grant agreement was signed in 1997 between the IEF (International Eye Foundation) —the grantor—and CCF (Christian Children's Fund)—the sub-grantee—to implement the program for the period from January 1997 to September 2000. However, the project agreement between CCF-Ethiopia, the Amhara National Regional Office of Disaster Prevention and Preparedness Commission, and the Regional Health Bureau was not signed until August 1998.

The goal of the project is to reduce infant, child, and maternal mortality by strengthening primary health care in Basonaworena Werana and Debre Birhan Woredas by promoting protective health behaviors at family level. The project targets 65,000 direct beneficiaries: 30,000 children under five years of age and 35,000 women of childbearing age. CCF has an established relationship with select *kebeles (or villages)* in the woreda because of ongoing child and family health projects.

Based upon the baseline KPC survey, four interventions were chosen. (See Annex A) To achieve its goal of reducing infant, child, and maternal mortality, the project integrated four major interventions:

1) Immunization of children and women
2) Diarrheal case management
3) Nutrition improvement and vitamin A promotion
4) Breastfeeding promotion.

A strong IEC (information, education, and communication) strategy supports each of the above interventions. (See IEC Report Annex B)

### 1.b. Evaluation Methods

The objectives of this mid-term evaluation were to assess achievement against project objectives; examine reasons why certain objectives were not met; explore strategies for future program direction; and develop project recommendations.

The field evaluation was undertaken from September 16–October 1, 2000, with considerable preparations in the months preceeding. A participatory evaluation method was selected at IEF's recommendation. Methods and exercises were drawn from established team planning and participatory program evaluation methods manuals.[2] Most strengths and weakness developed in this paper were based upon joint conclusions from the complete evaluation team. IEF and CCF Headquarters was responsible for merging the mid-term and final guidelines into the final guidelines used. CCF Headquarters worked with IEF and with CCF Ethiopia to develop the itinerary for the process, the Terms of Reference and scope of work for the evaluation. CCF requested two national independent evaluators to assist in the evaluation.

A core team of five evaluators conducted the evaluation, with eight additional members trained in evaluation techniques to assist in the field data collection. The evaluation team comprised Margie Ferris-Morris, external evaluator, John Barrows, IEF Headquarters representative, and two local consultants specializing in public health and IEC strategies, Dr. Shabbir Ismail and Mr. Hailu Meche. In addition, Dr. Tadesse Kassaye, Health and Nutrition Desk Coordinator of CCF- Ethiopia, CS XII Project Manager, was a key member of the core team. CCF Headquarter staff was not present for the evaluation. However Jill Coleman and Dr. Tom Kerkering of CCF/Richmond conducted a follow-up visit to the field and met with the national evaluators, the week of November 6th, 2000. Annex C contains a list of team members and assessment methodology. Annex F is an evaluation of the mid-term evaluation process.

The team used the following information sources for this evaluation:

1. **Field visits** to the two woredas (including five rural and two urban kebeles) where the project is operational.

2. **Focus group discussions and in-depth interviews** in three rural kebeles and two urban kebeles, representing one-sixth of the kebeles in which IEF/CCF is operating. Interviews were carried out with four project staff, two national staff, and three international headquarters staff. At the field level, interviews were carried out with five zonal leaders (council health and DPPC) and six woreda leaders (social department and health departments), nine Kebele leaders, three head health staff and one assistant health staff, fourteen health committee staff, seven depot holders, two opinion leaders, two CHAs, 39 volunteer mothers, and 22 mothers who were final recipients of the project interventions. A list of persons interviewed and contacts can be found in Annex D. Questionnaires for each of the above are found in Annex E.

3. **Discussions** with IEF staff (Bethesda, Maryland) and CCF staff (Richmond, Virginia and Ethiopia) involved in the CS project.

4. **Review of relevant project documentation** and USAID evaluation guidelines of CSXII projects.

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[2] W. Gormley and F. Rosensweig. 1985. "Facilitator Guide for Conducting a Team Planning Meeting." USAID/Environmental Health Project WASH Technical Report No. 32; and Judy Aubel. 1999. *Participatory Program Evaluation Manual*, 2nd edition USAID/CSTS, Marco Project.

## 2. Project Progress and Achievements

This section of the report describes the progress of the project to date in detail. A summary of progress to date can be found in figure I.

The project now operates in all of the 43 kebeles (community of villages) existing in the two woredas. The IEF/CCF Child Survival XII project has been operating for 26 months since signing of the country agreement, although the project duration was from January 1, 1997 to September 29, 2000. A no-cost extension was granted to IEF/CCF for three months (until December 31, 2000) to carry out the mid-term evaluation and final report to USAID under this current agreement. The evaluation team, IEF, and CCF agreed to conduct a mid-term evaluation instead of a final evaluation, based on the timing of the approval of the DIP and lengthy delays in putting the project in place. The project is half completed, and although the formal agreement with IEF will terminate in December 2000, CCF plans to continue supporting the project until the agreement with the Government of Ethiopia is completed, in April 2002. Alternatives for funding are being explored.

A summary of project goals and objectives and achievements to date toward project indicators are found in table 1. Some of the original project activities as presented in the proposal and DIP have been revised. These changes are noted below.

The project's particularly noteworthy accomplishments to date include:

Input and output level achievements

- Approved detailed implementation plan and country agreement.
- Established and staffed field office.
- Baseline knowledge, practices, and coverage survey and health facilities survey.
- Training conducted in 23 rounds for 1,158 people from all levels (zonal, Ministry of Health, and volunteer mothers, covering the four interventions areas— expanded program of immunization, diarrheal case management, nutrition and vitamin A, and breastfeeding promotion.
- Mid-term KPC.
- Successful initiation of the Hearth model (*Majet*) in two kebeles.
- Improved capacities of ten health facilities including the Zonal Hospital in Debre Birhan, to conduct EPI, diarrheal case management, and other health activities.
- Excellent working relationships established with all counterparts in the project.
- Trust and transparency developed with, MOH, kebeles, and all local partners involved with the project.
- Large pool of health cadres selected by the communities themselves have been trained and placed in the communities (CHAs, TBAs, DHs and volunteer mothers).

Impact level achievements

- EPI coverage has significantly increased from 15.5 to 22.6 percent of children fully immunized and from 22.3 to 78.2 percent of mothers immunized with two tetanus toxoid shots in the two woredas.
- The number of people holding health cards and records of their immunizations has nearly doubled since project implementation.
- All health facilities have an oral rehydration therapy (ORT) corner.

- Vitamin A is reaching significantly more postpartum mothers (from 4.3 to 15.3 percent) and children under five (from 6 to 69.3 percent).

Although the project experienced delays in starting, it has made every effort to make up for lost time, and with a thinly stretched staff. The establishment of solid relationships with the government administrative and health sectors has helped to facilitate project implementation. Most of the major inputs planned in the DIP have been undertaken, with the exception of the complementary food microenterprise component and quality assurance surveys/assessments (one short training on that topic was conducted by IEF). Nearly two-dozen training sessions were carried out over 20 months. (See Annex F Training Workshops Conducted) Although the printed materials are not ready, a detailed IEC strategy has been laid out based on the KPC reports and other resources. Health education has recently begun in the kebeles (health education was also extensively done in the last year by the project staff going out in the field, even before the CHAs were trained), using community mobilization, peer models, and food demonstrations for the Hearth model. Other signs of nascent community involvement, particularly in the EPI campaigns, are evident.

Knowledge about project activities in rural areas is mixed, however, with some confusion over which components are CCF child survival components and which are CCF child and family health components. The health workers and volunteer mothers in the urban area of Debre Birhan are impressive and active. Project interventions in the town appear to be making solid and steady progress.

*Modified Activities from DIP*

Quality assurance has not been introduced into the project in any serious manner, as planned in the Detailed Implementation Plan, partially because of lack of staff and consultants/experts to assist the field office in the area of quality assurance. Most aspects of activities to make ORS available at the community level have ceased due to lack of availability of ORS in the country. In terms of the nutrition inputs, given the low level of staff and high amount of responsibilities, IEF recommended that CCF drop the feasibility study of microenterprise for nutrient-rich complementary foods. CCF, on its own initiative, decided to introduce the Hearth Model as a new input activity since it was introducing it with CCF/Ethiopia Child and Family Health Projects and would complement the two projects nutrition components.

## 3. Mid-term KPC findings

A follow-up knowledge, practice, and coverage survey was carried out in Debre Birhan and Basona Worena Woredas of the North Shoa Zone in April 2000 (see Annex A). This work was successfully accomplished through close and active collaboration from the Child Survival Project staff and the local Ministry of Health staff at the Zonal Health Department and Woreda Health Offices. The survey consultant (a former CCF CS staff member) was formerly trained in the Johns Hopkins PVO Child Survival Support Program (JHU/CSSP) rapid KPC methodology. However, some of the results (such as significant declines in breast feeding initiation, and diarrheal indicators) suggest that the quality of the survey should be called into question.

TABLE 1: PROJECT GOALS, OBJECTIVES AND ACCOMPLISHMENTS (TO DATE)

| Project Objectives | Measurement Method | Major Inputs | Major Outputs | Measurement Methods | Accomplish-ments | Remarks |
|---|---|---|---|---|---|---|
| DCM Intervention | | | | | | |
| ncrease proportion of health acilities w/functioning ORT orner from 60% to 100% | - MOH and project records | - Make improvements to existing ORT corners in Health facilities | - Improvements to ORT corners made. | - Project records. | 100% | - All health facilities have functioning ORT corners |
| Observe no stock outs of ORS t health facilities in 3 months rior to final facilities survey. | - MOH records and facilities survey. | - Train MOH personnel in management and logistics. | - MOH personnel trained | - MOH and project records, pre and post-tests. | ORS is not available | - ORS is not available in markets for the last 6 - 7 months. |
| ncrease use of ORS/ORT from 5% to 80%. | - KPC survey | - Develop action plan for making ORS available at community level with MOH including Drug Depots | - Action plan developed and implemented. | - MOH and project records. | 7.3% | - Home made sons are being advocated |
| ncrease the % of mothers that give increased fluids from 13.5 o 30% | - KPC survey | - Develop IEC that includes locally available home-based fluids. | - IEC developed and home based fluids promoted. | - Educational materials available, project records. | 10% | - ORS was not available during the fort night period of the KPC study. |
| ncrease the % of mothers that give increased food from 6.2 to 30%. | - KPC survey | - Conduct health education sessions with key DCM messages emphasizing prevention of dehydration and home based fluids. | - Health education sessions conducted as scheduled. | - Project records. | 9.1% in foods provided by mother | Note:25.5% for same and increased foods |
| ncrease the % of mothers giving increased amounts of breastmilk from 13% to 30%. | - KPC survey | | | | 36.4% | |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Breast-feeding Intervention** | | | | | | |
| Increase exclusive breast-feeding from 17.7% to 40%. | - KPC survey | - Develop IEC material for use at community level. | - IEC materials developed. | - Educational materials available, project records. | 68% | Note: Exclusive breastfeeding in baseline is 0-4 months, midterm is 0-3 months which are different indicators |
| Increase the % of women breast-feeding within one hour of delivery from 21.8% to 40%. | - KPC survey | - Conduct health education sessions with key breast-feeding messages. | - Educational sessions conducted as scheduled. | - Project records | 24% | |
| **Nutrition/VA Intervention** | | | | | | |
| Increase coverage of VA to pp women from 4.3% (oral report) to 30% (on card). | - KPC survey | - Conduct VA campaigns linked to EPI. | - VA distributed at campaigns. | - KPC survey and campaign records | 15.3% | |
| Increase coverage of VA to children from 6% (oral report) to 75% (on card). | - KPC survey and campaign records. | - Identify and target defaulter PAs through HIS. | - Defaulter PAs identified and visited. | - Campaign records and project records. | 69.3% | |
| Increase the % of mothers giving solid and semisolid foods to 6 to 10 month olds from 46.7% to 70%. | - KPC survey | - Distribute VA to post-partum mothers though TBAs and campaigns. | - VA distributed to post partum mothers. | - Project records | 71.2% | Note: Midterm measured 6-9 months, baseline 6-10 |
| Increase % of mothers that know VA prevents night-blindness 8.7% to 60%. | - KPC survey | - Develop IEC for nutrition (and EPI and diarrhea).<br>- Conduct feasibility study of micro-enterprise based on the production of an energy/micro-nutrient rich weaning food.<br>- Conduct health education sessions with key nutrition and vitamin A messages. | - IEC developed<br>- Micro-enterprise assessment completed.<br>- If deemed appropriate, 2 pilot micro-enterprises created.<br>- Nutrition education session held as scheduled. | - Educational materials available, project records.<br>- Project records, report prepared.<br>- Project records.<br>- Project records. | 12% | Intervention dropped, time and monitoring constraints |

Immunization coverage markedly increased over the baseline. DPT3/polio3 coverage is at about 30% compared with 20 percent at baseline. Full immunization has increased by 7% (actual current levels are reported to be higher). The current immunization coverage according to the MOH and project documents is:

| | |
|---|---|
| BCG | 77.6% |
| Measles | 53.6% |
| DPT3 | 60.8% |
| Fully Immunized | 50% |

However, the dropout rate was at about the same level as during the baseline.

Mothers' knowledge of immunization was still low. About the same proportion of mothers (10.7%) reported not knowing the reason for tetanus toxoid vaccination. The proportion of mothers who reported that the measles vaccine should be given at nine months had increased by 25%.

Mothers were asked to identify children with diarrhea (18.3%) in the past two weeks. The prevalence of childhood diarrhea was reported to be nearly half as much as the level during baseline. Treatment-seeking behavior for diarrhea was assessed. Most mothers (60%) sought no help at all. No mother sought treatment from a health post or from community health workers (CHAs or TBAs).

Half as many mothers (2.7%) stated that rapid initiation of fluids was an important action to take during diarrhea. A few mothers (below 2%) stated that withholding fluid or food was an important response to diarrhea.

Early initiation of breastfeeding was particularly problematic to interpret or assess, both during the baseline and at follow-up. Only 24% of mothers (compared with 41.3% during the baseline) initiated breastfeeding within the first hour after delivery. The reason for the drop is unclear, although strong cultural taboos are associated with colostrum. Mothers practicing exclusive breastfeeding (0–3 months) increased from 17.7% at baseline to 50.3% at midterm KPC. However the baseline measured was 0-4 months, making comparison of the two indicators difficult. On the other hand, continuous breastfeeding dropped 7% below the baseline status. Mothers giving complementary foods (solid or semi-solid foods) in addition to breastmilk to their 6–9-month-old infants also increased, from 47% to 71%.

By the midterm KPC survey the proportion of mothers and children who received a vitamin A capsule had increased considerably: 69.3% of children and 15.3% of postpartum mothers had received vitamin A supplementation.

## B. Technical approach of the mid-term assessment

### 1. Overview

Because the project is in its 26th month of actual implementation, a final assessment was not conducted. About six months had passed since the mid-term KPC by the commencement of this evaluation. All activities are now implemented regularly, mostly without undue delay.

Project procurement is still slow, however, combined with an organizational as well as cultural norm of fiscal restraint to spend monies, make some aspects of the project less efficient than they could be. One example is the lack of sufficient checklists, IEC materials, and record books in the hands of frontline workers. Another is their ability to absorb/spend funds coupled with the low level of staff to carry out project interventions.

A real strength of this project is that it has established its credibility and acceptance with all stakeholders. These stakeholders include MOH officials at the Zonal, Woreda and kebele health post levels, Zonal Disaster Prevention and Prepared Commission (DPPC), woreda councils and with the communities themselves. A concerted effort has been made by project staff to be transparent and in constant communication with the government and the communities they serve. The evaluation team heard accolades such as, "*The CCF Child Survival Project is the model to be amplified*" in terms of communication and cooperation. When problems arise, there appears to be immediate discussion and feedback with the parties involved, reducing delays. This progress has been made in the past couple of years with deliberate efforts to involve the government, and will likely be one of the most important factors in project intervention sustainability.

The project has developed new tools such as IEC materials based on positive deviance and the Ethiopian and specific location conditions (see Annex B). These tools are aimed at audiences who are either literate or illiterate. The project staff reviewed many locally field-tested materials and designed ones appropriate for their target audiences and interventions. The project is also using materials designed specifically for the *Majet* training, although evaluation of these materials is still underway.

## 2. Progress Report by Intervention Area

a. EPI

The evaluators saw improvement over the mid-term KPC in child immunization knowledge, acceptance, and coverage. For example, by August the project has already reached two-thirds of its annual target, with 60% of children (38% of all children under one year) immunized against measles. Although tetanus toxoid coverage for women faces greater cultural barriers, signs of its gradual acceptance were noted, especially because of peer models and the use of positive deviance in training to mothers. The most recent statistics for TT coverage (September 2000) are Non-pregnant TT2- 73.7% and Pregnant TT2 - 19.8%. The trainers of trainers (depot holders and volunteer mothers) admitted that they were not initially convinced of the merits of tetanus toxoid immunization but now enthusiastically promote it as peer models.

b. Diarrheal case management

The mid-term evaluation confirmed the lack of progress with the intervention on diarrheal case management demonstrated by the KPC survey in April. The effectiveness of activities at the health posts (ORT corners) and village (through depot holders) has been severely hampered by the total unavailability of marketed oral rehydration salts and the lack of a perception of the need for ORS. This was precipitated by a World Health Organization recommendation not to use (certain) home solutions and by the lack of the Ethiopian-produced ORS countrywide for nearly six months. Despite the WHO recommendation, the CS project staff has not taken a strong initiative to promote home-based oral rehydration therapy, even though it was included in the trainings.

Furthermore, Depot holders did not have the materials available locally to make sugar and salt solutions (they have not been allocated project resources for purchase of these materials, even for demonstration purposes.)

To accomplish the project targets for this intervention, staff must:

- Begin immediate training in home-based solutions (drawing on literature of best solutions for Ethiopia) both at the community level and in ORT corners in health posts.
- Procure sugar and salt, and plastic, paper sachets for the mix for the health posts and particularly for the kebeles (depot holders).
- Modify Sustainability Goal Objective 5 in the DIP (*Establish community level drug depots to increase availability of drugs* to *and home-based solutions*) and the objectives to accomplish this goal to:

    a. *Increase the knowledge of women to prepare home solutions (including sugar/salt solutions).*
    b. *Establish depot holders as resident resource on diarrheal management.*
    c. *Increase the availability of ORS, ORT, and other medicines at the community level.*

An impact indicator of the success of the establishment of depot holders as resident resources might be: *Number of community members seeking DCM advice from the depot holders and community health agents.* This would measure the effectiveness of the establishment of these community-level health workers as credible resources for DCM. The health post health staff should be working hand in hand with the deport holders and CHAs to monitor the quality of information given and assure referral for severe cases of diarrhea.

**There should be an emphasis on a shift away from reliance on ORS**, and whose availability is outside the control of the project, and a shift **towards community self-reliance.**

c. Breastfeeding promotion

The advantages of breastfeeding—benefits, economy, sanitation, the infant's "first immunization" are communicated in each of trainings to health staff. However the midterm KPC survey results on this indicator were difficult to interpret, and showed mixed results: -- a significant decline in early initiation of breastfeeding (between 10-30%) and a 50% increase in exclusive breastfeeding from 0-3 months. In addition, this is a different indicator from baseline.

The community could benefit more directly if the project staff considered broadening the training to include kebele and opinion leaders, volunteer mothers, depot holders, and others. Additionally, segmentation and targeting audiences such as fathers, mothers-in-law, caretakers, and grandmothers with messages on a frequent basis may improve breastfeeding patterns.

d. Nutrition and vitamin A

About one and a half years into the actual field implementation of the CS project, CCF/Richmond decided to introduce the Hearth Model in the project activities. Hearth was first introduced to CCF's other Child and Family Health activities and CCF decided that it would be a good component to complement the CS project. This was a new activity outside the scope of activities in the DIP. As such, the Hearth model (*Majet*) had only been underway for a few months and in select localities at the time of this assessment. Regretfully, the evaluation team was unable to see a *Majet* demonstration and it was not possible to draw conclusions about the effectiveness of this training. The evaluation team felt, however, that the training was complete, volunteer mothers were enthusiastic about training mothers, and the use of positive deviance was already showing some small signs of impact on knowledge and practices. On the other hand, the use of *Majet* calls for intensive supervision and technical assistance during the startup phase and would benefit from a greater allocation of staff time to this activity.

Knowledge of the importance of vitamin A and foods rich in the nutrient may have improved somewhat from the mid-term KPC, although the small sample size makes this difficult to determine. Mothers were familiar with the capsule (although the colors had changed over the year from white to blue) and generally believed it to be "good for health." Few mothers knew vitamin A helped prevent night blindness or what foods were rich in vitamin A.

In summary, the technical approach is strong, appropriate and viable for the setting of this project. Interviews with the project director and staff revealed that maintaining a positive relationship was very important for the successful implementation of the project. The delay in the signing of the project agreement had taught the project management as well as CCF the importance of this strategy. Results of the various studies and ongoing monitoring activities have been carefully incorporated into the routine work of the project. Some of the feedback from the local government partners has been instrumental in shaping the project. The project staff is sensitive to the communities' wishes and specific needs. The KPC surveys conducted twice during the project lifespan showed some positive changes in the knowledge and attitudes of the public and higher service coverage on components such as EPI. The project is trying to capitalize on these positive developments and further strengthen them.

### C. Cross-cutting Approaches

The project has worked closely with the Ministry of Health in almost every aspect. Agreements have been signed for activities in the various interventions. Ministry staff assist with as well as receive training, and for the most part, solid support mechanisms are in place for immunization campaigns. The approach has earned mutual respect and is considered a strong factor in the potential sustainability of the project. The project has also formed linkages with youth groups and women's associations to promote educational messages. Developing this relationship will be important if the project staff considers adding an HIV/AIDS component.

One strategy that was not discussed in the DIP is the use of the Hearth model for food and nutrition education. Community demonstrations to make nutritious foods for young children and the use of peer models have already created enthusiasm among mothers and frontline project staff. A demand for more of these is growing. Peer models and positive deviance are entering other IEF/CCF interventions, such as EPI, where volunteer mothers have stood in front of the other mothers so their children could receive shots on the spot. The other mothers later saw

healthy children as a result. They also witnessed unhealthy children in one village as a result of the lack of immunization and became convinced of its importance.

### 1. Community Mobilization

**Strengths**

- Good communication strategy has been used to mobilize beneficiaries and communities to participate in the activities with the health institution.
- Key information has been communicated to women through their peers.
- Good communication is maintained with higher officials.
- Trust between the project staff and the community has been established at all levels.
- Project-generated awareness creation, training, and activities are very successful, enabling the community to know the purpose of vaccination and hence to vaccinate children and mothers.

**Weaknesses / limitations**

- The project was weak on establishing good communication between community health workers (CHAs and depot holders) and health facilities in the woreda, although it may be too early to judge this. Communication is poor between health posts and CHAs. A link should be developed.
- There is limited contact with the kebele leaders and health committees to discuss the weaknesses and strengths of the activities.

Close links have been maintained with the official government structures to *mobilize the communities*. These local administrative structures have been motivated to mobilize the various segments of the beneficiary communities. Communities are instrumental in project success.

Intensive sensitization activities are carried out through these community structures, particularly those at the grassroots level. Communities are involved in vaccination campaigns through outreach to households and through their time and labor (for example, carrying refrigerators to the lowlands in the most inaccessible areas), participating in campaigns through awareness raising, and participation in education sessions given by the various trainees of the project. Some volunteer mothers have hosted information/education sessions in their homes. At least two school clubs, youth and women associations, and the existing health and anti-AIDS clubs in the high schools have been actively involved in mobilizing the communities. Rural kebeles had less marked exposure, although results varied from community to community. The whole evaluation team confirmed these results as a project strength, at least in the major urban kebeles where it operates. The close relationship between the project partners and a sense of ownership have set the stage for a higher probability of sustainability of project activities.

According to the project management and staff, the response of the communities to the intensive mobilization effort does not yet seem satisfactory. This could be due in part to community expectations of aid from a development project. In addition, the mobilization activities have only just begun in some villages. The project focuses on developing community-level expertise and reinforcing the health system to better carry out child

survival activities. One positive response to the community mobilization effort has been the demand from local authorities to expand the service by opening more outreach sites.

There is a strong sense of partnership and transparency between the project and its stakeholders. Full involvement and participation of the project partners was reported in project planning once the DIP had been approved. Some partners such as community level partners noted, however, that they would like to have been involved when the project concept was developed. They maintain that the DIP could have been developed in a more collaborative manner.

The following **barriers/constraints** to project benefits for community members have added to some of the project shortcomings, such as inefficient monitoring of project activities and lack of change in such behavior indicators as nutrition and early initiation of breastfeeding:

- High expectations (of relief, handouts, construction, and so on).
- Geographic barriers (difficult terrain, especially in the Basona Worena woreda).
- Inaccessibility by road.
- Changes in local government policies (particularly in regard to CHAs and whether or not the project could have and train them, and delayed training of CHAs).
- Deep-rooted cultural beliefs, attitudes, perceptions, values, and practices in the project area.
- Government resistance to Child Survival programming delaying the onset of the project and insistence on low overhead (10%) caps.
- Lack of sufficient government health facilities and personnel to meet demand.
- Too few project staff for the many activities and wide geographical area to be covered and the capacity for impact will be limited by the number of staff (the acute need for at least two project personnel was apparent to the whole evaluation team).
- Lack of basic infrastructure in supplies and materials.

## 2. Communication for Behavior Change (Information, Education, and Communication)

### a. Training: Improving Skills

One of the main purposes of the Child Survival Project is to bring about critical and significant changes in the knowledge, attitudes, and behavior of the communities with regard to the four project interventions. One strategy employed to bring about change in knowledge is training at different levels of the community and government administration. The comprehensiveness of the training—in the content and the many levels of stakeholder involvement—and the content have been impressive. The evaluators believe that the project's success in knowledge change thus far is largely due to the comprehensiveness of the key target training audience as well as the targeting of information specific to each group's needs.

The training provided by the project is considered very useful by health staff at all levels and volunteer mothers. Opinion leaders and kebele leaders also attended some basic training—IEF/CCF has developed a comprehensive training

approach, putting the same basic information and health messages into the hands of everyone who may have a role in influencing behavior change.

Strengths

- The trainings use participatory and adult learning techniques and have an acceptable methodology, including pre- and post-tests.
- Training of mothers is helping them change slowly to develop more healthy and health-seeking behaviors (especially attending immunization campaigns).
- Volunteer mothers feel a certain confidence in conducting their own trainings to mothers (although this confidence varied by community).
- Success of the vegetable garden training is spreading and creating demand in other communities and among other community members.
- Manuals, state of the art IEC materials, and reporting formats have been developed.

Weaknesses/limitations

- The project needs to reach more women through intensive training. (This is early in the project.)
- Peer education models need close follow up.
- Development of the IEC strategy was unnecessarily long and delays could have been avoided, putting information into the end-users more quickly. (If national consultants are not available, international consultants should be engaged).
- Many IEC materials are not yet in the hands of those who need them for their work.

**b. Training: Knowledge and behavior**

Knowledge change is measured through pre- and post-training testing. Behavior change is measured in change from the baseline to the mid-term KPC survey. Moreover, village-level health staff give CCF staff feedback on progress.

The entire evaluation team observed that the project was able to create awareness among community members on immunization, resulting in increased vaccination coverage. The team also indicated some overall changes in the knowledge, attitude, and behavior of residents in the project coverage area, while noting that it is too early to judge these matters. The mass awareness and demonstration activities of the project have led the communities to demand more services in the project-covered areas as well as in other areas not served by the project. Examples of positive changes include increment in the duration of exclusive breastfeeding, infant immunization coverage, mothers and children receiving vitamin capsules, infant feeding of complementary foods between 4 and 6 months, possession of maternal health cards, and tetanus toxoid 2 coverage (see Annex A for results of the KPC survey).

Strengths

- There is some evidence of changes in the knowledge and attitudes among the community members, although it is too early to judge behavior changes.
- Attempts to promote health education in the communities are encouraging.

- The project has enhanced the knowledge and skills of beneficiaries with regard to project interventions (for example, better health practices).
- There are knowledgeable voluntary mothers in the town.
- The training given for volunteer mothers taught them the basic concepts of the training, implying that the training methodology was acceptable.
- People are well aware of the project in Debrebirhan.
- The project has strengthened community awareness in a short time.

**Weaknesses/limitations**

- Awareness in rural areas is inadequate, although varying by kebele.
- Refresher training will be needed for health staff, particularly in the community, as one training was not enough to solidify their knowledge.

*Recommendations*

One area for improvement is the contact of project management staff with kebele leaders and health committees. Strengthening this communication and coordination can improve project monitoring and supervision. If kebele leaders and health committees were more aware of the training and outreach expectations of the volunteer mothers and depot holders, they could play a role in ensuring expectations are met and advise staff of difficulties or obstacles. The communication between health stations and posts and the community health workers (CHAs) would benefit from strengthening. CHAs are the community arm of the health staff at stations and posts and can assist them in many ways (EPI campaigns, mobilizing communities for health activities, basic education, and referrals). Inadequate awareness about the project and health-related problems was noted in the rural areas, unlike in the urban sites. Additionally, IEF/CCF should investigate reasons why awareness is low in some rural areas.

Both the project and the woreda health offices have been using the KPC findings, outcomes of the review meetings, and other review data in their work. The information-sharing mechanism between the project and the respective zonal/woreda structures has also contributed to the positive communication and close relations between the two parties.

Project staff has attempted to transfer some skills and technology to the government partners by:

- Designing and developing appropriate training materials:
  Distributing guidelines and training handouts to the trainees including depot holders, school clubs, and health workers in the facilities
- Helping the national office prepare reporting formats.
- Assisting with IEC promotional activities of other CCF/Ethiopia projects in North Showa.

One major gap identified by the team was the delay in the development of IEC materials. The project is still waiting for IEC materials that are being printed in the capital to give to community-level staff and mothers or to post in the community. The project has provided simple and locally available materials such as common-sized bottles and cups for the preparation and use of rehydration

fluids. Many activities such as the needs assessment and development of the IEC strategy were done collaboratively and hence are thought to have transferred skills to the partners.

### 3. Capacity Building

The principal aim of the project is to reduce infant and child morbidity and mortality through immunization, control of diarrheal diseases, promotion of nutrition, and promotion of vitamin A and breastfeeding. The main strategy to achieve these objectives, as well as to create long-lasting sustainability of the interventions, is capacity building. Capacity building is defined as strengthening the partners and partnerships IEF/CCF, CCF/Ethiopia and their partners Ministry of Health such as health facilities, health worker performance, training, and program management (supervision of program staff and technical and administrative support).

Many of the planned activities in the last 12-18 months time were accomplished.

#### a. Strengthening PVO Organizations: Christian Children's Fund/Ethiopia and Richmond and International Eye Foundation (IEF)/Bethesda

The project staff anticipated that the project would build capacity among the partner PVOs through technical assistance, child survival program-to-program exchange of ideas, and staff enrichment training in the field and at other locations. Moreover, child survival programming, with its strong methods and technical support, is viewed as an asset to other Christian Children's Fund health programming, bringing expertise to other child and family support projects. CCF has implemented six child survival programs, four funded by USAID
(Angola, Guatemala, Senegal, and Ethiopia), and two others, one solely funded by CCF in Philippines and one funded by the USAID Mission in Zambia. When CCF submitted it's first grant application in 1996, the organization was relatively inexperienced in designing, implementing, monitoring and evaluation of child survival programs. However, CCF has strong community infrastructure and credibility needed for conducting quality maternal and child health interventions. As CCF gained experience in grant administration in the Guatemala child survival program (1996), the organization submitted and was awarded two additional grants in Angola, and Senegal. Presently, CCF is using USAID mid-term child survival evaluations as a learning tool and guide for developing new proposals. The expertise CCF gained in collaboration with IEF, and in the other CS projects, will provide the technical infrastructure to implement the current project.

Through this strong community infrastructure, specifically through the local parents' committees, CCF is able to mobilize human, material and financial resources; allocating a portion of them for health initiatives based on community priorities. Using the data derived from "AIMES", CCF collects meaningful information for health, nutrition, and education with a major focus on child survival indicators, which enables the local parent committees to design appropriate community-based interventions for CCF enrolled families. Six of our eleven AIMES indicators directly relate to child survival, thus extending the monitoring and evaluation of maternal and child health interventions beyond the four USAID grant funded countries. Through regional workshops, peer exchange, cross-training, an agency-wide health and nutrition working group, CCF shares and documents best practices and quality standards which improve the organizational capacity to respond to child survival needs, and other existing and emerging health and nutrition issues.

Christian Children's Fund headquarters staff plans ongoing trainings and exchanges of child survival staff with that of other CCF child survival projects. Two IEF/CCF-Ethiopia staff have benefited from such exchanges, one visiting the CCF/Guatemala child survival project and another visiting a Safe Motherhood regional training in Kenya. CCF/Richmond has an extensive agenda for organizational capacity building, relying heavily on training, information sharing across projects, project-to-project exchanges, and a virtual and real technical area network groups (nutrition, health, and others). CCF's health manager and program officer participate in (ongoing) CORE working groups.

IEF headquarters has a similar strategy for human resource development. Headquarter staff are involved in regular skills training (such as quality assurance, involvement in the CORE group, Child survival projects receive close backstopping and supervision). IEF has taken a strong lead in assisting this CSXII project with technical assistance, field visits, and communication. The project is seen as strengthening IEF's own staff expertise through the resources available through CORE and USAID, and as allowing IEF to broaden its exposure and experience in a new country.

The DIP design of program objectives included strengthening IEF/CCF-Ethiopia's expertise in a number of technical areas—assessment of EPI systems, surveying KPC and health facilities, designing IEC strategy and materials, and providing quality assurance. Partner-to-partner skills were transferred in several of these areas. Consultants were engaged for all surveys as well as for design of the hearth model, a complement to the ongoing activities. For quality assurance, IEF provided a field-based training in a direct PVO-to-PVO/NGO assistance. One planned intervention, a microenterprise activity to produce local complementary foods, was not undertaken because of the labor intensity of this component and the lack of staff for adequate design and monitoring. This decision was made after the decision to apply the Hearth Model was embraced. This substitution of activities was seen as more advantageous for long-term sustainability.

*Constraints with PVO to PVO partnerships*

The management of this Child Survival has some unique features in that two US PVOs were involved in management of the project. The International Eye Foundation /Bethesda (IEF) sub-granted an agreement with Christian Children's Fund (CCF/Richmond) to undertake the field implementation of the agreement. IEF choose CCF because of its long established presence in Ethiopia. IEF choose not to place any of their staff in the field for a variety of reasons, however this may have led to a number of difficulties, and on retrospect, they feel it may have been worthwhile to have done so.

While the two PVOs had a number of commonalities such as shared values (health programming) and some aspects of program strategy, they also had notable differences that without adequate and regular communication, caused frustrations for the organizations in management of field operations. The strengths that each organization had because of their management and organizational differences were not maximized to bring on the best programming in the field operations. Some examples of these differences include: management styles, personnel staffing, modes of communication, funding styles and capacities, i.e. child sponsorship, field offices and staff (vs. no office and staff), views on capacity building among others. One example of the two organizations differences that has had an impact on programming is with quality assurance. This intervention has not been fully realized as envisioned in the DIP. IEF provided a QA training to CCF, where only the field staff participated. IEF strongly advocated for more systematic application of

quality assurance throughout the project, offering training and materials, however interest was not reciprocated. Rather than communicating and meeting regularly to discuss differences and use these to the advantage in the field, the differences became a source of dissatisfaction between the PVOs that grew over time.

In the subcontract agreement, CCF was the implementing agency yet did not have full control over resources, and IEF was grantee yet did not have full freedom/control over managing CCF field staff. Many details of management were not worked out in the agreement and the insufficient number of meetings did not bring clarity to the numerous issues arising during the grant period. There was a certain understandable awkwardness for IEF in managing field operations of another agency and hesitancy in direct intervening in field staff operations and decisions. This manifested itself in many ways, not the least being comprised management and oversight of the project. In the case of Ethiopia, more technical assistance, project feedback, regular meetings between agencies, etc. may have improved some of the project outcomes. On the other hand, CCF/Richmond appeared to have more of a hands off style of management of the program, delegating the majority of implementation to their National Office and in turn national Office delegation to the field office deflecting responsibilities to IEF and to the field, where more direct involvement may have yielded quicker action, more detailed annual reports and work plans, and improved impact of field operations.

Lessons learned from this kind of partnership include:

- Detailed sub-agreement with as many aspects of the relationship (jointly developed clarification of roles and responsibilities, expectations for performance, communication, and management) worked out in detail.
- Shared communication from USAID (joint receipt of key information).
- Regular meetings between headquarter offices (at least quarterly, more if issues of management, technical assistance and field implementation arise) and consideration of an annual full day review of the project's progress.
- Thorough review and critique of all documents produced by the field, joint development of headquarter level documents (work plans, reports, etc.).
- Consideration of in country field staff from both organizations.
- Equitable input on technical assistance, review and commenting on reports, field visits, etc.

**b. Strengthening Local Partner Organizations: MOH**

Rather than conflicting with the other duties of zonal and woreda health staff, externally funded projects such as CSXII often give staff opportunities to perform more efficiently because they frequently provide technical assistance, supervision, and financial support. Health staff view the trainings provided by the project as part of their normal duties.

The principal partners of the project are the local Ministry of Health, composed of the Zonal Health Department, the two Woreda Health Offices of Basona Worena and Debre-Birhan, and health facilities and health workers. The project has undertaken its activities in close collaboration with the Ministry in immunization campaigns, diarrheal disease control, breastfeeding promotion, nutrition and vitamin A supplementation, and a polio immunization campaign. In all these activities, training of health workers, health education, and supervision of vaccination sites were done by project in collaboration with the Ministry. In addition, the

project provided essential drugs, cold chain facilities, and financial support for printing cards and forms.

As per the DIP, the project conducted training for Ministry personnel in management and logistics related to EPI and quality assurance in EPI. Diarrheal Case Management (DCM) project staff trained Ministry staff in oral rehydration therapy management and logistics.

As per the DIP, the project conducted EPI training for traditional birth attendants and depot holders. DCM trained traditional birth attendants and depot holders in preparation of oral rehydration salts. The project also trained traditional birth attendants and depot holders in nutrition and vitamin A supplementation and breastfeeding promotion.

Supervision is a fundamental element of effective project planning and implementation. Regular, ongoing supervision should be done jointly by project and Ministry staff. However, field-level supervision has been infrequent. Supervision of health facilities and community health workers has been unsatisfactory. Additional supervisory visits are needed and checklists should be developed, explained, and put into the hands of those who use them. Checklists should have mutually agreed monthly targets for oral rehydration therapy and food demonstrations, training, and community outreach activities. Kebele leaders should to be engaged in monitoring the project in that they can follow up on intervention activities by the volunteer mothers, CHAs, depot holders, and others on a monthly basis.

Quality assurance could be used to improve overall supervision, monitoring and evaluation skills by stressing performance over output indicators, however, it must be embraced by not only field staff, but their partners, the CCF national office, and ideally headquarters office as well.

### c. Strengthening Health Facilities and Health Worker Performance

A health facilities assessment (HFA) was undertaken prior to the implementation of the project. The survey showed that:

- Health worker knowledge of the vaccination schedule for mothers and children was high but awareness of the importance of checking the vaccination cards of children and their mothers was low.
- Although most growth monitoring sessions were taken and recorded/plotted correctly, few health workers could interpret them correctly.
- Health workers knew about the danger of vitamin A deficiency but did not know the correct dosage. Vitamin A was not available in all health stations.
- Appropriate treatment of common diseases and demonstrating medication for caretakers was observed less often. In addition, health facilities lacked essential drugs. Only one health worker received training in the 12 months prior to the KPC and HFA baseline surveys.
- Most health workers did not receive more than one supervision visit a year, and only few had received feedback from their supervisors.
- The findings of the KPC and HFA baseline surveys clearly showed the need for strengthening capacity building and program management.

- Only a few health facilities had functioning oral rehydration therapy corners and a number of health facilities did not have refrigerators and one-third were not functioning, impeding their ability to provide regular immunization services.

The findings of the KPC and HFA baseline surveys clearly showed the need for strengthening capacity building and program management. As outlined in the DIP, the following activities were undertaken to strengthen health facilities and health worker performance:

- Establishment of eight new oral rehydration therapy corners (compared with two in place at baseline).
- Supervision of immunization activities, CHAs, a search for EPI defaulters, oral rehydration therapy corners, and oral rehydration salts stock.
- Provision of supplies and equipment including essential drugs, refrigerators, ice boxes, steam sterilizers, vaccine holders, and vaccinating syringes and needles.
- Repair and maintenance of motorcycles and cold chain equipment.
- Printing and preparation (in progress) of IEC materials such as posters, leaflets, flipcharts, films, and cassettes to be distributed to partners for use before the end of the year.
- Training of teachers, health workers, and government officials at zonal and woreda levels in IEC.
- Financial support as part of capacity building given to partners at zonal and woreda levels.

There are no real constraints to making health facilities improvements under the project, other than the lack of certain drugs and oral rehydration salts on the market. The Ethiopian Ministry of Health drug policy does not allow the import of drugs by NGOs except under special conditions where they are specified in the GOE signed project documents. The project could play a major role in shifting health care workers' reliance on oral rehydration salts toward promoting sugar and salt and home-based solutions.

IEF/CCF has been asked to construct a needed health post in Basonaworena Woreda. CCF will likely fulfill this request during the second phase of the project in 2001 using CCF support. Additional construction of health posts needs careful review by the project, particularly in light of the lag time of the Ministry in staffing new facilities with trained staff.

### d. Strengthening Training

The training conducted at all levels was satisfactory and approaches were useful. Community level project staff expressed that the training has helped community members solve their basic health problems by involving beneficiaries from each site and showing the application of good community problem-solving to develop healthy behavior. Furthermore, the training for volunteer mothers enabled them to understand the concepts they will teach other mothers, implying that the training methodology was useful and acceptable.

The job expectations of Community Health Agents (CHAs), depot holders, and voluntary mothers after training have not been elaborated and followed up. Hence these auxiliary workers have not yet provided the services they are supposed to. Trained volunteers in the kebeles are not in regular contact with and do not report regularly to the health posts or the

health stations/clinics. The gaps among the community, CHAs, and health committees are wide and may affect the effectiveness of project output. Aspects of training have been discussed previously under Sections A, B and C above.

A summary of the project's training strengths and weaknesses is found above in the section on Communication for behavior change (Information, Education and Communication) and in Training (Capacity Building) In addition, a summary table of training topics, target audience and accomplishments is found in Annex F.

Raising mothers' awareness of breastfeeding issues could be more effective if training includes other groups, such as fathers, grandmothers, caretakers, depot holders, and volunteer mothers. The project could also benefit from training more project staff in nutrition and breastfeeding promotion, as only a select group has received that training. There are 17 project trained CHAs operating in kebeles, operating in about half the total kebeles to be covered to date. Some kebeles claim they already have a trained CHA and they don't need training. The project has proposed to give refresher training to all the CHAs despite who has trained them in the past. The project's objective is to have one trained CHA per kebele.

***Summary of strengths and weakness for local level partnerships***

**Strengths**

- Transparency with partners
- Planning together with health workers and woreda administrative structures
- Strong involvement of woreda, zonal, and kebele administration in project affairs
- Creation of a productive working environment with the two woreda councils and their respective health offices and health facilities
- Integration of work with zonal, woreda, DPPC, and kebele offices and staff in a collaborative spirit with good understanding of the project objectives
- Provision of materials (refrigerators, drugs, and so on) to the woreda health offices
- Filling the resource (for example, budgetary) gaps in the health institutions of the two woredas
- Support to the existing health facility with supplies and equipment
- Support to the health institutions, with training much appreciated
- Apparently well-developed partnership with all partners
- Active participation of woreda and kebele officials in realizing the project's activities, particularly in high immunization coverage.

**Weaknesses/limitations**

- Networking among the health institutions and community-level workers (for example, CHAs, voluntary mothers, deport holders) is still nascent.

## 4. Sustainability Strategy

The project's sustainability strategy was designed to attack the problem of poor child survival from the community level, increasing awareness and demand for services, and from the service delivery level, increasing the capacity of the Ministry to improve the quality and quantity of available services. The project intended to use quality assurance techniques to improve decision making control at the level of work performed and to enable Ministry personnel to overcome existing problems with EPI and continually monitor the process in the future without assistance from the project.

The project goals to achieve the above are to:

1. Increase the capacity of the Ministry of Health,
2. Increase community demand for Ministry services,
3. Improve the peasant associations' ability to organize health care,
4. Train community-level health workers based on the Ministry curriculum,
5. Establish community-level drug depots to increase the availability of drugs, and
6. Establish a weaning foods microenterprise.

The project has made great strides in most of these goals for laying the groundwork of sustainability. Ministry facilities have been upgraded to enable Ministry personnel to carry out EPI and other activities. Their services are in greater demand, as shown by steadily increasing immunization coverage and vitamin A capsule distribution. Training of community-level health workers is in full swing, although there are more rounds to go, and refresher courses will be needed to assure sustainability of basic knowledge and skills. The project has succeeded in supporting the Ministry in its lead role in health care, and staff has acted as support staff, or "extending arms," of the Ministry. The strategy to address quality in all aspects of the project needs improvement. Only one training in quality assurance has been conducted and more are clearly needed from the observations of the evaluation team. Quality assurance in monitoring and supervision are key to project effectiveness.

Oral rehydration therapy corners have been established at clinic level and through depot holders at village level. The depot holders ability to increase drugs available at the community level has been compromised by the difficulty of obtaining oral rehydration salts, as mentioned earlier. Suggested rewording of the sustainability strategy for the community-level drug depots objective is found in Section II. A. 1. d. It is still too early to tell whether the peasant association's ability to "organize" health care is making progress. The evaluation team did not have the opportunity to discuss this in depth with peasant associations They have started to assume this responsibility of organizing community health activities and whenever there is participation by the community required.

The project goal for long-term sustainable improvement in the supply of appropriate complementary foods to improve young child feeding through a small-scale complementary foods enterprise has been as dropped. This decision was made early on given the project's late start and lack of sufficient human resources, coupled with the demanding nature of starting such an endeavor. The evaluation team agreed that this was a prudent decision under the circumstances.

## III. PROJECT MANAGEMENT

This section discusses aspects of project management primarily from the field perspective, however were relevant, PVO headquarter management and National Office management are mentioned. They are also discussed in other sections under PVO partnerships and capacity building. Areas discussed here include: planning, staff training, supervision, and management, human resources and financial management,logistics, information management, technical and administrative support and management lessons learned.

<u>Strengths</u>

- Clear objectives and clear budgetary information.

- Aim to address some of the most serious problems of women and children—harmful traditional beliefs and practices—through CHA training.
- Success in addressing felt priority needs of the communities.
- Involvement of stakeholders in implementation of programs, which can facilitate sustainability.
- Follow up of project activities with joint review with all concerned partners at different levels of the Zonal administrative structures.
- Highly committed and qualified staff.
- Close collaboration and overall good coordination with Ministry staff in planning, implementing, monitoring, and supervising project activities, which applies to the concerned government bodies.

**Weaknesses/limitations**

- Lack of clarity about and monitoring of job expectations of CHAs, depot holders, and voluntary mothers after training.
- Lack of inventory of available human resources such as auxiliary health workers in baseline studies.
- Lag in provision of services by community health workers as designed.
- Problem of identifying the number of eligible children and mothers in advance through prior survey and registration.
- Insufficient project staffing.
- Absence of monitoring and evaluation mechanisms at the grassroots level.
- Irregular contact with and reporting to health posts or clinics by trained volunteers in the kebeles.
- Communication gap between community, CHAs, and health committees that may affect project effectiveness.
- Lack of clear communication to the community and local stakeholders of the role of each organization in the project. .

## A. Planning

The current Child Survival Project staff was not involved in the preparation of the draft proposal. Those who were included the project coordinator, National health advisor, one representative from IEF and CCF headquarters. However, the current project manager participated in the preparation of the final DIP. He was also involved in subsequent revisions of the current document, especially in the budget breakdown, plan of operation, and so on. Project management and staff were not present during the baseline KPC survey but participated fully with the consultant during the mid-term (2000) KPC survey.

The evaluation team observed good collaboration and coordination between the project and the partners in the health sector with regard to planning, implementing, monitoring, and supervision of project activities.

1. Annual Work Plans

The project manager was involved in the development of the annual work plans in the capacity of team leader. Other project staff were also fully involved in this process. Preparation of annual plans was based on the DIP and the objectives/targets of the original document. Annual plan development and approval is very detailed and requires the review and endorsement of many local as well as international agencies. Initially the project office prepares the draft proposal. The draft is then submitted to the Woreda Councils, Zonal and Woreda Health Offices, Zonal Disaster Prevention and Prepared Commission (DPPC), and Christian Children's Fund national office after which it was forwarded to IEF as well. After review by these offices, comments, suggestions, and

concerns are forwarded to and incorporated by the project office. The final annual plan is then submitted to the same offices for information and for monitoring and evaluation purposes. The final plans are also submitted to the Regional DPPC and Regional Health Bureau. The quality of these plans could use improvement and is an area for headquarter staff to add technical assistance.

2. Report Writing

The team leader obtained all reports, both technical and administrative, from project staff on time and accordingly compiled them and reported them to headquarters in Addis Ababa and to the other stakeholders both in country and internationally. Commenting and feedback on field reports and work plans could have been more extensive by the national office and CCF headquarters office.

3. Dissemination of Project Objectives and Reports

Project staff and local partners claim they are well aware of the contents (objectives, strategies and activities) of the project document. In contrast, the community members (beneficiaries) were not well-informed. In some instances (especially among rural residents in the project catchment areas), people did not even know of the existence of the project.

Project-related details are familiar to key partners because of various forums—monthly review meetings with woreda councils and quarterly review meetings at zonal levels, in which stakeholders usually from all sectors participate actively. Many reports are prepared either monthly or quarterly and submitted to familiarize key stakeholders with the project.

The project evaluation team observed that the project has clear objectives and that the information on budget is very clear. The objectives and activities have addressed the most serious problems of women and children.

The project office and staff have full access to the DIP; in fact, all project experts have a copy. On the other hand, the woreda council partners do not have access to the DIP, but instead to the annual plans and the main project document. The zonal and woreda health offices do have copies, although they received copies during the signing of the agreement. All project staff have access to the working budget. The government partners also have the budget, together with the annual plans. Financial reports are submitted to the woreda and zonal authorities.

## B. Staff Training, Supervision and Management

The supervision of program staff is designed to be undertaken jointly by the project staff and Ministry. In reality this aspect of the project is weak. Feedback from the project to the project staff is communicated irregularly. The staff members have no job descriptions. Workers' performance is rarely discussed in regular meetings. On the other hand, project staff have monthly meetings in which they discuss implementation of activities and problems encountered.

Technical and administrative support to the project staff is satisfactory. The field staff are provided with motorcycles and receive supplies and equipment on request. However, project

activities have lagged due to procurement difficulties with a number of key project items, such as a vehicle and oral rehydration salts.

In conclusion, the project has trained Ministry staff, CHAs, kebele leaders, volunteer mothers, health committees, and depot holders to provide services and disseminate health information. The project has prepared IEC materials to reinforce the work of the health workers and auxiliaries.

The findings of the interviews and focus group discussions carried out by the team show that most trained health workers, auxiliaries, and kebele health committees have acquired new knowledge and skills from the child survival training programs and have used the knowledge they acquired in their activities to solicit more participation in services and promote the health awareness of communities. By and large, there are positive trends in the increase of awareness and service utilization of communities in the project area, as confirmed by the increase in immunization services to mothers and children.

Most people who participated in the interviews and focus group discussions knew about the project and what it does. The project has stressed that it addresses one of the most serious problems of women and children. The project has managed to involve all stakeholders in implementation, enabling the project to establish strong partnerships with all concerned, including the beneficiary communities. Thus there has been good collaboration established with Ministry staff in planning, implementing, monitoring, and supervising project activities.

While the implementation stage of the project is too short to judge the ultimate effectiveness of the working environment, the strength of partnerships at all levels of the government administrative structure is commendable. Government officials at zonal and woreda councils and health offices confirmed this in interviews conducted by the evaluation team. Such collaboration enhances interaction for joint implementation and effective coordination of activities.

*Staff Training, Supervision and Management Recommendations*

- Minimize the gap between the community, CHAs, and health committees.
- Spell out the objectives and activities of the project and the job expectations of Depot holders, CHAs, and volunteer mothers as soon as possible and follow up their results. At the same time, discuss the issue of incentives to these community health workers with all concerned, to avoid negative consequences for the project.
- Undertake regular supervision of the health facilities, particularly the frontline health facilities, and the community health workers, developing and using checklists.
- Sustain and continue the project success in creating and establishing a conducive working environment and strong partnership with all stakeholders at all levels.
- Expand and increase the pace of satisfactory training activities, which have resulted in more services and community awareness.

*Supervision of Program Staff*

**Weaknesses / limitations**

- The supervision of CHAs and depot holders was lacking.
- The supervision of health facilities – hospital and clinics was lacking.
- Inadequate supervision of voluntary mothers.
- Supervisory visits and checklists need development.

- Inadequate scheduled follow-up and supervision of community health services of the project.
- Lack of monitoring system to follow-up the utilization.
- Supervision to field level has not been done as frequently as needed.

*Supervision from Headquarter to national and field staff:*

Direct communication from the national office or IEF and CCF headquarter offices with the field project has been less than desirable. First, physical infrastructure provides for intermittent fax and phone communications but no internet service to the IEF/CCF field office. Secondly, a clear regular schedule of weekly or regular communications would have been beneficial where issues, new ideas, project direction, etc. could have been discussed between field and the two PVO headquarters staff. Joint resolutions and decisions could have been made on a timely basis, pulling in the strengths of both PVOs. Additionally, mentoring to another organization's field staff, even though a sub-agreement was arranged, posed its own complexities.

## C. Human Resources and Financial Management

### 1. Human Resources and Staff Management

At both the IEF and CCF headquarters there are adequate number of technical, administrative, and financial staff supporting the field activities. At the IEF headquarters there is one Child Survival Coordinator responsible for daily back stopping duties and is supported by an assistant and a financial administrator. Since 1995 there have been changes (turn over) in the CS Coordinator post on three occasions. However, overlap support was provided by a consultant and by the Director of Programs during the transition periods.

At the CCF headquarters a Medical Advisor, Tom Kerkering provides a percentage of time to the project and Jill Coleman, Ethiopia Project Manager provides a percentage of time to daily backstopping duties supported by a financial department. At the CCF National Office a Medical technical advisor provides a percentage of time supporting the field Project Advisor. At the field level there is a small core staff responsible for implementation.

CCF is a highly structured organization capable of supporting 21 National offices worldwide. One general area they see themselves as improving in is evaluation.

Ethiopia has 30 child and family heal projects CFP's with 4 special projects and an annual budget of 5.5 million. (See CCF/ETHIOPIA Strategy Statement Annex G) Field staff have job descriptions however the project manager, responsible for performance evaluations has not yet performed annual staff reviews or written evaluation of their performance that is discussed with them. Additional, implementation staff expressed an interest in receiving more feedback from the national and international offices, saying they had little exchange of information on other child survival projects in Ethiopia or other countries, as well as technical information. It is recommended that periodic performance reviews are conducted and more regular feedback is given to the field staff, in addition to the provision of technical materials and technical support.

In the field, the morale cohesion and working relationships of program personnel are very good. Staff are highly dedicated, committed, and perform their duties diligently. In general, staff have clear areas of responsibility and work effectively together. The relationship between the National Office and the Field office is good as there is close contact between both. There does appear to be, however, some friction between the field office and the National office regarding their delegation of administrative duties, e.g., procurement. Under CCF policy, each project is responsible for project procurement that requires a three quote process before a purchase can be made. This has necessitated that the field office form a 'procurement committee' (verify) and frequent travel to the National Office to secure even basic supplies. These administrative requirements help ensure financial accountability, however, the process requires extra time away from daily implementation duties. Although the issue of streamlining procurement was raised with the National Director, the CS field program is instructed to follow central CCF policies.

CCF offers good positions with competitive salaries to qualified Ethiopian staff. Despite this, there have been changes in both the Field and National office health positions since the project started for different reasons. The first field manager left the project early on in part due to frustrations over the continuing government delays and was replaced by the present manager, Dr. Tadesse. The National Office Health Officer also recently left his position during the past year for a new position and the National office is in the process of recruiting a replacement. The National Director has also changed since 1997 with the new director taking his position 23 months ago. Despite these changes the CCF National office is stable supporting a large National program.

**2. Financial Management**

The financial budgeting and reporting is inclusive of the original IEF program in Eritrea. Of the total Cooperative Agreement amount of $935,726 provided in September 1995 intended for Eritrea approximately $124,516 was spent. In the modification of the C.A. the balance of $811,210 was reprogrammed for the IEF CCF partnership in Ethiopia. Out of this amount $92,408 was budgeted for the IEF headquarters and $718,802 was obligated to CCF in a sub-grant for their Headquarters, National Office, and Field project. (See pipeline and expenditure tables and graphs in Annex J).

Under the terms of the IEF/CCF agreement, IEF provided CCF with an advance amount of $41,000 to initiate start up activities and to maintain a cash balance of approximately $20,000 to ensure adequate cash flow. Further advances were provided to CCF on a quarterly basis after receipt of their financial reports. CCF agreed to account for all expenditure based on their standard accounting practices established between National Offices and their Headquarters office in Richmond. The National Office reported to Richmond on a monthly basis and a summary report was prepared by their headquarters and forwarded to IEF on a monthly basis. IEF in turn reviewed expenditure and aggregated expenditure with IEF expenditure reporting to USAID in standardized formats. On an annual basis IEF prepared overall pipeline analysis of all expenditure in comparison to agreement budgets.

All accounting provided by CCF was exemplary and was provided on time in a well organized manner throughout the agreement period. There were no reported gaps in funding availability to CCF.

As of June 30, 2000 (IEF's fiscal year end) a total of approximately $361,672 (45%) was spent out of the total of $811,210 designated for the new program. IEF exceeded its budget of $92,408 and CCF is under spent by approximately 64% ($256,000/$718,802) with six months remaining. Under expenditure is due primarily to the late start up of activities and the limited absorption capacity of the field office and MOH. Both IEF and CCF have meet the 25% matching requirement, IEF primarily during the period of programming in Eritrea, and CCF during the sub grant period through procurement of equipment and vehicles.

Out of the CCF budget the average quarterly burn rate per year (USAID funding) increased annually from $8,750, to $11,292, to $21,603, to $24,558 reflecting the increase in programming. Approximately 46% of total funding (USAID and CCF combined) was spent in Ethiopia between the National Office and the project field office. Based on the estimated quarterly burn rate of $25,000, at least an additional $50,000 is expected to be utilized by CCF through December. Other costs anticipated during this period are the costs of evaluation and some additional procurement for the field office to support EPI and ORT activities.

### 3. Human and Material Resources

**Strengths**

- The project has contributed to expedite quality of service in health facilities in the two Woredas through the provision of equipment and materials.
- Support with cold chain equipment, drugs is encouraging.
- Providing maintenance and service for motorcycles is encouraging.
- Material and training support for the health personnel are well done.

**Weaknesses**

- The project has few staff and hence not compatible with the coverage area and large number of target population.
- There is shortage of stationary and materials for depot holders to register and report their work.
- No regular supply of materials and at right times and in right amounts for each project kebeles.

The original project document envisaged at least 7 full time project staff and during the course of approval of the project the number has been reduced to three. To train, monitor and manage all the activities, including procurement, under each intervention in two woredas with disperse villages, takes more staff then presently exist. This is perhaps one factor in the delays of the project, as well as weaknesses in supervision and monitoring of the over 1100 trained health workers.

For all intents and purposes, the project is considered to be 70% completed (48 month contract with the GOE, ending April 2002). As of July, the project funds are 62% spent.

## D. Logistics

Logistics have presented numerous challenges to this Child Survival Project. The combination of The Government of Ethiopia's bureaucratic structure and the CCF internal structure, delays have been pronounced. Manifestations of these delays are obvious – the country agreement was signed late, project activities were started late, even after the signed agreement, and CCF national procurement processes are unduly burdensome on the thinly stretched staff. Prolonged custom procedures to clear the project vehicle from the port led to delays (still not resolved). However, the CCF head quarters in Addis Ababa have provided a vehicle, and this has solved the problem temporarily.

The government changed its policies regarding importation of goods during the start up period giving the customs bureau authority over all importation of goods regardless of the status of agreements a PVO may have had with the MOH. Even basic supplies of vitamin A and vaccines were reported to have been held by customs due to policy changes and cumbersome customs procedures. The purchase of supplies supporting EPI (spare parts and refrigerators) and DCM (ORS packets) will continue to present a major management burden on CCF staff. **CCF might explore the possibilities of joint bulk orders of basic supplies with other NGOs and PVOs in Ethiopia.** In this manner the purchase price may be reduced through bulk negotiated pricing and more than one organization may bring additional pressure on the customs to expedite processing.

## E. Information Management

For each project intervention component, its own information system has been developed where there is a difference in the scope and depth of information collected as well as in the balance between qualitative and quantitative data components.

Health services data is collected for its use in monitoring on an ongoing basis, such as in the case of EPI. Coverage data is collected from the various health facilities from routine work as well as from the campaigns. The compiled data is then reported back to health offices, discussed and commonly shared.

CHAs, volunteers and the depot holders are expected to report every 15 days, which establishes strong relationship with these community-based workers and service providers. Most of the reports are in written form. Feedback is given to the community-based service providers and then jointly assessed when they come to the project office to submit their reports. At these times they are given moral encouragement as well as some technical support.

All reports are compiled on quarterly basis except the monthly EPI reports. Feedback is obtained from the Woreda health office, in form of an informal communications, i.e., during review meetings and when there are specific concerns). The project also discusses on surveillance related issues with the respective Woreda Health Offices.

In the project office, all the experts are expected to submit their schedules to the team leader every month, where he prepares Gantt charts. For monitoring purpose all project experts meet once every week to review whether the activities were carried out or not. Every month written reports are submitted.

The routine system of data collection involves the preparation of the various reports, their analysis, submission and the feedback processes. The process of reporting is such that the

quarterly reports are submitted to the National Office, Zonal council, Zonal DPCC, ZHD and also to the two Woredas. Each Woreda splits activities. Moreover, reports are also submitted to the RHB, RDPPC, International PVO Headquarters, and USAID mission office in Addis Ababa. Reports are prepared in either of the languages, i.e., Amharic or English.

The reporting system is said to be working effectively with no unnecessary reporting delays encountered. CHAs report regularly. The project has influenced the Zonal health authorities to incorporate on the MOH report forms some key health information like statistics on vitamin A supplementation. Reporting form are designed in such a way for as much information as possible be on a single form.

The evaluation team members indicated that there is some information gap at the community level as well as limited contact between the health facilities and the community health workers, hence, making information exchange very limited.

According to the project management, various actions were taken based on the routine reporting system (*monitoring data for quarterly and annual planning).* One such major action was organizing and launching campaigns on immunization, where coverage was found to be very low. Therefore, reporting process has been very important. Review meetings and feedback mechanisms were also used for further planning.

Besides the ongoing data collection, other data collection is undertaken such as surveys and assessments. Some of these include: nutritional baseline assessment before beginning the health programs; focus group discussions on causes of low Tetanus Toxoid immunization and an assessment of health facility capacities for EPI planning.

## F. Technical and Administrative Support

Technical support to the project comes through both international offices of IEF and CCF, as well as through the Health Advisor at CCF/Ethiopia's national office. (The later Health Advisor position has been unfilled for the past half year.) Each international office has a program officer who assists in a technical capacity. IEF has a resident expert on child survival programs, with strengths in child survival, vitamin A and quality assurance. In the case of CCF, a medical doctor advises on program operations as well as a health program officer. The country program officer advises on administrative, financial and other matters. While technical assistance is readily available, it demands that those who need it request it. The evaluation team felt the project staff are not fully exploiting the wealth of technical resources available to them and that requests for information and TA be more aggressively pursued.

Administrative support to the project is similar. The national CCF office does not have the resources to provide much administrative support, however for matters such as workshops or evaluations held in the capital, excellent support is provided. One other difficulty observed was the layers of organizations involved sometimes complicated understandings of administrative and financial support (USAID, IEF, CCF headquarters and national levels).

## IV. CONCLUSIONS, RECOMMENDATIONS AND NEXT STEPS

### A. Conclusions

In conclusion, the project has made great strides since the actual field implementation began, although the start-up period experienced lengthy delays causing the timing, evaluation and financing of the CS cycle to off schedule. Notable accomplishments have been made in the areas of obtaining qualified staff, training key stakeholders as well as health staff in the four intervention areas, improving health facilities capacity and establishment of eight oral rehydration corners, significantly greater EPI and vitamin A capsule coverage to women and to children by improving both the ability for the MOH to do more outreach and regular campaigns and by enabling the project staff to assist the MOH and mobilize the communities to receive immunizations, and successful initiation of a proven nutrition model (Hearth Model). Knowledge in some areas of the four interventions has improved, however it is too early to elaborate on behavior change other then the improvement in knowledge of immunization and acting upon it. In the area of developing relationships and trust for ease of project implementation and longer-term project sustainability, the project staff has gone above and beyond the norm.

Areas for improvement include intensifying the supervision and monitoring, by establishing roles for MOH staff, project staff as well as kebele leaders to lessen the burden on the project itself and to build the capacity of their partners. This also includes clearly defining expectations from each level of project staff, putting necessary checklists and tools into their hands and reviewing them on a regular basis. The project also has the opportunity to address the gap in communications between the community health workers and the health posts and stations, including support to each other's work, defining roles and responsibilities (such as assisting with campaigns, monitoring, referrals). Strengthening the diarrheal case management intervention needs particular attention, whereby purchase and provision of sugar and salt at the community level (as well as health posts) should be done without delay. The project has a prime opportunity to help move the cultural shift away from dependence on the unavailable ORS to (more self-reliance) home solutions, which are readily available.

To operate more efficiently and best address the four interventions including the planned training and expansion, the whole evaluation team agreed the project needed more staff, at least two field level positions to cover what is needed at present. While the project is contemplating adding components such as HIV/AIDS and family planning, it would be ill-advised to do so with out more staff. There should be careful consideration of any other interventions (such as ARI – for reasons discussed in the early project reports and reviewers comments), as mentioned previously, because the staff is insufficient.

## B. RECOMMENDATIONS

### 1. PROJECT OBJECTIVES AND INTERVENTIONS:

a) Maintain scope of project interventions. Consider adding HIV/AIDS and family planning component if an additional technical staff person can be recruited.

b) Strengthen activities in the following intervention areas:

i. *Breastfeeding Promotion and Nutrition –*
expand target audience for breast-feeding to include more groups that may have influence on mother's behaviors; expand *Majet* to other kebeles using trained volunteer mothers to assist in the training.

ii. *Diarrheal Case Management-*
It is recommended that to accomplish the project targets for this intervention the staff must:

- Begin immediate training of home-based solutions (drawing upon literature of best solutions for Ethiopia) both at the community level and ORT corners in health posts;
- Procure sugar and salt, and sachets for the mix, for the health posts and particularly for the kebeles (depot holders); and
- Modify the Sustainability Goal Objective in the DIP # *5. Establish community level drug depots to increase availability of drugs* to *Establish community level drug depots to increase availability of drugs and home-based solutions;* and the modify the objectives to accomplish this goal to *a. Increase the knowledge of women to prepare home solutions (including sugar/salt solutions) b. Establish depot holders as resident resource on diarrheal management and c. increase the availability of ORS, ORT and other medicines at the community level.* An impact indicator of the success of the depot holder establishing her or himself as a resident resources might be- *Number of community members seeking DCM advice from the depot holders and community health agents* which would measure the effectiveness of these community level health workers establishing themselves as credible resources for DCM. The health posts health staff should be working hand-in hand with the deport holders and CHAs to monitor quality of information given and assure referral process for severe cases of diarrhea.

c) Incorporate Quality Assurance (QA) in training and in all aspects of the project as planned in the DIP, to greatly facilitate project interventions as well as monitoring and management. Contract services of a quality assurance expert to integrate QA into all aspects of the project and within the CCF National office.

d) Carefully weigh adding ANY intervention in the next phase of the project. Project staff is presently unable to effectively supervise, and monitor kebele-level staff while conducting al lother project interventions. Addition of an intervention would necessitate addition of staff.

ARI may face the same obstacles as in the beginning of the project. A consultant (such as in country child survival PVO staff from other organizations) should be engaged to determine if health facilities can effectively handle severe ARI cases.

## 2. COMMUNICATIONS: AWARENESS AND SPREAD OF INTERVENTIONS

a) IEF/CCF should investigate reasons why awareness is low in some rural areas. Some of these areas were visited by the mid-term evaluation team.

b) Improve communications within the community: CHAs, deport holders, volunteer mothers, and the health committees, by delineating their job expectations and sharing them amongst each other.

c) Expand training activities for health workers and community members should be expanded and continued at a faster pace.

d) IEF/CCF project staff should more aggressively pursue information, TA and materials needed for the project. While technical assistance in readily available, it is not being fully exploited. Likewise, IEF and CCF Headquarters should actively deliver child survival information, technical assistance, and materials to the field.

## 3. PROJECT MANAGEMENT

### a. Project Management

i. Elaborate upon the objectives, project activities and the job expectations of DHs, DAs and volunteer mothers combined with checklists for activities performed each month. Assure checklists are distributed regularly. Coordinate with MOH on expectation from MOH staff vis-à-vis project interventions that fall under the normal work domain of MOH staff.

ii. Actively facilitate working relationships between health posts staff and community health workers (CHAs and Depot Holders). Bridge gaps by hosting joint sessions with higher level MOH staff present, outline expectations and areas of support and cooperation.

iii. Further discuss the issue of incentives with the MOH to make a final recommendation.

iv. Plan out areas where kebele leaders can interact and assist in project activities with the community-level staff. Design and provide simple incentives for kebele leaders (and other community level volunteer workers) to be more involved in the project.

v. Establish regular joint planning between all partners; take planning higher than the Zonal level by inviting the Regional level to directly participate. This planning should revolve around formalizing objectives on capacity building, partnership building and sustainability.

vi. CCF should also be supporting, if possible, some of the other direct needs of the MOH, i.e., infrastructure, supplies or the important and visible things that

would make them feel they are being listened too. Some of this support could be provided to them in a small 'grant' format thus encouraging trust, accountability and transparency.

vii. There should be objectives established for capacity building and sustainability for CCF and partners. CCF/Richmond should also contribute to assisting in defining measures for capacity building of the national office (if not already done so).

viii. New interventions should only be those that CCF plans to include and support in CFH approach and their standardization of interventions. This would help ensure support, development of lessons learned, and integration within CCF.

ix. CCF should also be more explicit in defining what integration of CS and CFH projects means to them and child sponsorship in general.

x. Baseline and mid-term KPC surveys should be reviewed for indicator wording, and where different, reevaluate the data so the indicator and the measure of these indicators match. This will be important to achieve an accurate final survey and determine the project's real impact.

**b. Supervision**

i. Supervision of the health facilities particularly the frontline health facilities, the community health workers has to be undertaken regularly.

- Plan supervision and follow-up visits at least one month in advance with each community so project volunteer staff can be available for the visit.
- Schedule follow-up visits with each kebele at least one each month – visits should include progress reports on all interventions (not just each technical staff's specialty).

ii. Continue to foster the transparent and cooperative environment with all government and local partners for the project. Set aside a week for planning and budgeting in this next phase of the project. Build in a chain of monitoring and supervision responsibilities that both complement the normal job responsibilities of partners and facilitate project interventions. Examples are: MOH health posts monitor/supervise CHAs and deport holders, kebele leaders monitor/supervise health committees, volunteer mothers, others, etc. Sharing these responsibilities amongst project staff and partners will set the stage for longer term sustainability of project interventions as well as disperses the supervisory load of the project staff.

iii. Provide more direct TA from HQ to National Office to field with planned objectives and indicators. Visits should be at least 2-3 times per year if possible. Emphasis should be on further strengthening supervision, monitoring and evaluation. Visits should be of sufficient time to ensure objectives are met.

**c. Human Resources**

i. Funds permitting, recruit and train at least two staff members for field monitoring the project's four intervention areas. Discuss with the MOH officials the difficulty of running an effective project with a low overhead, and the need to increase it for more staff to be hired.

ii. If the MOH would like an HIV/AIDS component added, recruit and hire a technical specialist in family planning, mother health and HIV/AIDS and address critical areas under that those matters.

iii. Plan for greater core project staff capacity building through training in technical areas as well as program management (such as QA, monitoring and evaluation, etc.) and exposure to other related child survival projects in country.

**d. Materials and Supplies**

i. Put in the hands of all community level workers more IEC materials with standardized messages (so the frontline health worker is strengthened in his/her knowledge of the subject area, and the community receives the same messages (correct messages).

ii. Provide every project staff with register books to record activities.

iii. Provide every depot holder and health stations and posts with sugar and salt to make ORT. Provide enough to have home made sachets ready for the caretakers of sick children. Restock monthly.

**e. Financial Resources**

i. Spend resources available, increasing present burn-rate, to ensure maximum efficiency of project interventions. This includes early procurement for supplies to reduce delays in delivery to the field.

ii. Explore potential for extension of funding through USAID /Addis Ababa or USAID/BHR/PVC to carry out project activities according to agreement with the Government of Ethiopia designed to end April 2002.

iii. Budget information needs to be in the hands of the users. The field office needs to review monthly expenditures on a regular basis in order to appropriately plan and budget.

**f. Effective Partnerships**

i. Communication flow between all levels of PVOs offices and USAID should be constant, consistent, and transparent. Each agency involved (in a sub-grantee relationship) should be copied on necessary project information simultaneously.

ii. Regular PVO to PVO meetings need to be undertaken to discuss project implementation, joint visits, recommendations, etc.

iii. Entering into partnerships with other agencies should be undertaken with caution and due consideration and deliberate calculations of every aspect of project management

## C. NEXT STEPS

The evaluation team in conjunction with the child survival project staff outlined some steps to consider for the next phase of the project. All agreed that the project should continue and go on to expand service coverage area. All those who were interviewed during this evaluation agreed on the above points and added some areas they would like to see covered in the next phase. These are noted below. The recommendations suggest that if any new technical interventions are added, each are considered carefully and staff are added to the project, in addition to the field monitor staff needed at present.

**Service Expansion**

- Less emphasis (or non-existent) of vegetable promotion in rural areas, where it should have been very strong. (Expansion planned for all the kebeles in Debrebirhan.)
- Income generating scheme for Majet-trained mothers by providing sheep to raise and sell.
- Expansion of essential EPI services should continue as planned.
- The project should carefully weigh the addition of HIV/AIDS and family planning activities, and if added, only done so with the addition of new technical and field monitor staff.
- Infrastructure based capacity building was needed but not included in activities thus far. Construction of health facilities. (This is already included in the revised CSP plan and is planned to commence as of January 2001.)

CCF/Ethiopia plans to develop a new work plan for 2001 with the assistance of CCF/Richmond. CCF/Richmond will continue to support the Child Survival Project until other funding sources are obtained.

## V. Annexes

# Annex A
## KPC Mid-term Results

**Summary KPC Table**

The following table describes the comparative findings between the Baseline and Follow-up KPC surveys. A total of 300 mother-child pairs were studied using the standard KPC survey methodology. Age of the mothers ranged from 17-49 years, with a median age of 27.

*Note: As the project is still half way through its life, any comparison of performance cannot be compared directly to the overall targets that are planned to be attained by the end of the implementation period. The necessary caution should be made in this regard.*

**Table 1. KPC Mid-term Summary**

| Pattern | Baseline (%) | Follow-up (%) | Change |
|---|---|---|---|
| ***Breastfeeding Pattern of Children 0-23 Months:*** | | | |
| Currently | | | |
| Breastfeeding | 91.6 | 94.0 | + 2.4% |
| Ever Breastfed | 66.7 | 77.8 | + 11.1% |
| Initiation of Breastfeeding, | | | |
| within one hour | 41.3 | 24.0 | - 17.3% |
| within half a day | 21.3 | 11.0 | - 10.3% |
| after half a day | 35.5 | 65.0 | - 30.3% |
| Exclusive Breastfeeding, | | | |
| at 0-3 months | 17.7 | 68.0 | + 50.3% |
| Supplementary Feeding | | | |
| at 6-9 months | 46.7 | 71.2 | + 24.5% |
| Continuation of Breastfeeding, | | | |
| at 20-23 months | 82.4 | 75.0 | - 7.4% |

| Age Complementary Foods | Baseline (%) | Follow-up | (%) Change |
|---|---|---|---|
| ***Knowledge about Age of Introduction of Complementary Food*** | | | |
| Before four months of age | 5.0 | 9.3 | + 4.3% |
| Four to six months of age | 25.8 | 13.3 | - 12.5% |
| Around the sixth month | 29.4 | 30.3 | + 0.9% |
| After the sixth month | 31.1 | 37.3 | + 6.2% |
| Don't know | 8.7 | 9.7 | + 1.0% |
| ***Feeding practice to children six months and above:*** | | | |
| Dark green leafy vegetables | 35.3 | 26.4 | - 8.9% |
| Fruits | 30.0 | 30.2 | + 0.2% |
| Meat and/or fish | 45.5 | 31.6 | - 13.9% |
| Beans | 47.4 | 36.8 | - 10.6% |
| Eggs or Yogurt | 59.6 | 40.1 | - 19.5% |
| Add sugar or honey | 82.1 | 84.0 | + 1.9% |
| Add butter or oil | 71.2 | 65.1 | - 6.1% |
| Add iodized salt | 3.4 | 21.7 | + 18.3% |

| Characteristics | Baseline (%) | Follow-up | (%) Change |
|---|---|---|---|
| ***Knowledge about and Coverage with Vitamin A supplementation,*** | | | |
| Which vitamin helps prevent Nightblindness? | | | |
| Vitamin A | 8.7 | 12.0 | + 3.3% |
| Which foods can be given to prevent Night Blindness? | | | |
| Don't Know | 13.7 | 85.3 | + 71.6% |
| Dark-Green-Leafy-Veg . | 10.2 | 7.7 | - 2.5% |

| | | | |
|---|---|---|---|
| Carrots | 6.7 | 5.9 | - 0.8% |
| Fruits | 11.7 | 1.6 | - 10.1% |
| Liver | 13.7 | 0.6 | - 13.1% |
| Breast milk | 13.3 | 0.0 | - 13.3% |
| Egg yolk | 12.7 | 0.6 | - 12.1% |
| Vitamin A Supplementation to: | | | |
| Child | 6.0 | 69.3 | + 66.0% |
| Mother | 4.3 | 15.3 | + 14.0% |

| DCM | Baseline (%) | Follow-up | (%) Change |
|---|---|---|---|
| ***Feeding of Infants during Diarrheal Episodes*** | | | |
| Breastfeeding | | | |
| same as usual | 49.5 | 52.7 | + 3.2% |
| more than usual | 10.3 | 36.4 | + 26.1% |
| less than usual | 28.9 | 7.3 | - 21.6% |
| stopped/discontinued | 4.1 | 0.0 | - 4.1% |
| *Fluids* | | | |
| same as usual | 21.6 | 21.8 | + 0.2% |
| more than usual | 7.2 | 9.1 | + 1.9% |
| less than usual | 23.7 | 27.3 | + 3.6% |
| stopped/discontinued | 11.3 | 9.1 | - 2.2% |
| *Foods* | | | |
| same as usual | 19.8 | 25.5 | + 5.7% |
| more than usual | 6.3 | 9.1 | + 2.8% |
| less than usual | 26.0 | 29.1 | + 3.1% |
| stopped/discontinued | 14.6 | 12.7 | - 1.9% |
| ***Home-care to children during Diarrheal Episodes*** | | | |
| ORS | 2.0 | 1.8 | |
| Salt-sugar solution | 4.0 | 3.6 | |
| Cereal based ORT | 2.0 | 1.8 | |

| | | |
|---|---|---|
| Home-fluids | 4.0 | 5.5 |
| Antibiotics | 2.0 | 3.6 |
| Other | 32.6 | 21.8 |
| No home-treatment | 62.2 | 60.0 |

***Source of Medical Care/Advice Sought during Diarrheal Episodes***

| | | | |
|---|---|---|---|
| Hospital | 56.2 | 64.7 | + 8.5% |
| Health station | 25.0 | 29.4 | + 4.4% |
| Private clinic/physician | 3.1 | 0.0 | - 3.1% |
| Pharmacy/drug store | 3.1 | 0.0 | - 3.1% |
| Health post | 6.2 | 0.0 | - 6.2% |
| Friends, relatives | 3.1 | 5.9 | + 2.8% |
| Other places | 3.1 | 0.0 | - 3.1% |

.

| EPI | Baseline (%) | Follow-up | (%) Change |
|---|---|---|---|
| ***Immunization status of children aged 12-23 months*** | | | |
| BCG | 30.3 | 43.5 | + 13.2% |
| Polio: OPV 1 | 28.6 | 45.2 | + 16.6% |
| OPV 2 | 24.5 | 37.9 | + 13.4% |
| OPV 3 | 19.6 | 29.0 | + 9.4% |
| DPT : DPT 1 | 30.3 | 45.2 | + 14.9% |
| DPT 2 | 27.0 | 39.5 | + 12.5% |
| DPT 3 | 21.3 | 30.6 | + 9.3% |
| Measles | 21.3 | 28.2 | + 6.9% |
| Drop-out Rate | | | |
| OPV1-OPV3 | 31.4 | 35.7 | + 4.3% |
| DPT1-DPT3 | 29.7 | 32.1 | + 2.4% |
| Overall Immunization status | | | |
| Not Immunized | 68.8 | 52.4 | - 16.4% |
| Partially Immunized | 15.5 | 25.0 | + 9.5% |
| Fully Immunized | 15.5 | 22.6 | + 7.1% |

| Mothercare | Baseline (%) | Follow-up | (%) | Change |
|---|---|---|---|---|
| ***Knowledge, Practice and Coverage on Maternal Care:*** | | | | |
| Maternal (TT) Card | | | | |
| Present | 30.0 | 49.0 | | + 19.0% |
| Tetanus-toxoid vaccine, | | | | |
| two or more doses | 22.3 | 39.3 | | + 17.0% |
| Antenatal visit, | | | | |
| at least once | 19.3 | 29.3 | | + 10.0 |
| Ate more food than usual | | | | |
| during last pregnancy | 6.7 | 3.3 | | - 3.4% |
| Delivery attendance | | | | |
| by trained birth attendant | 15.0 | 26.0 | | + 11.0% |
| by traditional birth attend. | 39.3 | 52.3 | | + 13.0% |
| Knowledge about food, preventing | | | | |
| pregnancy-anemia | 29.7 | 24.0 | | - 5.7% |
| Knowledge about time of first visit to health | | | | |
| care during pregnancy | 14.7 | 14.0 | | - 0.7% |

**Acknowledgements**

The study team would like to thank all the interviewers and supervisors and those that gave their assistance to complete the survey in a timely manner. The entire survey staff gives thanks to the mothers and families that gave their time to be interviewed, in hope of supporting maternal and child health interventions in their locality.

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**Executive Summary**

A follow-up knowledge, practice and coverage (KPC) Survey was carried out in Debre Birhan and Basona Worana Woredas of the North Shoa Zone, Amhara Regional Government, Ethiopia between 15 – 22 April, 2000. The two woredas are implementation areas for the IEF/CCF Child Survival Program. This work was successfully accomplished through a close and active collaboration from Child Survival Project (CSP) staff and the local Ministry of Health (MOH) staff at the Zonal Health Department and Woreda Health Office.

Objectives of the survey were to obtain a follow-up assessment on the knowledge and practices of mothers with children under two years of age in the IEF/CCF Child Survival Project area concerning immunization coverage for children 12-23 months of age, and to identify health factors most commonly involved at the household level for childhood illness. The objectives of the survey were accomplished within two weeks.

The survey consultant was formerly trained in the Johns Hopkins PVO Child Survival Support Program (JHU/CSSP) Rapid KPC methodology. The consultant subsequently trained the interviewers and supervisors in proper survey techniques based on the JHU/CSSP method which uses the WHO 30 cluster sampling method. Each cluster included 10 consecutive household survey interviews with mothers of the children. A total of 300 mothers were interviewed.

**Major findings include:**

For management purposes of the program it is important to note that almost a third (35%) of mother's reported being able to read and write. The vast majority are available at their homes during the day, and 98% are from the ethnic group Amhara.

Immunization coverage is found out to be much higher than the baseline status. The DPT3/Polio3 coverage is at about 30% as compared to 20% at baseline. Full immunization is increased by 7%. However, the drop-out rate was at about the same level as during the baseline.

Mother's knowledge of immunization is still low. About the same proportion of mothers (10.7%) reported not knowing why TT vaccination was given. However, over 25% increase has been observed on the proportion of mothers who reported that the measles vaccine should be given at 9 months.

Mother's were asked to identify children with diarrhea (18.3%) in the past two weeks. The prevalence of childhood diarrhoea was reported to be nearly half as much as the level during baseline. Treatment seeking behavior for diarrhea was assessed. The majority of mother's (60%) sought no help at all. No mother sought treatment from a health post or from community health workers (CHA or TBA).

Half as much (2.7%) number of mothers stated that rapid initiation of fluids was an important action to take during diarrhea. A few mothers (below 2%) stated that withholding fluid or food was an important response to diarrhea.

Continuous breast feeding was found to be at 75%, which is a level 7% below the baseline status. However, exclusive breast feeding showed a 50.3% increase from the baseline status at 17.7%. Supplementary feeding, giving solid or semi-solid foods to their 6 through 9 month old infants, has also improved from 47% to 71%.

Initiation of breast feeding has been a particularly problematic area both during the baseline and at follow-up, with only 24% (as compared to41.3% during baseline) of initiating breastfeeding within the first hour after delivery. On the other hand, a considerable increase has been noted in the proportion of mothers and children who received a vitamin A capsule. Accordingly, 69.3% of children and 15.3% of mothers have received vitamin A supplementation.

# Introduction

The IEF/ CCF Child Survival – Vitamin A Project has been operational since August 1998 in the two woredas (districts) of North Shewa Zone, namely Debre-Birhan town and Basona-Worana District.

The child survival program targets maternal and child health interventions which are proven to reduce child mortality rates. The interventions are consistent with the Ministry of Health (MOH) strategies nation-wide and address the major causes of childhood morbidity and mortality in Ethiopia. The objectives of the project as are that by the end of the project period:

**Immunization**

1) 70% of children 12-23 months of age will be fully immunized,
2) 30% of women 15-49 years will be immunized against tetanus.

**Case Management of Diarrhea**

1) 75% of children will receive ORT during diarrheal episodes,
2) 75% of children will receive the same amount or more liquids during a diarrheal episode,
3) 75% of children will receive the same amount or more of breast milk during a diarrheal episode,
4) 75% of mothers can correctly identify dehydration and appropriate therapy,
4) 75% of mothers can correctly identify the 3 rules of home management of diarrhea.

**Nutrition and Vitamin A**

1) 60% of children 6-71 months receive high dose vitamin A semi-annually,
2) 30% of post-partum women receive high dose vitamin A within 30 days following delivery,
3) 40% of children 0-4 months will be exclusively breastfed,
4) 80% of children at CCF project sites identified with severe malnutrition or measles will be treated with high dose vitamin A.

**Survey Methodology**

All methods for the survey were employed in accordance with the JHU/CSSP Rapid KPC Training Guide. Mother's of children up to two years old were included in the survey. Only the youngest child in the proper age range was used for questioning (index child). Cluster selection was based on the Probability Proportionate to Size (PPS) Cluster Sampling technique, performed by the consultant and survey team. A total of 30 clusters were chosen from all peasant villages and kebeles in the two woredas. House selection was at random, using a sampling frame of tax payers' list available for each population unit. Once the first house was identified, subsequent households were chosen by nearest proximity. If the mother of a child under two was identified to live in the home but was unavailable, the interview rescheduled a visit for later the same day. Mothers that were away from their homes for longer than the survey day were skipped.

The Supervisor/ Interviewer training took three days. A questionnaire was developed from the standard JHU/CSSP format, which was modified during the training for the initial baseline survey. The questionnaire was field-tested in kebele 03 of Debre Birhan and in a nearby rural village. Neither field test area has bee chosen as a survey cluster. In general, teams of one supervisor and two interviewers were used per cluster.

**Conduct of the Survey**

The field data collection was conducted from Tuesday, April 18 through Saturday, April 22, 2000. All clusters were reached as originally selected and by Saturday all teams had returned safely. The maximum distance that was traveled was nine hours walking from Debre Birhan. Teams traveling to the most remote clusters spent the night in the village, usually at the home of the peasant association head or with some other contact person.

Supervisors were given the name of the first household to select and were responsible for checking the questionnaires for completeness and correctness. An events calendar was devised by the core team prior to survey activities, which was used to determine the age of the child in months.

## RESULTS

The following responses were elicited after administration of the standard KPC questionnaire to 300 mother-child pairs (mothers who have children younger than 24 months of age). Completeness and correctness of the questionnaires was checked daily at the survey site. Over 75% of the sample population enrolled in this KPC survey was contributed to by Basona Worana Woreda (district) while the remaining were from Debreberhan town. The results described below are based on the entire 300 questionnaire unless stated otherwise.

### Identification Module

1. The age of mothers enrolled in this study ranged from 17-49 years. The majority 153 (60.0%) of women were in the age group 20-29 years. The median age of respondents was 27.0 years. Fifteen (5.0%) of the mothers were below the age of 19 years and another 61 (20.3%) of the mothers were over 35 years old.

2. The majority of children studied 196 (58.7%) were in the age group 0-11 months. Those below six months of age comprised of 29.3%. Infants in the age group 0-3 months constitute 50 (16.7%) of the total, while those in their second year of life (12-23 months) make up 124 (41.3%) of all children. The mean age of children studied was 10.5 months.

Distribution of Children by Age

| Age group (months) | Number of Children | Percent |
|---|---|---|
| 0 - 1 | 14 | 4.7 |
| 2 - 3 | 36 | 12.0 |
| 4 - 5 | 38 | 12.7 |
| 6 - 7 | 31 | 10.3 |
| 8 - 9 | 21 | 7.0 |
| 10-11 | 36 | 12.0 |
| 12-13 | 22 | 7.3 |
| 14-15 | 25 | 8.3 |
| 16-17 | 19 | 6.3 |
| 18-19 | 28 | 9.3 |
| 20-21 | 17 | 5.7 |
| 22-23 | 13 | 4.3 |
| All age groups | 300 | 100.0 |

## Mothers' Education and Occupation Module

3. Majority of the mothers 195 (65.0%) interviewed were unable to read and write, while 23 mothers reported that they are able to read and write. Another 76 (24.6%) mothers reported having attended formal education. Eight women reported being able to read only. Overall, 65% of the respondents were illiterate while the remaining 35% were literate.

4. Majority of the mothers 217 (73.0%) reported that they do not do any income generating work, while the remaining are involved in some kind of income generating

work. Accordingly, 42 (14.0%) of them reported that they prepare and sell local drinks such as 'Tella' and/or 'Arakie'.

5. Most of the mothers 251 (83.7%) reported that they are usually available at home throughout the whole day, while 16 mothers are not available at home the whole day. The remaining 21 and 12 mothers reported that they are usually available at home either during the morning or the afternoon, respectively.

6. In 127 (42.3%) of the cases the mothers take their children with them whenever they leave home for some reason, while older children and relatives are the guardians taking care of children when the mothers are away in 131 (43.6%) of the cases.

## Breast Feeding/ Nutrition Module

7. Most of the mothers 282 (94.0%) have been breast feeding during the study period while the remaining 18 women reported to have not been breast-feeding at the time.

8. Among the 18 mothers who have not been breast-feeding during the study period, 4 reported to have never breastfed their youngest child.

9. Only 72 (24.0%) of the mothers reported to have initiated breast feeding immediately (within the first hour) after delivery, while another 33 (11.0%) initiated breast feeding within one to eight hours after delivery, adding to a total of 105 (35.0%)

women who initiated breast feeding within the first eight hours. The remaining mothers started breast feeding more than eight hours after delivery, out of which 12 (4.0%) replied that they don't recall exactly when they initiated breast-feeding.

10. Among 50 infants younger than four months of age, 34 (68.0%) were exclusively breastfed during the study period. Whereas, among another 52 infants in the age group 6-9 months, supplementary feeding was introduced to 37 (71.2%).

Of the 52 infants aged between 6-9 months, 26 (50.0%) were receiving cow's milk, goat milk or formula, whereas, semi-solid foods such as gruel, porridge or semolina was given to the remaining 50%.

Among 250 children four months old and above, 74 (29.6%) were reported to be given foods rich with vitamin A such as yellow fruits or dark-green vegetables. Similarly, 127 (50.8%) of the same group of children were receiving foods enriched in protein, such as meat or fish, lentils or beans, or eggs or yogurt.

The inquiry of mothers whether they were adding various food items to their child's meal indicated that leafy green vegetables were added to meals in 46 (18.4%), honey or sugar were added in 199 (79.6%), and fat or oil was added in 148 (59.2%) of children's meals. About 20% of the mothers reported that they are adding iodized salt to their child's meals.

Out of 40 mothers who have children in the age group 20-23 months old, the majority 30 (75%) have still been breastfeeding during the study period.

11. The age for introducing additional foods to breastfeeding was reported to be between four and six months by 40 (13.3%) mothers, while another 91 (30.3%) mothers said that it is around the age of six months. However, a higher proportion of the women 112 (37.3%) said that additional foods should be introduced after the age of six months, and another 28 (9.3%) replied earlier than four months. The remaining 29 (9.7%) mothers said that they don't know.

12. The foods to be given in addition to breastfeeding were stated to be foods rich in vitamin A 30 (10.0%), iron 15 (5.0%), food rich in and addition of oil to food 3 (1.0%). Other foods were mentioned in 112 (37.3%) cases, while 28 (9.3%) of mothers said that they don't know what the foods additional to breastfeeding should be.

13. Vitamin A was known to be preventing from "night blindness" by 36 (12.0%) mothers. The remaining 264 (88.0%) mothers replied that they don't know.

14. The majority of mothers 256 (85.3%) replied that they don't know which food contain Vitamin A. Whereas, green leafy vegetables were mentioned in 23 (7.7%) of the cases, and carrots in 19 (6.3%). Two food categories were mentioned by 17 mothers.

## Diarrheal Disease Module

15. Fifty-five (18.3%) of mothers reported that their child had diarrhea in the two weeks prior to the survey. The remaining 241 (80.3%) replied no to the same question while four mothers replied that they don't know.

16. Among the mothers whose child had diarrhea in the two weeks prior to the survey, 29 (52.7%) mothers continued to breastfeed their child as usual, while 20 (36.4%) of mothers gave more amount of breastmilk. Four mothers reduced

breastfeeding during diarrhea. In summary, 49 (89.1%) children were given breastmilk the same amount or more than usual during their diarrhea. Whereas, few mothers gave less amount of breast feeding during their child's diarrhea.

17. Among the same 55 children who had diarrhea in the two weeks prior to the survey, 12 (21.8%) were provided with fluids other than breastmilk in the same amount as usual. While 15 (27.3%) were given less amount of fluids than usual, five mothers completely stopped giving fluids to their child during diarrhea. Another five mothers claimed to have given more fluids than usual during their child's diarrhea.

In summary, 17 (30.9%) mothers continued to give the same amount or more fluids during their child's diarrhea, while 20 (36.4%) mothers gave less fluid or completely stopped giving fluids during their child's diarrhea.

18. Of the 55 mothers whose child had diarrhea in the two weeks prior to the survey, 16 (29.1%) gave less amount of solid/semisolid foods, while 14 (25.5%) continued to provide same amount of solid/semisolid foods. On the other hand, 5 (9.1%) mothers provided more solid/semisolid food than usual during their child's diarrhea, and another 7 (12.7%) mothers stopped giving foods completely.

In summary, 19 (34.5%) mothers continued to provide the same or more amount of solid/semisolid foods to their child during diarrhea, whereas another 23 (41.8%) mothers gave less amount or completely stopped giving foods to their child with diarrhea.

19. Among the 55 children with diarrhea in the two weeks prior to the survey, one child was given Oral Rehydration Salts (ORS). Cereal-based ORT was also given to another child. Similarly, sugar-salt solution was given to two children, and antibiotics were given to another 2 children. In 33 (60.0%) cases none of the above mentioned help was offered. Twelve (21.8%) of the children were given other than the items listed in the questionnaire.

20. Among the mothers whose child had diarrhea in the two weeks prior to the survey, 17 (31.5%) claimed to have sought advice or treatment for the diarrhea while the remaining did not seek any advice or treatment.

21. Of the 17 mothers who sought advice or treatment, 11 (64.7%) reported to have visited a hospital, while another five visited a health station.

22. Signs/ symptoms which would cause mothers' to seek advice or treatment for their child's diarrhea are listed below. As multiple responses were possible, 91 mothers reported two sign/symptoms each and another 23 reported three each. Accordingly, a total of 416 signs and symptoms were recorded.

Signs and symptoms that would alert mothers to seek advice or care

| Sign/symptom (N = 416) | Number | Percent |
|---|---|---|
| Fever | 82 | 19.7 |
| Vomiting | 52 | 12.5 |
| Dysentery (blood in stool) | 32 | 7.7 |
| Prolonged diarrhea (at least 14 days) | 26 | 6.3 |
| Weakness or tiredness | 18 | 4.3 |
| Loss of appetite | 17 | 4.1 |
| Dehydration (dry mouth; sunken eyes; decreased urine output | 5 | 1.2 |
| Don't know | 54 | 13.0 |
| Other sign/symptoms | 130 | 31.3 |

23. Important actions that mothers would take if their child has diarrhea were reported as indicated below. A total of 329 replies were elicited, of which 13 mothers mentioned two measures each.

Actions that mothers would take during a child's diarrhea

| Actions to be taken (N = 329) | Number | Percent |
|---|---|---|

| | | |
|---|---|---|
| Take child to hospital/health centre | 165 | 50.2 |
| Initiate fluids rapidly | 9 | 2.7 |
| Other actions | 50 | 15.2 |
| Give the child more to drink than usual | 8 | 2.4 |
| Proper mixing and administration of ORS | 25 | 7.6 |
| Don't know | 64 | 19.5 |
| Withhold fluids | 2 | 0.6 |
| Withhold foods | 6 | 1.8 |

24. Important actions a mother should take when a child is recovering from diarrhea were indicated as follows (multiple answers possible),

Actions that would be taken when a child recovers from diarrhea

| Actions to be taken (N=310) | Number | Percent |
|---|---|---|
| Give more foods than usual | 20 | 6.5 |
| Give foods with high caloric content | 20 | 6.5 |
| Give the child smaller more frequent feeds | 60 | 47.3 |
| Other actions | 128 | 41.3 |

## Immunization Module

25. The majority of mothers 175 (58.3%) replied that their child has received immunization, while 125 (41.7%) said that the child has never received immunization.

26. More mothers 126 (42.0%) replied that a child should receive measles vaccine at the age of 9-12 months, while the remaining 174 (58.0%) replied that they don't know.

27. The main reason why pregnant women need to be vaccinated with tetanus toxoid vaccine was stated to be to protect both mother/ newborn against tetanus 32 (10.7%), to protect only the newborn against tetanus 30 (10.0 %). Majority of mothers 232 (77.3%) replied that they don't know or gave other reasons.

28. Of the 300 women 90 (30.0 %) replied that a pregnant woman needs more than two injections of tetanus toxoid so that the newborn infant will be protected from tetanus. Another 11 (3.7%) women said two injections, 2 (0.7%) said one and nine women said none. However, a major proportion of the women, 188 (24.7%) replied that they don't know. In summary, 101 (33.7%) of the women knew that a pregnant women needs at least two or more injections of tetanus toxoid to protect the newborn infant from tetanus, while the remaining 199 (66.3%) women did not know the correct number of tetanus toxoid injections.

29. While 122 (40.7%) of mothers had an immunization card for their child, 149 (49.7%) never had one and the remaining 29 (9.7%) said that they have lost the card.

30. The immunization status of 124 children aged 12-23 months for whom the mothers had the immunization card is indicated in the table below.

| Antigen | (N = 124) | Number | Percent |
|---|---|---|---|
| BCG | | 54 | 43.5 |

| | | | |
|---|---|---|---|
| Polio: | OPV 1 | 56 | 45.2 |
| | OPV 2 | 47 | 37.9 |
| | OPV 3 | 36 | 29.0 |
| DPT : | DPT 1 | 56 | 45.2 |
| | DPT 2 | 49 | 39.5 |
| | DPT 3 | 38 | 30.6 |
| Measles | | 35 | 28.2 |

## Vitamin A Supplementation

31. Mothers were also asked if the child was given Vitamin A capsules before. Interviewers showed the capsules to mothers to avoid any misunderstanding. Accordingly, 208 (69.3%) mother replied that the child was given Vitamin A capsule before, and 90 (30.0%) said no. Only two mothers replied that they don't know. Mothers were also asked if they themselves were given Vitamin A capsules after they delivered the youngest child. The response showed that only 46 (15.3%) of the mothers were given Vitamin A and a major proportion 251 (83.7%) replied that they have not been given any Vitamin A. Three mothers replied that they don't remember.

Of the 300 children covered by the study, 71 (23.7%) have had experienced an illness with symptoms related to pneumonia during the two week period prior to the survey.

## Maternal Care Module

32. About half of mothers 147 (49.0%) had a maternal health card, while 115 (38.3%) never had one. Another 35 (11.7%) of the mothers reported to have lost their card. Three mothers said that the maternal health card is together with the child's immunization card.

33. Among the 150 mothers who had a maternal health card, 118 (78.2%) had received two or more doses of tetanus toxoid vaccine, while 32 (21.3%) received only one dose of tetanus toxoid, as indicated in the card.

34. Only 88 (29.3%) of the women reported that they have made at least one ante-natal visit during their last pregnancy, while the remaining 70.7% have not made any visit.

35. Mothers response to when a pregnant women should first see a health professional indicates that 45 (15.0%) replied in the middle of pregnancy (4-6 months), 42 (14.0%) said during the first trimester (1-3 months), and 41 said during the last trimester (7-9 months). A higher proportion of mothers 168 (56.0%) replied that they don't know and four mothers said that there is no need to see a health worker.

36. The foods a pregnant woman should eat to prevent pregnancy anemia were indicated as leafy green vegetables rich in iron 49 (16.3%), and proteins rich in iron (eggs, fish, meat) 23 ( 7.7%). In 85 (28.3%) of the cases, other foods were mentioned and 143 (47.7%) of mothers replied that they don't know.

37. The amount of food a woman has been eating during the last pregnancy was less than usual in 177 (59.0%) of the cases, same as usual in 111 (37.0%) of women and more than usual in only 10 (3.3%) of the women.

38. Untrained traditional birth attendants cut/ tied the cord during the last delivery in 157 (52.3%) of the women, while trained traditional birth attendants were involved in 27 (9.0%) of the deliveries. Family members tied and cut the cord in 45 (15.0%), and health professionals in 51 (17.0%) of the cases. Another 13 (4.3%) of last deliveries were attended by others. Six women tied and cut the cord themselves during their last delivery and one woman said that she doesn't remember who tied and cut the cord.

## LIST OF TABLES

The following tables describe the comparative findings between the Baseline and Follow-up KPC surveys.

Table 1. Breast Feeding Pattern of Children 0-23 Months,

| Pattern | Baseline (%) | Follow-up (%) | Difference |
|---|---|---|---|
| Currently Breast Feeding | 91.6 | 94.0 | + 2.4% |
| Ever Breastfed | 66.7 | 77.8 | + 11.1% |

| | | | |
|---|---|---|---|
| Initiation of Breast Feeding, | | | |
| within one hour | 41.3 | 24.0 | - 17.3% |
| within half a day | 21.3 | 11.0 | - 10.3% |
| after half a day | 35.5 | 65.0 | - 30.3% |
| Exclusive Breast Feeding, | | | |
| at 0-3 months | 17.7 | 68.0 | + 50.3% |
| Supplementary Feeding | | | |
| at 6-9 months | 46.7 | 71.2 | + 24.5% |
| Continuation of Breast Feeding, | | | |
| at 20-23 months | 82.4 | 75.0 | - 7.4% |

Table 2. Knowledge about Age of Introduction of Weaning Food

| Age | Baseline (%) | Follow-up (%) | Difference |
|---|---|---|---|
| Before four months of age | 5.0 | 9.3 | + 4.3% |
| Four to six months of age | 25.8 | 13.3 | - 12.5% |
| Around the sixth month | 29.4 | 30.3 | + 0.9% |
| After the sixth month | 31.1 | 37.3 | + 6.2% |
| Don't know | 8.7 | 9.7 | + 1.0% |

Table 3. Feeding practice to children six months and above,

| Pattern | Baseline (%) | Follow-up (%) | Difference |
|---|---|---|---|
| Dark green leafy vegetables | 35.3 | 26.4 | - 8.9% |
| Fruits | 30.0 | 30.2 | + 0.2% |
| Meat and/or fish | 45.5 | 31.6 | - 13.9% |
| Beans | 47.4 | 36.8 | - 10.6% |
| Eggs or Yoghurt | 59.6 | 40.1 | - 19.5% |
| Add sugar or honey | 82.1 | 84.0 | + 1.9% |
| Add butter or oil | 71.2 | 65.1 | - 6.1% |
| Add iodised salt | 3.4 | 21.7 | + 18.3% |

Table 4. Knowledge about and Coverage with Vitamin A supplementation,

| Characteristics | Baseline (%) | Follow-up (%) | Difference |
|---|---|---|---|
| Which vitamin helps prevent Night Blindness? | | | |
| Vitamin A | 8.7 | 12.0 | + 3.3% |
| Which foods can be given to prevent Night Blindness? | | | |
| Don't Know | 13.7 | 85.3 | + 71.6% |
| Dark-Green-Leafy-Veg. | 10.2 | 7.7 | - 2.5% |
| Carrots | 6.7 | 5.9 | - 0.8% |
| Fruits | 11.7 | 1.6 | - 10.1% |
| Liver | 13.7 | 0.6 | - 13.1% |
| Breast milk | 13.3 | 0.0 | - 13.3% |
| Egg yolk | 12.7 | 0.6 | - 12.1% |
| Vitamin A Supplementation to | | | |
| Child | 6.0 | 69.3 | + 66.0% |
| Mother | 4.3 | 15.3 | + 14.0% |

Table 5. Feeding of Infants during Diarrhoeal Episodes

| Feeding Pattern | Baseline (%) | Follow-up (%) | Difference |
|---|---|---|---|
| Breast feeding | | | |
| same as usual | 49.5 | 52.7 | + 3.2% |
| more than usual | 10.3 | 36.4 | + 26.1% |
| less than usual | 28.9 | 7.3 | - 21.6% |
| stopped/discontinued | 4.1 | 0.0 | - 4.1% |
| Fluids | | | |
| same as usual | 21.6 | 21.8 | + 0.2% |
| more than usual | 7.2 | 9.1 | + 1.9% |
| less than usual | 23.7 | 27.3 | + 3.6% |
| stopped/discontinued | 11.3 | 9.1 | - 2.2% |
| Foods | | | |
| same as usual | 19.8 | 25.5 | + 5.7% |
| more than usual | 6.3 | 9.1 | + 2.8% |
| less than usual | 26.0 | 29.1 | + 3.1% |
| stopped/discontinued | 14.6 | 12.7 | - 1.9% |

Table 6. Home-care to children during Diarrhoeal Episodes

| Type of Care | Baseline (%) | Follow-up (%) |
|---|---|---|
| ORS | 2.0 | 1.8 |
| Salt-sugar solution | 4.0 | 3.6 |
| Cereal based ORT | 2.0 | 1.8 |
| Home-fluids | 4.0 | 5.5 |
| Antibiotics | 2.0 | 3.6 |
| Other | 32.6 | 21.8 |
| No home-treatment | 62.2 | 60.0 |

Table 7. Source of Medical Care/Advice Sought during Diarrhoeal Episodes

| Source of Care | Baseline (%) | Follow-up (%) | Difference |
|---|---|---|---|
| Hospital | 56.2 | 64.7 | + 8.5% |
| Health station | 25.0 | 29.4 | + 4.4% |
| Private clinic/physician | 3.1 | 0.0 | - 3.1% |
| Pharmacy/drug store | 3.1 | 0.0 | - 3.1% |
| Health post | 6.2 | 0.0 | - 6.2% |
| Friends, relatives | 3.1 | 5.9 | + 2.8% |
| Other places | 3.1 | 0.0 | - 3.1% |

Table 8. Immunization status of children aged 12-23 months, at Baseline and Follow-up KPC Surveys.

| Antigen | Baseline (%) | Follow-up (%) | Difference |
|---|---|---|---|
| BCG | 30.3 | 43.5 | + 13.2% |
| Polio: OPV 1 | 28.6 | 45.2 | + 16.6% |
| OPV 2 | 24.5 | 37.9 | + 13.4% |
| OPV 3 | 19.6 | 29.0 | + 9.4% |
| DPT : DPT 1 | 30.3 | 45.2 | + 14.9% |
| DPT 2 | 27.0 | 39.5 | + 12.5% |
| DPT 3 | 21.3 | 30.6 | + 9.3% |
| Measles | 21.3 | 28.2 | + 6.9% |
| Drop-out Rate | | | |
| OPV1-OPV3 | 31.4 | 35.7 | + 4.3% |
| DPT1-DPT3 | 29.7 | 32.1 | + 2.4% |
| Overall Immunization status | | | |
| Not Immunized | 68.8 | 52.4 | - 16.4% |
| Partially Immunized | 15.5 | 25.0 | + 9.5% |
| Fully Immunized | 15.5 | 22.6 | + 7.1% |

Table 9. Knowledge, Practice and Coverage on Maternal Care,

| Maternal Care | Baseline (%) | Follow-up (%) | Difference |
|---|---|---|---|
| Maternal (TT) Card | | | |
| Present | 30.0 | 49.0 | + 19.0% |
| Tetanus-toxoid vaccine, | | | |
| two or more doses | 22.3 | 39.3 | + 17.0% |
| Antenatal visit, | | | |
| at least once | 19.3 | 29.3 | + 10.0 |
| Ate more food than usual | | | |
| during last pregnancy | 6.7 | 3.3 | - 3.4% |
| Delivery attendance | | | |
| by trained birth attendant | 15.0 | 26.0 | + 11.0% |
| by traditional birth attend. | 39.3 | 52.3 | + 13.0% |
| Knowledge about food, preventing | | | |
| pregnancy-anaemia | 29.7 | 24.0 | - 5.7% |
| Knowledge about time of first visit to health | | | |
| care during pregnancy | 14.7 | 14.0 | - 0.7% |

## DISCUSSION/ CONCLUSION AND RECOMMENDATIONS

In accordance with the earlier baseline KPC survey, this follow-up KPC survey attempted to address the four major areas in child heath; Diarrhoea Case Management, Immunisation, Nutrition and Vitamin-A supplementation, as well as Breast-feeding Promotion, that are the primary intervention strategies of the IEF/ CCF Child Survival Program.

The follow-up KPC survey is aimed at the comparison of findings to the baseline KPC and the subsequent measurement of any progress made towards achieving improvement in the core child survival program indicators, that are essentially outcome indicators.

The findings reported in this survey are based entirely on a quantitative survey that applied a structured questionnaire. As, this KPC survey does not endeavour to examine the various strategies, inputs and activities of the project, it is not intended to provide a comprehensive evaluation of the child survival program.

As the project is still half way through its life, any comparison of performance can not be compared directly to the overall targets that are planned to be attained by the end of the implementation period. The necessary caution should be made in this regard.

A total of 300 mother-child pairs were studied using the standard KPC survey methodology. Age of the mothers ranged from 17-49 years, with a median age of 27.

**Breast Feeding/ Nutrition**

It is a well established fact that mothers should start to breastfeed their newborns as soon as possible after delivery, that infants should be exclusively breastfed during the first four to six months of life, that supplementary food in addition to breast milk should be introduced between four to six months of age, and that breast feeding should continue well into the second year of a child's life and longer if possible.

Nearly all women in the study area reported having breastfed their younger child with 94% of them still breastfeeding during the study period. This finding has revealed a 2.4% increase from the baseline status. Such a high level of breast feeding prevalence needs to be promoted and protected continuously.

Although generally a high level of breastfeeding prevalence is reported elsewhere in the country, sub-optimal breastfeeding practices are widespread. Findings of the follow-up KPC survey also reveal various sub-optimal practices.

Initiation of breast-feeding appears to be late, with only 35% of the mothers breast feeding within the first eight hours after delivery, which is nearly half of the baseline

status (62.5%). At the same time, continuation of breastfeeding through the second year of life was found out to be lower than the baseline status.

Over 30% of the infants younger than four months of age were being given some food other than breast milk. However, the prevalence of exclusive breastfeeding obtained during the follow-up survey (68.0%) is considerably higher than the 17.7% reported at baseline.

The overall status of breastfeeding in the follow-up period indicates the need for protection of the favorable practices while at the same time identifying mothers with poor knowledge and practices and subsequently helping them improve. In this regard, the training and deployment of community health workers such as traditional birth attendants may prove effective.

A remarkable improvement has also been observed concerning supplementary feeding practices. Nearly 25% increment is recorded in the proportion of infants on supplementary feeding at the age of 6-9 months. However, assessment of knowledge of mothers about the appropriate age for introduction of weaning food revealed a 12.5% reduction from the baseline status. In addition to the decline, another concern is still the very low proportion of women who reported the correct age for introducing supplementary feeding that is only at 13.3%.

About a third of the children six months old and above were receiving foods rich in Vitamin A. However, this proportion was noted to be lower than the baseline status. A

very small proportion of mothers were able to mention food items that are useful to prevent night blindness.

On the other hand, a remarkable increment has also been recorded in the proportion of mothers and children who received vitamin A supplementation. Apparently, the distribution of Vitamin A capsules during the Polio Vaccination Campaigns has contributed to the marked increase in the Vitamin A coverage level. Similarly, over 18% increment has been observed in the proportion of mothers adding iodized salt in their child's food.

*Problems Identified with regard to Infant Feeding and Nutrition:*

a. Proportion of infants younger than four months of age who are exclusively breast fed is low and requires to be improved. The proportion of newborns who are fed on breast milk within the first eight hours is also much lower. To this effect, mothers may be educated about the importance of early initiation of breastfeeding, the significance of clostrum, as well as the importance, adequacy and completeness of the breast milk during the first four months of life. There is also a need to raise the level of knowledge that mothers require to be able to continue breast feeding during the first four months of an infant's life.

b. Although majority of infants in the age group 6-9 months are receiving supplementary feeding, there is still a considerable proportion of children who

are deprived of this care. The corresponding knowledge about appropriate age of introducing supplementary feeding is lacking in about a third of the women.

c. There is only little knowledge about the importance of vitamin A in preventing night blindness, with only 12.0% of mothers giving correct response. Likewise, dietary sources of Vitamin A are not still well known by majority of the mothers.

**Diarrheal Diseases**

Proper management of diarrhea involves giving extra fluids and continued (breast) feeding during diarrheal episodes. The provision of extra foods is also recommended while the child is recovering from diarrhea. Furthermore, medical care has to be sought in severe cases leading to dehydration, and during bloody diarrhea (dysentery) or during persistent diarrhea. Antibiotics and medicines other than ORS should not be used unless medically indicated.

The proportion of children with diarrhea in the two weeks preceding the survey who were given the same or increased amount of breast milk is close to 90%. However, a considerable proportion (36.7%) of mothers gave less fluid or completely stopped giving fluids during their child's diarrhea. Similarly, 41.8% of mothers gave less amount or completely stopped giving foods to their children. Both of the above indicators are at about the same level as the baseline status.

In this study, less than 2% of the children with diarrhea received ORS and/or cereal based ORT. According to the National Multiple Indicator Cluster Survey (MICS, 1996) high coverage with ORT was the single most indicator that surpassed the Mid-decade goal. The home management of acute childhood diarrhea needs due emphasis owing

to the fact that the accessibility and affordability of health services is considerably low in many parts of the county including the present study area. The health messages from local health institutions as well as CHAs and TBAs should emphasize the need for giving more fluids and continued (breast) feeding to children during diarrhea.

Unfavorable practices such as reducing or withholding food, fluids, or breast feeding have to be subject to change through continuous efforts of health education by health workers as well as CHAs and TBAs. Health workers should try to identify mothers' reasons for practices and beliefs related to diarrhea management. They should also educate mothers on the preparation of homemade diarrhea treatment fluids and about the proper mixing and preparation of ORS. In this regard, the need for training and retraining of health workers can not be overemphasized.

Among the mothers whose child had diarrhea in the two weeks prior to the survey, only 31.5% sought health care, most of which visited a hospital or a health station. There is a low level of knowledge among mothers about signs and symptoms which would cause them seek health care to their child with diarrhoea. Fever, vomiting, and weakness/tiredness were mentioned as important signs/symptoms in less than 20% of the cases.

Along with increasing recognition of important (dangerous) signs and symptoms, mothers need increased understanding of what to do when diarrhea occurs. Only 50% of the mothers indicated the need to visit a health facility. Other favourable

diarrhoea management practices such as rapid initiation of fluids and giving the child more fluids than usual were mentioned in less than 3% of the cases. Activities aimed at improving the home management of diarrhea cases should also enable mothers to identify dangerous signs and to practice appropriate home care behaviors.

A very small proportion of the mothers in the study have correct knowledge about actions to be taken during recovery of the child from diarrhea such as giving more food than usual. Giving the child smaller more frequent feeds and giving foods with high caloric content were mentioned in less that 7% of the cases, indicating a low level of knowledge in this regard. Other actions were mentioned in more than 40% of the replies.

*Problem areas identified with management of diarrheal diseases are:*

a. Correct practices in the management of diarrhea such as continued breastfeeding, giving more fluids, and giving more foods, are seen to be

practised by about 30 - 60% of the mothers, indicating the need for much more efforts in order to improve the situation.

The level of ORS usage is extremely low (below 2%), while the corresponding level of visit to a health care facility was about 30%. This discrepancy should alert the local health facilities regarding their diarrhea treatment protocols. There is also a need to look into the knowledge and skills of health workers to

identify and respond to training needs in the proper management of a child with diarrhoea.

b. As the proper management of a child with diarrhea should start at home the proportion of mothers with the correct knowledge about dangerous symptoms/signs of diarrhea and the corresponding measures they need to take is an important parameter to be addressed. Health education activities should give the necessary emphasis to the above mentioned knowledge and behavior.

**Immunization**

Immunization is well known to protect children against a wide variety of dangerous diseases. A child who is not immunized is more likely to become malnourished,

disabled or to die. Immunization should be completed in the first year of life so as to be more effective in protecting children.

In this study 58.3% of the mothers claimed that their child received immunization at least once, whereas, only 40.7% were able to produce the immunization card. Likewise, 124 children aged 12-23 months had immunization cards. Based on information obtained from immunization cards, 119 of the 300 children (39.7%) have access to immunization services as determined by the DPT1/Polio 1 coverage. On the other hand, the coverage estimate considering the 12-23 month olds reveals an access rate of nearly 45% based on DPT/Polio 1 coverage, and an immunization coverage (based on Polio3/ DPT3) of 30%. The immunization coverage has increased remarkably, about 10% higher than the baseline status. (See Table 8).

The drop-out rate from immunization, as estimated by the proportion of children who had the first DPT vaccination but have not received the last DPT3, is about 32%. Whereas, estimation of the drop-out rate based on the difference between measles and BCG coverage is also 32%. The drop-out rate estimated either way is close to the national drop out rate between DPT1 and DPT3 which was reported at 36% (MOH, 1990).

The accessibility and coverage level of immunization in this area is still low, and therefore needs to be augmented further. Various strategies such as minimizing drop-outs and missed-opportunities, and expansion of outreach immunization sites still need to be promoted as applicable. The importance of in-service training (and retraining) and motivation of health workers should not be undermined.

Knowledge about immunization is not high enough either. Below half of the women knew the correct age for measles immunization and only about 10% of them knew that the purpose of tetanus toxoid vaccination is to protect both the mother and the newborn against tetanus. A low level of knowledge (30%) was also observed regarding the number of tetanus toxoid injections (doses) required to protect the newborn infant from tetanus.

The increasing pace of immunization coverage requires a continuous effort through various coordinated strategies so as to achieve a level high enough to prevent disease transmission.

*Problem area identified with regard to immunization:*

a. Knowledge about the appropriate age for measles vaccination, and that tetanus toxoid vaccination protects both the mother and the infant against tetanus, is low. There is also poor knowledge about the number of tetanus toxoid injections required to protect the newborn infant from tetanus.
b. The accessibility and coverage level of immunization is much low. The drop-out rate between DPT1 and DPT3 or that between BCG and Measles is very high, and needs to be minimized.

**Maternal Care**

Maternal care components such as antenatal examinations and skilled attendance at delivery, and increased food intake during pregnancy help to prevent deaths, which could otherwise be caused due to child bearing, and to prevent morbidity. Families, communities and governments must support these efforts in order to achieve improvement in maternal health.

About half of the mothers (49%) have their maternal health card with them, out of which 78% had received two or more doses of tetanus toxoid vaccine, while another 21% received only one dose. On the other hand, only 29% of all mothers reported to have made at least one antenatal visit during their last pregnancy.

Regarding mothers' knowledge as to when a pregnant women should first see a health professional indicates that only 14% of mothers gave the correct reply as within the first trimester. Below 25% of the mothers knew the type of foods a pregnant women has to eat so as to prevent pregnancy anemia. Likewise, only 40% of the mothers reported to have been eating the same as usual or more than usual during their last pregnancy.

Just over 25% of the women were assisted by health professionals and/or trained traditional birth attendants during their last delivery. Proportion of deliveries by skilled personnel is very low elsewhere in the country and this is considered to be one of the main contributing factors to the unacceptably high maternal morbidity and mortality. Training and re-training of traditional birth attendants to enable them identify high-risk pregnancies and deliveries early and to facilitate referral of such women should be promoted in the area. The training of local community such as traditional birth

attendants also contributes in increasing coverage (accessibility) of services. Health messages in this regard have to be targeted also to these untrained traditional birth attendants and other family members as they are involved in assisting delivery.

There is an apparent need to expand maternal care services, such as attendance of delivery by trained personnel, to the community through training of traditional birth attendants and other health workers, as well as, providing technical and material support to these health workers. Promotion of antenatal visits so as to identify high risk pregnancies and deliveries, improving the coverage of Tetanus Toxoid immunization and education on maternal nutrition are all areas which require great attention and appropriate intervention.

*Problem area identified with regard to maternal care are:*

a. Access to maternal health services in the study area requires a considerable improvement. The level of antenatal care visit and tetanus toxoid immunization coverage still require a lot of improvement.

b. Knowledge on maternal nutrition is low. Nearly 60% of the women ate less than usual during their last pregnancy.

c Majority of women are assisted at delivery by an untrained attendants. Strategies must be developed to increase the number of deliveries attended by skilled personnel. To this end, more and more traditional birth attendant should be trained.

Annex B

**IEC Report**

(Insert electronic copy)

## TABLE OF CONTENTS

## ACCRONYM

| | |
|---|---|
| ARI | Acute Respiratory tract Infection |
| BCC | Behavioral Change Communication |
| BF | Breastfeeding |
| CCF | Christian Children's Fund |
| CHA | Community Health Agent |
| DCM | Diarrhoeal Case Management |
| ENI | Ethiopian Nutrition Institute (formerly known) |
| IEC | Information, Education and Communication |
| IEF | International Eye Foundation |
| KAP | Knowledge, Attitude and Practice |
| KPC | Knowledge, Practice and Coverage |
| JHU | Johns Hopkins University |
| ORT | Oral Rehydration Therapy |
| TBA | Traditional Birth Attendant |
| TOR | Terms of Reference |
| VA | Vitamin A |

## EXECUTIVE SUMMARY

The IEF/CCF Child Survival/Vitamin A Project has started its project interventions since over one year in two Woredas, Basona-Warena and Debre Berhan in Northern Shoa Zone, Amhara Region. Basona-Warena Woreda covers rural areas of 25 kebeles while Debre Berhan covers 9 kebeles of urban areas. As indicated in the facility survey report (1997), the Woredas have a catchment population of 159,818. There are significant infant and child mortality rates and high rates of malnutrition in the project areas. The overall goal of the project is to decrease infant and child morbidity and mortality through promotion of immunization, control of diarrhoeal diseases and promotion of vitamin A/nutrition and breastfeeding.

The project staff has been involved in coordinating and implementing project interventions through ensuring integration of interventions within the existing programs of collaborating health sector. The project has four intervention areas, namely promotion of immunization, diarrhoeal case management, promotion of breastfeeding and vitamin A.

The IEF/CCF Child Survival Project has recognized the need for the development of a communication strategy for effective implementation of the interventions. In addition, the KPC survey conducted in the project area (1997) has strongly recommended the need for the integration of communication component within the major project interventions. To this effect, the project has commissioned a consulting firm to develop a communication strategy for the project in the two Woredas.

Communication is an essential component for a child survival project, cutting across all interventions and involved sectors in the project and helping to mobilize partners, change attitudes and behaviors among target populations and build alliance with important partners at all levels. The IEF/CCF Child Survival Project will benefit from intensive communication inputs through mobilizing potential community-level partners and development of materials with appropriate messages tailored for specific audiences. Hence, a comprehensive communication planning/strategy component has been developed following social marketing approach by the consulting service.

The KPC study has identified major behavior of mothers with regard to the interventions. However, some behaviors, which could have vital importance to the development of communication strategy, have not been covered in the KPC findings.

The consulting team conducted needs assessment survey in both projects Woredas to identify KAP of mothers focussing on breastfeeding and vitamin A, which were not well covered by the KPC survey. However, the needs assessment survey also addressed other segment of the community, such as elders, religious and opinion leaders, traditional healers and household heads (husbands) who may have direct or indirect influence on the mothers' day to day activities. In general, the findings of the study on the other segments of the community have revealed that

there are no much deviant behaviors than that of the mothers. Hence, on the basis of the KPC and needs assessment findings this communication planning/strategy document is developed by the consulting firm.

The communication component should be integrated with other elements of the project. Different communication inputs must be planned in line with the project interventions. A communication strategy relies heavily on KAP/behavior analysis. Information from and about target audiences, their characteristics, and their current beliefs and behavior on the

intended interventions is required to help shape the overall communication component. Investigation through examination of resource materials and conducting audience survey by using qualitative methods has been undertaken to identify existing behavior of the target population. On the basis of behavior analysis the desired behavior on the interventions are clearly described in this strategy document.

The media used must be carefully selected according to their functions and strengths and the audience to be addressed. The combination of media used must allow the audience to also speak back if there is to be real communication. In this regard, communication in the project area has been examined and appropriate media have been identified and selected based on media analysis approach.

There is no one blue print communication strategy that could be designed. Not all programs will rely primarily on radio and TV; not all programs will have a poster, or flip chart. Every program/project will have to carefully analyze its own audience, set communication objectives which are consistent with the overall program/project objectives, and build upon local resources. Existing communication materials were reviewed and recommendations were forwarded. In addition, new sample materials on all interventions were designed, developed and field-tested.

Based on the analysis factors contributory to change in behavior in the area of project interventions, were identified. Accordingly, to enable the synthesis of the communication strategy the desired behaviors specific to area of interventions were identified that need to be emphasized in the IEC activities.

The communication strategy has to come up with training plan based on analysis of participants in the program/project. The training need of participants (service providers) has been identified and a training plan is outlined which will be refined through discussion with concerned project staff members.

Monitoring and evaluation of the communication strategy has been outlined. This is very important in the implementation phase to detect problems and unexpected obstacles and make the necessary changes. This also need further review by the concerned project staff.

Operational implementation plan of the communication strategy has been drafted and is subject for discussion with concerned project staff.

Finally a two days workshop on Orientation on Communication Strategy & Training on Communication Skills was given to the partners /stakeholders on June9-10, 2000 at Debre Berhan, Amhara National Regional State. The objectives were to orient the development of Communication Strategy of IEF/CCF Child Survival Project and introduce the content and strategy, and to up grade the communication skills of the participants by providing basic elements of Communication Skills and practicing exercises through Microteaching methods. 26 participants from different institutions have attended the workshop..

It is our strong conviction that the IEF/CCF CSP Communication Strategy developed would assist in making .a meaningful contribution towards the behavioral changes of the target groups.and enable the Child Survival Project in attaining its objectives.

# I. INTRODUCTION

With an estimated population of 60 million, Ethiopia is one of the poorest countries of the world. The estimated per capita GNP is $ 167 with about 34 million people living below the absolute poverty line. Approximately 85% of its population living in rural areas, and according to the 1994 Census of Ethiopia, Ethiopia's population will approach 84 million by the year 2010. This will cause unmanageable burden on the health system, which is already unable to meet needed services.

Approximately, almost one sixth of Ethiopian Children die before their 5th birthday, most often due to dehydration from diarrhea, complication of Malaria and other preventable diseases. Poor nutritional status and infections, together with high fertility, contributes one of the highest maternal mortality rates in the world, estimated between five to eight maternal deaths per 1000 live births. Because health facilities are often out of reach, both financially and geographically, treatable conditions often lead to death. Fewer than 40% of Ethiopians live within a two-hour walk of a modern health care facility. Nearly 65% of children under the age of five children are stunted and 25% are iodine deficient.

According to the Ministry of health, the contraceptive prevalence rate is currently approximately 9%. HIV/AIDS threatens the gains in health and socio-economic development achieved over the past several decades. Current estimates suggest that one of every 14 adults in Ethiopia may be infected with HIV. Thus, approximately three to four million people are infected with HIV.
Under financing and under utilization of available resources have severely limited the availability of basic health services. Limited resources, the continued need for the strengthening of management and health care delivery capacity and a lack of supply, basic drugs, and trained personnel have limited access to basic health services.

## 1.1 IEF/CCF- Child Survival/Vitamin A Project

The Christian Children Fund (CCF), as a sub grantee to the International Eye Foundation (IEF), is currently implementing a child survival project in the Basona -Warena and Debre-Berhan Woredas in North Shewa Zone of Amhara Regional State, Ethiopia. Amhara tribes primarily inhabit the project site with the estimated population of about 165,000 people living in 25 peasant associations and 9 urban dwelling associations, out of which about 39% are beneficiary population (64,303): 29,768 under 5 children and 34, 625 women of 15-49 years. It is a four years project, which has started in August 1998.

The Knowledge, Practice and Coverage (KPC) survey conducted in 1997, as pre-intervention baseline information, revealed that the project area has got low child immunization rate (15.5% fully immunized), low use of Oral Dehydration Therapy (10-30%) and high rates of malnutrition (7% sever and 29% moderate). The survey has also attributed the high prevalence of diarrhoeal diseases and ARI to poor environmental sanitation

and personal hygiene

practices. Eighteen percent of the under-five children surveyed in the project area have been reported to have diarrhea two weeks prior the survey. Although an assessment of the prevalence of Vitamin A deficiency has not been part of the survey, other studies performed in the previous administrative region of Shoa (where the present project zone exists) by the former Ethiopian Nutrition Institute, revealed that the prevalence is greater than .5% (Bitot's Spot) higher than the WHO cut-off point for being public health problem.

Moreover, the health facility survey conducted as part of baseline information has also indicated, that although most health workers do have the adequate knowledge that VA prevents night blindness, only few of the surveyed health workers mentioned the right dose of VA for treatment. Similarly, the survey has showed that growth monitoring is being conducted by all facilities in the project area, but only few of them have the knowledge on how to interpret and use the result.

The project document further outlines the basic factors affecting delivery of health services as being acute shortage of health workers, lack of drugs and basic health services including immunization services. Recognizing the problem and the relationship of these factors to high rates of childhood morbidity in the project areas, the community contacted CCF to initiate child survival interventions that could help to address the stated problems.

Accordingly, the project has been designed and developed with the participation of the community. The project goal, as stated in the document, is to reduce infant, child and maternal morbidity and mortality and strengthening Primary Health Care in selected project areas by promoting key protective health behaviors. The specific objectives included under this project are; increasing the rate of fully immunized children aged 12-23 months from 15.5% to 80, and ensuring that; 80% of children with diarrhea will receive ORT, 75% of children receive same or more liquid or breast milk, 75% of mother identify dehydration and appropriate therapy including three rules of home management, 80% of children receive VA semi annually including those with measles and sever PEM, 30 % of postpartum women receive VA within 4 weeks following delivery and 40% of infants aged 0-4 months will be exclusively breast fed.

The key intervention areas that need to be emphasized (as a way of achieving the objectives stated above) during the project implementation period are: Expanded Program on Immunization, Diarrhea Case Management, Nutrition with emphasis on VA, Breast Feeding Promotion and support to existing health education on acute respiratory infection, water and sanitation and family planning programs.

The major approach used to deliver the identified intervention package is through collaborative venture with the public sector health institutions at all levels of implementation and through expanded use of community based health system (TBA and CHA). The project support mainly focuses on system strengthening (both at facility and community levels) with inputs such as technical assistance, training, and provision of selected commodities and financial support of key project activities.

It assumed that strengthening of the health system at project areas would enable them to deliver quality of health care services in a more sustainable way with whatever resources are made available to the health institutions. From the review of the project, it has also been learnt that health education is the major cross cutting activity that is identified as a key to increasing the health seeking behaviors of the community for key child and maternal health services.

Review of the performance reports revealed that there has been a move forward to implement activities outlined under each intervention. The focus has been more in the area of capacity building related to immunization, DCM, VA and nutrition/breast feeding. Several training have been offered in the aforementioned areas to the health workers at all levels. In addition, several health education sessions have been offered to the communities as part of BCC. Support to EPI and DCM service has been given that has impacted planned achievements. Training of community health workers has also been initiated.

Looking at the project document and as stated above, communication (IEC) plays a catalytic role to enhance implementation of planned activities and also is sated as the major strategy to achieving the stated results. The findings of the review of the documents do also justify the need to develop a strong communication strategy to support the effectiveness of the proposed CS activities that are believed to impact child mortality and morbidity in the project areas. Thus, having realized the role it plays, the project needed a structured guideline in order to implement communication activities in a more systematic way. Hence, is the need for this consultancy service, which has come up with a feasible strategy after assessing needs, review of existing educational approaches and materials being used currently by the staff.

### 1.2 Objective of TOR

The project requires a consultancy service to develop an IEC strategy on the project interventions (EPI, DCM, BF promotion, nutrition and Vitamin A) with more emphasis on Nutrition and Vitamin A.

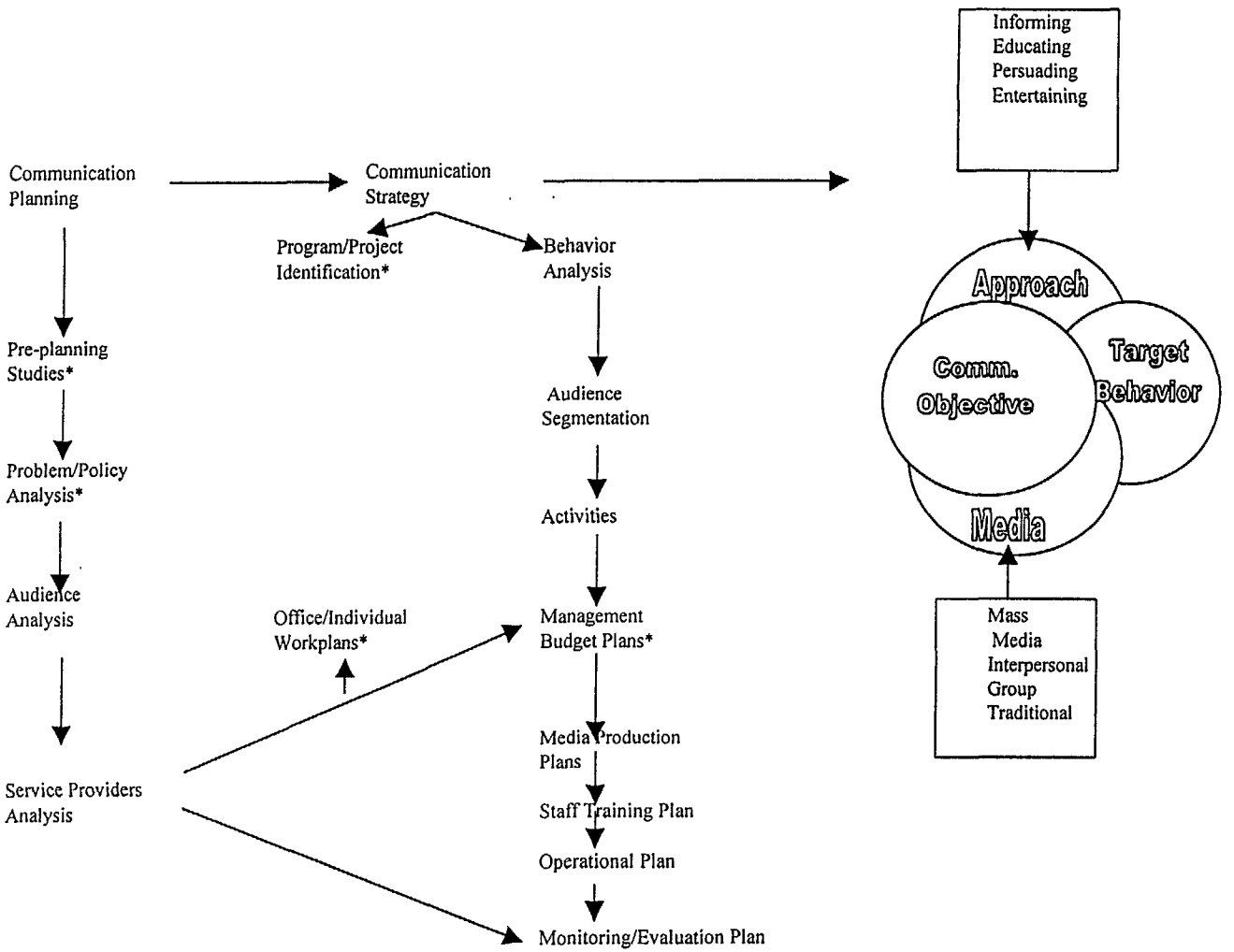
## II. COMMUNICATION IN THE PROJECT AREA

The needs assessment survey findings and the observation and discussions made by the consulting team have enabled to get adequate information on the current status of communication activities in the project area. As indicated by the project staff, the communication component has not been fully implemented in the project area mainly awaiting the development of communication strategy. However, the project staff and main partners – health workers and health education club leaders in schools have taken the initiative to use available communication materials for the implementation of the project's interventions. The project has already established networking with the health institutions in both Woredas and three schools (two in Debre Berhan and one in Bosena-Warena Woredas).

Project staff members have adapted/developed manuals for peripheral health workers on the main interventions. The project staff and the health workers in health posts (clinics) are using flip charts, posters and leaflets which were produced by MOH and the former Ethiopian Nutrition Institute (ENI). The flip charts are mainly on EPI and HIV/AIDS. Demonstration materials are used in health posts to promote ORT. Tape recorders with batteries and audiocassettes on EPI have been provided to health posts to complement health education activities but have been used once so far. There is need for continuos replenishment of batteries. The hospital has also a tape recorder with taped messages on EPI. The taped messages are used for out patients during health education sessions. Most of the communication materials (posters and leaflets), that have been used by the health education clubs are on HIV/AIDS. The project staff members are also involved in providing training for health workers, teachers and students, and community members at the grassroots level.

In general, there is shortage of communication materials for promotion of the project's interventions and need to up grade the communication skill of service providers – mainly project staff members, health workers and teachers involved in health clubs. Existing communication materials must also be reviewed/developed and pretested in terms of their appropriateness, acceptance and understandability.

## II. CONCEPTUAL FRAMEWORK FOR COMMUNICATION PLANNING/STRATEGY



N.B. * The elements indicated in the above framework, have already been undertaken prior the inception of the project. All the other elements are treated below under the social marketing approach.

The communication strategy is developed systematically following this framework.

# IV. COMMUNICATION PLANNING/STRATEGY

## 4.1 SOCIAL MARKETING APPROACH

A social marketing approach is adapted from resource books of IVACG and HEALTHCOM (a project of USAID) to develop a communication (IEC) strategy for IEF/CCF Child Survival Project, focussing on four interventions - Vitamin A, EPI, DCM and BF. For the purpose of the IEF/CCF Child Survival/Vitamin A project, relevant elements of the above-mentioned conceptual framework on the communication planning/strategy are considered and adapted to fit into the concept of social marketing approach.

Traditionally, health and nutrition education focussed on disseminating scientific knowledge. However, there was little change in behavior - community members were not persuaded and motivated. Only giving information does not change behavior, but new approaches are required to support existing endeavors. The commercial sector has good experiences in changing human behavior. This strategy can be adapted to promote health and nutrition issues.
Advertising products like food items and beverages to create demands is relatively easy as compared to promoting social issues or ideas in a given society. Some commercial communication techniques are appropriate and have important contribution for getting across required change in human behavior which can be related to health and nutrition communication programmes.

This new approach is called social marketing, which is the design and promotion (in cultural context) of social issues, or ideas based on the needs of the consumer or the community. Social marketing delineates a straightforward steps that specifies conduct of field investigation and/or examining resource documents for behavior analysis, participant analysis and identifying target behavior, identifying target audiences, modifying and/or developing creative messages and selecting appropriate methods or media such as posters, leaflets, billboard, taped cassettes, drama shows, radio/TV spots, banners, etc. in order to disseminate the messages. In social marketing, it is more than advertising, it requires repetitive education to ensure behavioral change in using new innovations and conceptualize the idea behind a given message.

The development of an appropriate communication strategy must be grounded on field investigation and review of resource materials regarding knowledge, attitudes and practices of the target population. The strategy should address basic questions, such as to whom should the message be directed, what messages should be communicated, how can the message best reflect the audiences' attitudes and beliefs, which media should be used, what settings are most appropriate for effective communications, and what times are best suited to successful communication. The strategy is the framework of the communications package and comprises of the necessary decisions with regard to the communication programme. To this effect, the communication strategy is develop systematically following the strategy framework mentioned above.

## 4.2 Behavior Change

What stimulates behavior change? There are six major stimuli to changing behavior:

- **Physical - based on fear of future pain and discomfort and the memory of past pain;**
- **Rational – based on knowledge, assuming that if people have facts, they will choose to do the right thing;**
- **Emotional – based on the intensity of attitudes or feelings of fear, love, or hope;**
- **Skills – based on the ability to use a new behavior;**
- **Family and Personal Networks – a major source of influence and peer pressure; and**
- **Social Structures – including social, economic and technological aspects of daily life.**

Any or all of these stimuli may be necessary in changing a particular behavior. However, the process is not simple. People take longer time to change their behavior. Hearing just once about a new idea may not bring about change in behavior. The process of behavior change can be divided into four stages:

- **Knowledge - the intended audience first needs to be exposed to information about the specific behavior change that is desired, to pay attention, to be attracted to the message, to understand it, and to learn to do the desired behavior.**
- **Persuasion – those who understand the message need to have a favorable attitude toward the desired behavior and to remember what they should at the appropriate time.**
- **Decision – the people who are motivated need to decide to adopt the proposed behavior and implement this decision,**
- **Confirmation – the people who have tried the behavior once need to practice it regularly with the support of others and personally to affirm the importance of the changed behavior.**

## 4.3 KAP/Behavior Analysis

The audience is the corner stone in social marketing approach. Hence, it has been found crucial to analyze the KAP/behavior of the consumer or the audience to find out what people know and are doing concerning a particular health or nutrition problem and why do they do it. KAP/behavior analysis is a systematic approach to determine KAP/behavior that are appropriate to change and bringing about and maintaining behavior change. For example, in the context of child survival, a mother may face with difficult situation like maintaining existing practices or adapting new behavior. It is, therefore, important to look into existing practices with regard to health and nutrition issues through investigation at field level and/or referring to already conducted studies. In the case of the IEF/CCF Child Survival Project, the KPC study (1997 and needs assessment survey (2000,) conducted in the project area , findings are considered to look into the KAP/behavior analysis process.

The KPC survey has indicated the existing knowledge and practices of the target audiences with respect to the project's interventions. The recent needs assessment survey undertaken by the consulting group for the communication strategy has filled in the information gap which was not covered by the KPC survey. With reference to both findings, following are discussions on the KAP/behavior analysis with regard to the four interventions (VA, EPI, DCM and BF).

KAP/behavior of mothers, household heads (husbands), grandmothers, older siblings, elders, religious leaders and traditional healers with regard to diarrhoeal diseases, immunization and childhood nutrition (breastfeeding and vitamin A):

### 4.3.1 Breastfeeding

The KPC study indicates that even though breastfeeding is not a problem in the project area considering the age group of studied children (zero to 23 months), the initiation period was found to be late. The delay in starting breastfeeding (more than 8 hours after delivery) has been a traditional practice by most mothers. The majority of mothers do not have the knowledge of early initiation of breastfeeding and the importance of colostrum for their child. Exclusive breastfeeding to infants under four months of age is significantly low in the study area. Mothers do give to infant hot water with sugar and/or swallow butter during the first hours to three days after delivery. This practice is one of the factors for delayed initiation of breastfeeding. Most mothers neither introduce complementary food at the right age of the child nor give the proper complementary food to their children.

The findings of the needs assessment survey has confirmed that all mothers in the focus group do breast-feed their children up to 2-3 years. Urban mothers do not give colostrum to the newborn infants. They believe that colostrum causes stomach cramps to the infants. On the contrary, rural women give colostrum to the newborn. Besides, most urban mothers give supplementary food to their children 3 times daily, but a few literate mothers give 5-6 times. Rural mothers do not pay attention to feed their children as required. Rural mothers also delay breastfeeding until

2-3 days after delivery. They give to the newborn butter and water with sugar. Household heads also believe that colostrum must not be given to the newborns. Household heads strongly support the idea that mothers need to eat proper food to produce enough milk. Grandmothers, older siblings, elders, religious leaders and traditional healers give advice to mothers to breast-feed their children up to 3 years. Most grandmothers believe that colostrum should not be given to the newborn. However, rural religious leaders believe that colostrum must be given to the newborn.

### 4.3.2 Vitamin A

According to the KPC survey, one-third of the studied children got food enriched with dark green leafy vegetable and a few children got other foods rich in vitamin A. Insignificant number of mothers reported that they received vitamin A capsules at least once, and knew little that vitamin A prevents night blindness. The EPI-Plus service in the project area is in its early stage of implementation.

As is indicated in the needs assessment report, night blindness is well known by all subjects – locally known as "Dafint," identified with sloppiness of a child in dark rooms. Most subjects do not know its causes and prevention. Vitamin A rich food items are not commonly eaten in the project area, it is unaffordable by most subjects. Most mothers who go to vaccination centers identify the color of vitamin A capsule, but they do not know its benefits. Rural mothers and grandmothers believe that night blindness is caused by stepping on dirty water used by women to wash their genitalia parts. Religious leaders believe that night blindness is caused by evil spirit. Older siblings who attended school know about VA deficiency, causes and its prevention – eating VA rich food items, prevents vitamin A deficiency diseases.

### 4.3.3 Diarrhoeal Disease

The practice of breastfeeding during diarrhoeal episodes is relatively high (88.8%) in the studied area. However, more than one-third of mothers gave less fluid or stopped giving fluids completely, and over 40% of mothers gave less food or stopped giving food completely during their child's diarrhoeal episodes.

According to the needs assessment findings, household heads (husbands) and elders recommend that children with diarrhea episodes must be taken to health institutions. They indicated that boiled linseed water and rice water are given to children with diarrhea. Unbilled water is used for drinking. It is believed by household heads that diarrhea can be prevented through practicing proper hygiene. Subjects indicated that traditionally leafy juices, from a root plant, called "Atuchi" and coffee powder with honey are given to cure diarrhea. "Abish" water is also given to stop diarrhea. They also give tea with milk to stop diarrhea. Traditional healers believe that diarrhea is caused by evil eye.

### 4.3.4 Immunization

The study has indicated that 68.8% of children aged 12–23 months were not immunized at all, whereas 15.5% were fully immunized and another 15.5% were partially immunized. There were contributory factors for low coverage of immunization – shortage of health units, facilities and health workers in the project area and limited efforts in social mobilization and communication activities.
Vaccination for measles was taken as an indicator for knowledge of mothers. Thus, the study has shown that majority of mothers in the study group did not know that children should get measles vaccine at nine months of age. About three-fourth of mothers did not know how many TT injections a pregnant woman must take to protect her newborn infant from tetanus.

On the basis of the needs assessment survey, husbands are much more aware of importance of vaccination. Elders and grandmothers expressed that measles is not common in their area. However, they mentioned that there is traditional treatment if measles occurs. A child with measles is isolated in from other family members. The sick child's room is kept warm with coffee ceremony. "Kitta" made of red teff is given to the sick child. And perfume or "Arti" – a type of plant, is rubbed on the body of the child. Most subjects do not know about the other vaccine preventable childhood diseases like polio and tetanus. Religious leaders give advice to mothers to immerse in holy water when a child has fever. Traditional healers believe that polio is curse from God or caused by evil spirit. They mentioned that polio could be cured if the child is immersed in holy water.

## Factors contributing (positively or negatively) to Change in Behavior

| Knowledge, Attitude and Practice | Environmental, Cultural and Socioeconomic | Technical |
|---|---|---|
| BF<br>Negative<br>▪ Initiation of breastfeeding is late.<br>▪ Mothers do not know the importance of colostrum.<br>▪ Urban mothers do not give colostrum to their newborns.<br>▪ Exclusive breastfeeding is very low.<br>▪ Mothers are not aware of proper complementary food and when to start giving complementary food.<br>▪ Mothers give complementary food 3 times daily.<br><br>Positive<br>▪ Most mothers do breast-feed up to 2-3 years. Other also believe to breast-feed up to 3 years.<br>▪ Husbands encourage mothers to eat proper food to produce enough milk for the infants.<br>▪ Rural mothers give colostrum to the newborn.<br>▪ Rural religious leaders believe colostrum must be given to the newborns.<br>▪ Literate mothers give supplementary food 5-6 times daily. | Reliance on traditional practice before initiating breastfeeding.<br><br>Urban mothers in the project area believe that colostrum causes stomach cramp to newborns. | Illiteracy seems as a major factor for negative practices. |

| Knowledge, Attitude and Practice | Environmental, Cultural and Socioeconomic | Technical |
|---|---|---|
| <u>VA</u><br><br><u>Negative</u><br><br>▪ Mothers do not have any knowledge on importance of VA capsules.<br><br>▪ VA rich food items are not commonly eaten in the project area.<br><br><u>Positive</u><br><br>▪ Night blindness is well known by community members.<br><br>▪ Older siblings who attended school are aware of VA deficiency and its prevention. | VA rich food items are unaffordable by community members.<br><br>Believe in superstition causes of night blindness. | ---- |

| Knowledge, Attitude and Practice | Environmental, Cultural and Socioeconomic | Technical |
|---|---|---|
| **DCM**<br>Negative<br>▪ Mothers stop giving food during diarrhea episodes.<br>Positive<br>▪ Husbands and elders recommend taking children with diarrhea to health units.<br>▪ Husbands are aware of prevention of diarrhea – practicing proper hygiene. | Dependence on traditional way of curing diarrhea. | --- |
| **EPI**<br>Negative<br>▪ Mothers do not know the importance of vaccination.<br>Positive<br>▪ Husbands are aware of the importance of vaccination. | Dependence on traditional treatment for measles and polio. | Shortage of health units and facilities, and health workers. |

Based on the above analysis, one has to decide and focus on the *Importance and Change ability of Behaviors* in order to specify and set ideal behaviors.

## 4.4. Target Behavior (Desired Behavior)

The target behavior or message content for each intervention should be clearly identified and described. The target behavior is the behavior we want the target audience to encourage to change. If the target behavior is identified it helps to state a precise and clear message that target audiences, in this case mothers should do. The target behavior is directly related to the identified gaps referring to knowledge and practice through the above analysis process. The target behavior must also address resistance points and misconceptions that hinder people from changing their behavior. or instance traditional views and taboos against giving colostrum to the newborn.

Following are key target behaviors (prevention behaviors) as related to the KAP/behavior analysis:

- **Breastfeeding**

**Enabling Knowledge:**

1. Breastfeeding should start right after delivery.
2. Colostrum is like a vaccination for the infant and should be given to the infant right after delivery.
3. Breast milk is Best and makes child healthy.
4. Breast milk is safer and reduces chances of illness.
5. Breast-feed the infant as much as possible.
6. Mothers need to eat well when they are breastfeeding.
7. Water with sugar or swallowing butter should not be given to newborn infants.
8. Infants should get only breast milk until they are four months old, then breast milk plus other foods until they are 18 months old.
9. Breastfeeding should not be discontinued during and after child illnesses.

- **Vitamin A**

**Enabling Knowledge**

1. Vitamin A is a micronutrient found in animal and plant sources.
2. From animal source, liver is rich in vitamin A. It also occurs in meat and the flesh of fatty fish, in eggs and milk fat.
3. In plant origin, it is found in dark green leaves and bright yellow or orange vegetables, such as pumpkin, or fruits like papaya or

mangoes, carrots, tomatoes and melon.

4. Vitamin A is fairly stable during normal cooking methods and it does not dissolve in water.
5. Bright sunlight causes losses and affects the value of green leaves if they are left out in the direct rays of the sun to wither or dry.
6. It is essential for vision, reproduction cell differentiation, bone growth and resistance to infections.
7. The most common of vitamin A deficiency is night blindness.
8. Vitamin A deficiency increases the risk to childhood infections such as ARI and diarrhea.
9. Vitamin A deficiency is prevented by regular consumption of vitamin A rich foods.
10. Vitamin A supplementation is important for children under six years and newly delivered mothers (4-6 weeks after).

- **Diarrhoeal Diseases**

**Enabling Knowledge**

1. Diarrhea is dangerous, it dries out the child and can kill.
2. Child/infant is different from adult and must receive special treatment.
3. Contaminated food can contain germs, which are dangerous.
4. Unclean water can contain germs, which are dangerous.
5. Fecal matter contains germs, which are dangerous.
6. Leaving food uncovered makes it easier for germs to get in.
7. Heat kills germs.
8. Reheat food and give to child/infant.
9. Keep boiled water in a covered jar.
10. Keep cooked food covered when not eating.
11. Do not store infant food; make it fresh. Do not keep it more than two hours.
12. Wash hands with soap before preparing food and feeding the infant/child.
13. Wash water/food containers or utensils.

**Treatment Behaviors:**

14. Recognize that the child's stool is abnormal.
15. Confirm symptoms such as restlessness, loss of appetite, more than three stools in a day and watery stool are present.
16. Give more fluid such as rice water, soup, etc.
17. If the child/infant has persistent diarrhea and vomiting go to a clinic/hospital.
18. Continue to breast-feed while dehydrating.
19. If a child vomits allow him/her to rest for a few minutes and start to give small amounts again slowly.
20. Continued feeding and increased in take of fluids during illness is important to prevent weight loss.
21. Never withhold food.

*Demonstrate to mothers how to prepare home-based ORT.

- **EPI**

**Enabling Knowledge**

1. Vaccine is a preventive medicine. It protects against several dangerous childhood diseases.
2. A child who is not immunized is more likely to become undernourished, to become disabled, and to die.
3. Immunization is urgent. All immunizations should be completed in the first year of the child's life. A child should be taken for immunization five times.
4. Infants must get measles vaccine at the age of nine months.
5. It is safe to immunize a sick child.
6. Every woman between the ages of 15 and 44 should be fully immunized against tetanus.
7. Every pregnant woman should be immunized against tetanus.

***Example:* Specifying Ideal Behavior**

**Intervention: Immunization**

| AUDIENCE GROUP | IDEAL BEHAVIOR |
|---|---|
| **PRIMARY**<br>Mothers with under one year children | Should get their children complete all vaccination series before their first birthday. |
| **SECONDARY**<br><br>Mothers who have completed vaccination for their children | Act as role models to vaccinations for other mothers to take their children to vaccination centers. |
| Household heads or husbands who influence decision making in the family | Tell their spouses about the importance of vaccination and encourage and support them to take their children to vaccination centers. |
| Health workers and TBAs | Teach mothers that vaccine is a preventive medicine and protects against several dangerous childhood diseases. And ensure when mothers should come back for next vaccination for their children. |

## 4.5 Participant (Service Providers) Analysis

IEF/CCF Child Survival Project has established collaboration and networking with all health institutions and some schools in the project area. Mainly health assistants and leaders of health and anti AIDS clubs have been involved in the activities of the child survival project. The project staff undertakes activities like coordination, training and support materials preparations. Project staff members train mothers and peer educators at community level on project interventions.

The facility assessment report has shown that health workers in the project need a regular in-service training on project interventions.

The needs assessment findings have revealed that project staff including health workers and leaders of health/anti-AIDS clubs in schools have not been trained in communication skill. As these workers are front line promoters of project interventions, they should be trained in communication skill and proper utilization of communication materials.

## 4.6 Communication Objectives

Measurable objectives are important to look into the impact of the success of the programme in reaching its goals. A communication objective is a target which specifies the intended audience, the type of change that is expected, when and where the communication activity is to take place and finally, what criteria will be used to measure its degree of success.

1. X per cent of the target audiences will have heard about DCM, breastfeeding, EPI and vitamin A interventions from service providers within X months of communication activities.
2. X per cent of women aged 15-49 years will be exposed to interpersonal communication supported by print media and will have the knowledge on the importance of vaccination and breastfeeding, DCM and vitamin A with X months of the project.
3. X per cent of mothers will practice ORT for their under five children within the project cycle.
4. X per cent of children of under one year will be fully vaccinated within the project cycle.
5. X per cent of mothers of under two years will initiate early breastfeeding and give colostrum to infants right after delivery.
6. X per cent of the target population will be convinced to give vitamin A capsules to children under two years of age.

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## 4.7 Audience Segmentation

Even in a homogenous society, message development and media and formats are different for different segments of the community members. There are three major segments to be considered for the communication strategy:

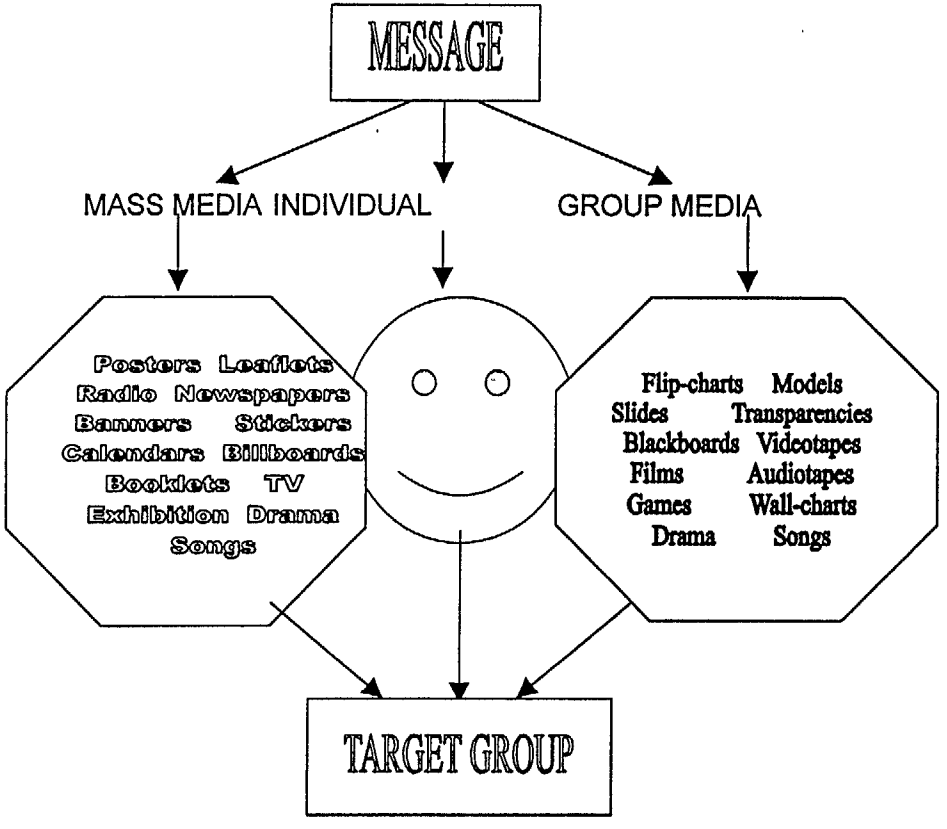
1. The *primary target audiences* – for which the project intends to get across health and nutrition knowledge and practices.
2. The *secondary audiences* are those who teach and influence the primary audience to change (for example, service providers, peer groups, elders and opinion leaders).
3. The *tertiary audiences* – decision makers/policy makers and influential people are considered to belong in this group. This group can contribute to the success of the project.

Generally, in child survival projects the primary audiences are caretakers – mothers, grand mothers and older siblings. Secondary audiences could be considered as primary audiences in the beginning of the project. If the service providers (health workers, teachers and opinion leaders) have limited knowledge and acceptance of the new skill or innovation, they will be treated as primary audience for a short period of time.

Primary audiences like caretakers are again segmented into smaller sub-audiences. For instance, rural mothers may require different educational materials than urban mothers. Urban mothers may have resources and outreaches and better exposure to the new behaviors. Different interventions may be targeted to different primary and secondary audiences. For example, many studies indicate that breastfeeding is common among rural mothers, there is low trend among urban women. In this case, the primary audience is urban women while the secondary is their husbands and neighbors. In the case of diarrhoeal diseases, our focus could be on rural caretakers as primary audience since there is limited health services and minimal exposure to ORS. Hence, traditional healers and older women could be taken as secondary audiences for they are influential in promoting ORS. For EPI campaign our primary audiences are caretakers (mothers, grandmothers and older siblings) who usually bring children to vaccination centers. Other family members, opinion leaders, religious leaders, women leaders, TBAs and CHAs and school teachers are secondary audiences who could support in mobilizing and persuading the primary audiences to bring their children to vaccination centers. The same is true for vitamin A capsule supplementation, which is usually effected along with EPI programme. However, in the promotion of food diversification approach for vitamin A deficiency, students and teachers could be our primary audiences to promote vegetable gardens within the school community.

## 4.8 Media Analysis/Choices

Choices of Media



### 4.8.1 Various Media in Health/Nutrition Programmes

We cannot predetermine and say one medium is better than the other. Situation and requirements of project interventions govern which media should be used. Selection of media is influenced on the basis of audience research regarding media access, credibility and the available media. Dissemination of message in different forms and through different channels has the most impact in motivating people to change behavior. Therefore, multimedia approaches are usually preferred and are most effective in addressing issues and eventually helping people towards behavioral change.

Exposure to media by itself does not bring about behavioral change, but it should be combined with face-to-face discussions (interpersonal communication) with someone more knowledgeable about the issues or innovations. Information must be absorbed and evaluated for its usefulness and appropriateness in the audiences' situation before audiences take any action.
Media have pros and cons, which should be considered during media selection for any intervention.

| MEDIA | PROS | CONS | SUMMARY |
|---|---|---|---|
| PRINTED MATERIALS | Relatively cheap, simple and easy to produce.<br><br>Could be taken home, consulted, and kept as permanent reminder. | Particularly valuable for service providers like health workers, teachers, extension workers, etc.<br><br>Have limited use among illiterates, but we can consider family literacy as opposed to individuals. | Well designed, carefully written for their intended audience, printed materials can provide a vitally important and cheap source of reference for service providers and literate audiences. |

| MEDIA | PROS | CONS | SUMMARY |
|---|---|---|---|
| FOLK MEDIA (Theatre, Puppetry, Storytelling, Drama, etc.) | Does not require capital investment.<br><br>Does not depend on technology that is liable to break down.<br><br>Intrinsically adapted to local cultural scene.<br><br>May be highly credible and persuasive where folk media has a strong tradition. | Requires skilled crafting of messages into the fabric of the folk media.<br><br>May be difficult to organize and calls for close working relationship between service providers and folk media artists. | Creative use of folk media – in cultures where it is popular and well entrenched – can be a subtle and effective way of introducing ideas and messages. Care required ensuring that the mix of entertainment and development is appropriate, so furthering the latter without damaging the former. |
| FLIP CHARTS | Cheap and simple to produce and use.<br><br>Good for training and intervention support. | Not as realistic as projected aids.<br><br>Care required making drawings understandable to illiterates.<br><br>Lack the attraction of audiovisual materials. | Flip charts are very useful to help service providers in their work with target population. Careful design and pretesting required. |

| MEDIA | PROS | CONS | SUMMARY |
|---|---|---|---|
| AUDIO CASSETTES | Easy and relatively cheap to produce programmes.<br><br>Cassette players quite widely available.<br><br>Easy to localize information.<br><br>Good for feedback because audiences can record their questions and reactions.<br><br>Can be used well in conjunction with rural radio. | Audio only may suffer some of the weakness of radio, though repeated listening may help to overcome it. | Very good low-cost medium. Potential has not been sufficiently recognized. Especially useful in conjunction with rural radio. |

| MEDIA | PROS | CONS | SUMMARY |
|---|---|---|---|
| SLIDES/FILM STRIPS | Slide sets are relatively simple to produce.<br><br>Low-cost equipment for production and projection.<br><br>Very good color and visual quality.<br><br>Filmstrips are made of robust material and are small, easy to transport.<br><br>Excellent training medium for all subjects except those few for which showing movement an absolute essential. | Production requires laboratory process.<br><br>Cannot be used in daylight without special rear projection screen.<br><br>Lacks the appeal of video (which relates to TV In most minds).<br><br>Turning slides into filmstrips requires laboratory process. | Slide sets/filmstrips have proved an invaluable training support, but they are tending to lose out to video, despite the higher cost of production of the video films. |
| RADIO | Wide coverage and availability in rural areas.<br><br>Relatively cheap production and reception.<br><br>Local radio stations facilitate localized information. | Weak as a medium for training and education since is audio only. | Excellent medium for motivation and for drawing attention for new ideas and techniques but weak for providing detailed knowledge and training. |

| MEDIA | PROS | CONS | SUMMARY |
|---|---|---|---|
| TELEVISION | Prestigious and persuasive. | Not available in all rural areas.<br><br>Expensive production and reception.<br><br>Difficult to localize information since local TV stations are rare in developing countries. | Although potentially powerful, television is not easy to use for rural interventions in developing countries. |
| VIDEO | Highly persuasive.<br><br>Electronic image/sound recording gives immediate playback and production flexibility.<br><br>Allows more than one language to be recorded as commentary on a single tape.<br><br>Can be shown in daylight using battery-powered equipment. | Requires talent, skill, and experience to produce good programmes.<br><br>Requires rather sophisticated repair and maintenance facilities.<br><br>May call for quite large capital investment for production and use. | Video has become the media in the minds of many. Indeed it is highly effective but calls for a careful strategy, skilled producer, and incurs a high cost. |

### 4.8.2. Selection of Media

- Assess all available media (based on studies) and then strike out those that are not appropriate, practical, or feasible.
- Evaluate each medium in terms of the approach and style of message selected.
- Determine comparative cost effectiveness of each medium.
- Use a combination of media whenever possible. Media mix approach is effective.

There are key questions to be considered in selecting appropriate media to disseminate health and nutrition messages, to attain behavior changes, intended to promote child survival interventions.

1. What medium or media are best to disseminate health and nutrition messages?
2. Which medium or media are most effective for changing people's behavior? Which ones are available in the project area?
3. From where do people get their information?

A study conducted by UNICEF (1990) has shown the most frequently used media for communication of development innovations in Ethiopia is interpersonal communication (person-to-person) to which respondents gave maximum attention. Religious institutions and associations like peasant and urban associations (Kebele associations) were indicated as important sources for audience exposure. The same study has indicated that radio is very important as means of learning. Exposure to TV has been found very low. Print media (newspapers, posters, leaflets, etc.) is also important to audience exposure. Even though the study was conducted 10 years ago, from our day to day experiences the findings are still valid and have significant implication in development endeavors.

It is, therefore, **interpersonal communication and print media** are the most appropriate media for the child survival interventions in Debre Berhan and Basona-Warena Woredas. This has been confirmed by information gathered during the recent needs assessment survey. Though radio has very strong power in reaching people, it cannot be considered for this particular project which is localized in two Woredas.

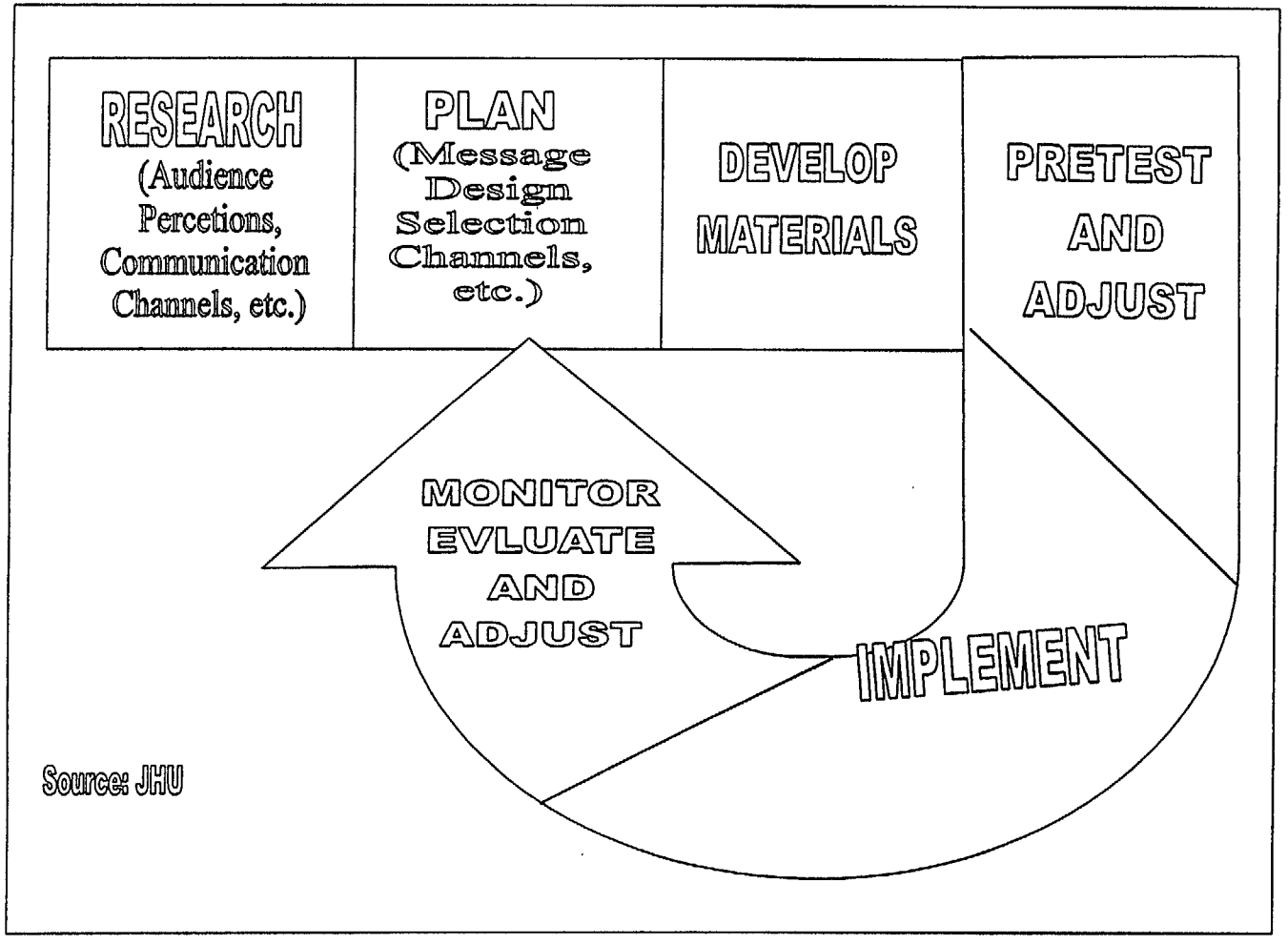
However, some messages that are broadcast by the national radio stations which are relevant to the child survival project could be taken up and emphasized and used to raise discussions among target audiences especially during EPI and Vitamin A supplementation campaigns. In addition, as is started in the project area, taped messages (audio-tapes) could be used during health education sessions and for health education clubs in schools. Videotapes could be strong in disseminating messages, but for this particular project it is not cost effective and appropriate to use in rural settings. Videotapes require a TV screen, a video recorder and power source like a generator or direct electric power. However, videotapes could be considered for training of service providers. Production cost of videotapes is relatively expensive. There are readily available videotapes on health and nutrition in the Ministry of Health and with some donor agencies.

It holds true that most people are exposed to religious institutions, associations like "Ider" and kebeles. The service providers could provide effectively reach the primary audiences – caretakers, to disseminate the required information and meet the intended change in behavior through these structures. In addition, as is indicated in the needs assessment report, household heads (husbands), religious, elders and opinion leaders are potential allies to promote the project interventions.

## 4.9 Communication Materials Design and Development

- As long as resource allows, professional and experienced people should undertake media materials production.
- On the basis of field investigation and research reports communication materials are designed and developed containing creative messages that translate the strategy into action.
- Messages are designed and developed referring to the attitudes, perceptions, beliefs, preferences and resistance points of the target population.
- Materials are developed based on the availability of media outlets and the target population's familiarity of media.
- Each medium has various alternative ways to disseminate the message. Message treatment must match with the format selected to deliver the message.
- Creative message should be attractive, memorable, persuasive, and convincing. It should not conflict with the audience's social customs.
- Message must be organized in the best order for learning – from simple to complex

## THE P-PROCESS AS APPLIED TO MESSAGE DEVELOPMENT



Message translates project behavior objectives into concert content terms. It serves as a bridge between the audiences existing behavior and terminal desired behavior. Possible subject matter content (target behavior) should be analyzed and then specific selection will be made in terms of the desired behavior. Information must be gathered through studies, research reports and subject matter specialists.

- The development of communication materials for IEF/CCF project has two prongs approach –examining existing materials and developing new sample materials. The consulting team has identified relevant communication materials developed by other agencies of which some of them are being used by the project staff and collaborating sectors (health institutions and schools). The vitamin A chart and vitamin A booklets, which were originally produced by the former ENI, are strongly recommended to be used in the project area. Both materials were well researched and field-tested. The audiocassettes on EPI, which are being used by the health institutes, are still valid and must be used in EPI centers. Other materials like posters on breastfeeding and child health in general produced by ENI are relevant and should continue to be used. Two leaflets, one on DCM for teachers/students produced by UNICEF/MOH and the other on vitamin A for teachers/students produced by MOH, are worthwhile to be considered.

  New communication materials on each of the interventions have been designed and prototypes developed. The sample materials have photos and sketch drawings.

  - **A booklet on vitamin A for field workers, that includes storytelling approach and questions, for discussions with audiences.**
  - **A booklet on breastfeeding (with a drama script) for field workers.**
  - **A poster on EPI.**
  - **A booklet on DCM.**
  - **A flip chart on DCM.**
  - **11 billboard messages on all of the interventions.**

## 4.10 Pre-testing of Materials

Basic research, design and product testing ensure the quality of the communication materials. Having prepared the communication materials, it is very important to conduct expert appraisal for the appropriateness of the materials in general and field pretesting of the materials specifically to determine the reaction of the audiences to the messages. There are commonly known and specific questions that should be considered during pretesting:

- **Do audience members understand the message?**
- **Do they believe in it?**

- **Do the materials (message and pictures) relevant to the audiences' culture – cultural sensitivity?**
- **Do the audience members find the materials interesting.**
- **Does the message encourage or motivate them to change their behavior?**

Pretesting is usually conducted using qualitative research technique rather than quantitative. The potentiality of materials is assessed through detailed and in-depth reactions of the audiences. Information is gathered using both in-depth and focus group discussions.

The way pretesting is conducted may depend on the format of the materials. For example, it could be adequate to preset a poster to the audiences and collect their reactions on the basis of pertinent questions. Taped messages could be played to the audience group and their reactions will be recorded accordingly.

The above mentioned new materials have undergone expert appraisal process and have been pretested in the project area with the appropriate audience members through focus group discussion, central location intercept and one to one interview and focus group discussions both in urban and rural settings. The findings of the field pretesting will help to adjust the form, picture and content of the materials.

The package of media materials that has been designed and developed in different formats includes posters on EPI, BF, VA, and healthy child, flipcharts on DCM, manuals on EPI, BF, VA and 11 billboard messages on nutrition and health issues. The manual

on BF and VA includes a drama and stories respectively. All the materials were pre-tested with the intended audiences. The pre-testing was conducted in urban and rural settings in the project areas. The pre-testing was undertaken with mothers, fathers, siblings and community leaders. Besides expert appraisal was collected from health workers and project staff members (service providers) for all materials.

Pre-testing of posters (EPI, BF, VA and healthy child) with mothers, fathers, siblings and community elders in terms of attraction, acceptability and comprehension has indicated that all the four posters are very much appropriate to supplement interpersonal communication. On the same posters, the expert appraisal information from the service providers, which was collected through focus group discussion, has pointed out the need for some pertinent improvement on pictures and captions. Hence, the suggestions have been taken into account to review and improve the posters.

A drama on BF and two stories on VA (which are included within the manuals) were pre-tested with mothers, fathers, siblings and community elders using one-to-one interview technique. All respondents liked the drama and the stories and believed that the events do reflect their situation clearly. Service providers have also provided their suggestions on manuals on BF (with the drama), VA (with the stories), DCM and

EPI in order to improve them. Accordingly, the manuals' context and pictures will be reviewed and improved.

11 billboard messages were pre-tested with health professionals, teachers, students, community members and project staff members. The subjects have forwarded invaluable suggestions. The billboard messages are not exhaustive enough to cover all the desired behaviors for each of the interventions. However, the 11 messages are only to supplement the other media materials. Based on the suggestions the content of the messages will be reviewed and improved.

## EXAMPLE OF A COMMUNICATION STRATEGY MATRIX

| TARGET BEHAVIOR (DESIRED BEHAVIOR) | AUDIENCE IDETFICATION | OBJECTIVES | COMMUNICATION APPROACH | METHOD | | MONITORING AND EVALUATION |
|---|---|---|---|---|---|---|
| | | | | MEDIA | INTERPERSONAL | |
| (DCM)<br>➢ Boiling water<br>➢ Drinking safe and clean water | Mothers with children and family members | 20% of mothers give boiled water to their children after a year | | Audio tapes<br>Posters<br>Leaflets | Individual/groups learning by health workers, opinion or religious leaders<br>Home visits | Monitoring.<br>Observation<br>Supervision<br>Reporting<br>Evaluation<br>Assessment surveys |
| (EPI)<br>➢ Vaccination against six diseases<br>➢ Bringing children to vaccination sites | Mothers with children and pregnant women | 50% of mothers bring their children to vaccination centers & 30% of women of 15-49 cover vaccination in a year | Informing<br>Educating<br>Persuading<br>Training | | | |
| (Breastfeeding)<br>➢ Breast milk is clean<br>➢ Breast milk protects against childhood diseases | Mothers with under two children | 90% of mothers give breast milk to their children in a year | | | | |
| (Vitamin A)<br>➢ Vitamin A is important for vision<br>➢ Vitamin A is found in liver | Mothers with children | 50% of mothers give vitamin A capsules to their children in a year | | | | |

## 4.11 Training Plan (Tentative)

As is identified by the needs assessment survey, people involved in the implementation of project interventions, mainly project staff, health workers and teachers, require basic training in communication skill and utilization of communication materials. Subsequent trainers must be given for various audiences. Major training requirements are identified in the matrix below and are subject for further discussions and finalization by concerned project staff.

| TRAINEES | TRAINING OBJECTIVES | TRAINING MATERIALS | Description/ Number of | | DATE/DURATION & LOCATION | RESPONSIBLE PERSONS |
|---|---|---|---|---|---|---|
| | | | Trainees | Trainers | | |
| Project Staff<br>*Health Personnel*<br>Teachers | Trainees will be able to disseminate technically correct messages and select and use communication materials properly. | Collection of reading materials and handouts | 25 | 2 | End March 2000<br>2 days<br>Debre Berhan | Consulting team and project staff |
| Health Personnel | All health workers involved in IEF/CF project will be able to educate audiences with technical correct messages based on project interventions. | Hand outs, flip charts | | | | |
| Teachers | Teachers involved in health education clubs will be able to conduct technically correct sessions and demonstrations on project interventions especially on vitamin A. | | | | | |
| TBAs and Opinion & Religious Leaders | Trainees will be able to undertake mobilization activities within the project area so that community members are motivate to realize the importance of interventions and take proper actions. | Flip charts, posters, leaflets, etc. | | | | |

## 4.12 Monitoring and Evaluation

**Monitoring**

1. It is vitally important to undertake monitoring activities to determine that the programme is meeting its goal.
2. Communication activities will be checked through regular monitoring process to take midcourse actions and changes.
3. Project staff and others involved in the project can carry out monitoring activities on project progress.
4. The frequency of monitoring depends on the nature of programme communication activities.
5. Individual project components, activities, workers and media must be listed to develop a communication monitoring system.

**Evaluation**

1. Assess the extent of behavior change in the target population as the result of the communication strategy.
2. Attempt to find out how and why a change happened in the target population. What part of the message convinced them to change their behavior.
3. It is important to know why the target population found it difficult to understand or accept the new information.
4. Evaluation to be organized in a series of before, during, and after studies.
5. It assesses various communication activities and elements like message content and appropriateness of media used to disseminate the message.
6. It will provide insight into the design and implementation of future communication strategies.

Relevant variables or indicators should be developed to undertake monitoring of communication activities. For example, in terms of interpersonal communication carried out by health workers and teachers, monitoring could be structured around the following questions:

- **Are the workers provided with the necessary material?**
- **Are the materials in proper condition and adequate supply?**
- **Are the materials used correctly and as often as planned?**
- **Is the target audience attending the learning sessions?**
- **How is the audience reacting to the messages?**
- **How are the communicators responding to the reactions?**

As regards posters/billboards, monitoring questions could be organized in such away that:

- **Have posters/billboards been posted at proper places?**
- **Are posters/billboards in good condition?**
- **Is the target audience noticing the posters/billboards?**
- **How is the audience reacting to the posters/billboards?**

Health workers or teachers can directly report at regular intervals regarding how many sessions conducted, number of people participated and the reactions of the participants. However, responsible project staff can undertake monitoring activities regularly.

## 4.13 Operational Plan

An operational plan serves as a guide for project staff as well as a record of the program objectives and strategies. The plan can be modified as the need arises. It is also a management tool. The actual writing of the plan is worked out by a group of people involved in the project including outsiders. The plan usually runs for a year or more. This is a draft plan for discussion with the project staff.

The operational plan includes:

- **Main research findings: summarized data and findings of field investigation.**
- **Behavior analysis.**
- **Program objectives: specific statements, do-able, measurable communication objectives.**
- **Audience segmentation: description of the different segments of audiences – primary and secondary.**
- **Promotional plan: indication the media mix and their relationships and distribution plan of materials.**
- **Training plan: identifying people to be trained.**
- **Monitoring plan: refine program strategy and assess any change overtime.**
- **Management plan: indicating the responsibility of participating agencies and the project itself and outline implementation timetable.**
- **Evaluation plan: looking into behavioral changes as well as rates of morbidity and mortality. Behavior.**

## TENTATIVE ONE YEAR OPERANTIONAL PLANNING MATRIX (IMPLEMENTATION PLAN)

| TARGET AUDIENCE | OBJECTIVES (CHANGE NEEDED) | MESSAGE | METHOD | RESPONSI-BILITY | MONITORING& EVALUATION | TIME FRAME |
|---|---|---|---|---|---|---|
| Policy makers/ High level admin. (Tertiary Audience) | To get commitment and support for implementation of project interventions | • Background information on the magnitude of the problem with regard to project interventions.<br>• Project strategy for implementation<br>• Commitment and support required | Conference and workshop supported by films and printed materials | Project staff | Long term observation | |
| Health personnel Teachers (Secondary Audience) | • To provide project intervention services<br>• To mobilize/motivate target audiences<br>• To cooperate and assist in all stages of implementation | • Background information<br>• Project interventions objectives and roles<br>• Detailed technical knowledge and skill<br>• Communication skills<br>• How to use communication materials | • In service training supported by printed materials, films and slides, etc.<br>• Programmed instruction, using role plays and printed materials | Project staff<br><br>Communicatio n experts | Pr-test, post-test during training sessions<br><br>Continuos supervision<br><br>Incorporating project interventions into monthly meetings | |
| TBAs, Opinion leaders, Religious leaders, etc. (Secondary Audience) | To mobilize and motivate target audiences | • Background and objectives of project interventions<br>• How to motivate target audiences | Printed materials and tapped messages | Project staff and health personnel | Continuos supervision<br><br>Reporting | |
| Care takers – mothers | • Be able to explain project interventions | • Background information on the problem | Interpersonal communications (face | Project staff and health | Observation | |

| TARGET AUDIENCE | OBJECTIVES (CHANGE NEEDED) | MESSAGE | METHOD | RESPONSI-BILITY | MONITORING& EVALUATION | TIME FRAME |
|---|---|---|---|---|---|---|
| (Primary Audience) | • Acquire a positive attitude towards project interventions and explain the needs for interventions<br>• Be able to ask services of other villagers<br>• Start practicing required behaviors of interventions | • Benefits of project interventions<br>• How to get services | to face contact) with support of flip charts, posters, drama, songs, demonstration, models billboards, etc.<br><br>Home visits | personnel | Follow up surveys | |
| Students (Primary Audience) | • Be able to describe essential learning points of the interventions<br>• Acquire positive attitude towards project interventions<br>• Be able to educate other students and community members with regard to project interventions<br>• Participate in backyard gardening activities and transfer knowledge and skills to their parents | • Background information on problems<br>• Detailed learning points on project intervention focusing on vitamin A | Interpersonal communication supported by tapped messages, printed materials, dramas, songs, etc.<br><br>Home visits<br><br>Introduce school gardening on vitamin A rich vegetables | Project staff and teachers | Observation<br><br>Follow up school activities of project interventions<br><br>Reporting | |

## V. Conclusion

The development of this communication strategy followed a two pronged approach. First, existing project area-specific studies and relevant literature were reviewed and adapted in the strategy. Secondly, rapid survey was conducted to investigate prevailing knowledge, attitudes, beliefs and practices pertaining to project interventions. The latter approach has substantially enriched the former. It has helped to lay the ground for the development of a conceptual framework for the communication strategy. The strategy framework incorporates the essence of social marketing approach.

In light of the framework, core elements of the communication strategy, such as existing project communication activities, prevailing behaviors and media choices were thoroughly analyzed. The synthesis of the core elements has enabled to outline tangible communication opportunities to put in place for the implementation of child survival project in the two Woredas, Debre Berhan and Basona-Werana.

The synthesis of the desired behaviors for each intervention has clearly delineated and helped to put together the communication strategy in terms of audience segmentation, media choices, message design/development, and monitoring and evaluation. Training needs for service providers and allies are outlined but still require further review by the concerned project staff and stakeholders. Prototype of media materials in different formats are developed and pretested. These materials will be reviewed and as deemed necessary, corrections will be made according to the results of the pre-testing. It is recommended that the final prototypes should be produced and used properly along with interpersonal communication. The operational plan is the overall direction of implementation of the communication plan. The operational plan is subject to further discussion and improvement by the concerned project staff and stakeholders.

Finally a two days workshop on Orientation on Communication Strategy & Training on Communication Skills was given to the partners /stakeholders on June9-10, 2000 at Debre Berhan, Amhara National Regional State. The objectives were to orient the development of Communication Strategy of IEF/CCF Child Survival Project and introduce the content and strategy, .and to up grade the communication skills of the participants by providing basic elements of Communication Skills and practicing exercises through Microteaching methods. 26 participants from different institutions have attended the workshop.. (Workshop Report shown in Annex 2)

It is our strong conviction that the IEF/CCF CSP Communication Strategy developed would assist in making .a meaningful contribution towards the behavioral changes of the target groups.and enable the Child Survival Project in attaining its objectives.

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Our special thanks and appreciation goes to all CSP staff and specifically to Manager Dr. Tadesse Kassaye for their unreserved support and facilitation through the study and the successful Completion of the TOT workshop at Debre Berhan.

## Annex C
## ASSESSMENT METHODOLOGY, EVALAUTION TEAM

**Evaluation Team**

Methods: Core team planning consisted of five days, group expectations and norms, development of participatory methodology, selection and review interviewing techniques, site selection and survey design, and development of tools for evaluation.
The evaluation team drew Project team planning workshop tools from the Environmental Health Project WASH Technical Report No. 32 Facilitator Guide for Conducting a Team Planning Meeting and from Judy Aubel's Participatory Program Evaluation Manual.

The field team was given a half-day orientation and training and first field day testing of survey instruments. Modification of instruments was made thereafter.

***Core Team***

John Barrows, MPH, Director of Programs, IEF Headquarters, Bethesda, MD
Margie Ferris-Morris, MS, RD, External Evaluator, Falls Church, VA
Dr. Shabbir Ismail, MPH, Addis Ababa University, Faculty of Medicine, Consultant
Ato Hailu Meche, MPH, Consultant
Dr. Tadesse Kassaye, CCF/Ethiopia, CS Project Coordinator*
Mr. Derege Dejene, Program Manager, CCF/Ethiopia

***Field Team***

Zonal DPPC:
Ato Ayalew, NGO Coordinator*
Ato Solomon, Social Affairs Office*

Woreda Offices:
Ato Walelign Ambaw, Basonaworena Health/Office Head*
Dr. Yosef, Debrebirhan Health Office*

CCF DebreBirhan Office:
Ato Demessew Guluma, EPI*
Ato Abenet Leykun, DCM*
S/r Tsehai Agonager, Nutrition*

Zonal Health Office:
Ato Hailu, Zonal Health Office*

## Annex D
## List of Persons Contacted*

**denotes in-depth interview*

IEF Headquarters:
Mr. John Barrows, Director of Programs*

CCF Headquarters:
Jill Coverton, MBA, Project Manager*
Dr. Tom Kerkering, Medical Advisor*
Mary Anne Javed, Health Advisor
Michele Poulton, Program Director

CCF National Office:
Ato Fikeru Abebe, National Director, National Office*
Ato Derege Program Manager, National Office
Mr. Derege Dejene, Program Manager, CCF/Ethiopia

CCF Debre Birhan Office:
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Ato Demessew Guluma, EPI*
Ato Abenet Leykun, DCM*
S/r Tsehai Agonager, Nutrition*

Zonal Health Office:
Dr. Daniel Zewde, Zonal Health Office*
Ato Hailu, Zonal Health Office*

Zonal Council:
Ato Wondim Gezaw*

Zonal DPPC:
Ato Ayalew, NGO Coordinator*
Ato Solomon, Social Affairs Office*

Woreda Offices:
Ato Walelign Ambaw, Basonaworena Health/Office Head*
Dr. Yosef, Hospital Director, Debrebirhan Health Office*

Councils:
Ato Mesfin, Debrebirhan Woreda Council*
Ato Teshome, Debrebirhan Woreda Council*
Ato Birhanu, Woreda Council*

USAID/Addis:
Ms. Vathani Amirthanayagam, Population, Health and Nutrition Chief

## Annex E Questionnaires for In-depth Interview and Focus Group Discussions (Zone, Woreda, Community, MOH, PVO)

1. Interview Guide CCF and IEF
2. In-depth Interview –Zonal and Woreda Level (Council, Social, DPPC, Health)
3. In-depth Interview – Health Staff (Head health facility, nurses, CHA, depot holders)
4. Focus group discussions – Kebele Leaders, volunteer mothers, mothers, opinion leaders

### 1. CCF and IEF Interview Guide

Interview Guideline -- CCF, IEF

Name interviewer: Date:
Name interviewee: Position:

**Introduction to interview: Introductions, purpose of interview**

How many years have you been with the project?

Where did you work before joining CCF?

What are your expectations of the evaluation underway?

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**Cross cutting issues:**

**1. Community mobilization**

1.1. What kinds of barriers exist to prevent the members of the community from benefiting from the program? How have these been addressed?

1.2. What factors have an impact (positive or negative) on program implementation? (Such as roads, policies, use of mass media, other)

**2. Communication for behavior change**

2.1. How is the project measuring behavior change? What tools are being used? Has anything been changed as a result of monitoring behavior change?

2.2. Who uses the data regarding the effects of behavior change activities? Have the communities used the data to reinforce or promote other behavior changes? How?

## 3. Capacity building

3.1. What does "capacity building" mean to you, describe?

3.2. What are the capacity building approaches/plans of this project?
- What progress has there been?

- What are the strengths and weakness of the approaches/ plans?

3.3. What capacities have changed within CCF as a result of involvement in this project?

3.4 What capacities have changed within your partners as a result of involvement in this project?
- Area
- Woreda
- Health posts/ health workers
- Community level

## 4. Local Partnerships

4.1. Who are the partners in this project?
4.2. What are the strengths and weaknesses in these partnerships?
4.3. How can partnerships be improved?

## 5. Training

5.1. What training activities have you been responsible for?
5.2. What are your impressions on how effective training has been?

## 6. Sustainability

6.1. What does "sustainability" mean to you and the project, describe?

6.2. What do you think should be sustained or not sustained of the CS project?
- How likely do you think these identified elements can be sustained without CCF assistance?

6.3. Do you feel that CCF should continue supporting the MOH as it has?
- If not, what changes do you suggest?

6.4 Do you feel that CCF should continue supporting communities as it has?
- If not what changes do you suggest?

6.5. What are your impressions of CCF strategic plans?
- How involved have you been in the strategic planning process?

6.6. Describe your impressions on how CS fits CCF mission, priorities, and strategies (how has CS programming influenced other CCF programs and vice versa.
6.7. Are the intentions of CCF for continuing CS programming in this area?

**Program Management**

### 7. Planning/ reporting

7.1. Describe you role and involvement in planning activities?
- Proposal
- KPC surveys
- DIP
- Annual work plans
- Reports

7.2. Do you have a copy of the DIP or access to the DIP?
7.3. Do you have a copy or access to a working budget?

### 8. Staff training

8.1. What training have you received from CCF or the project?
- Are you satisfied with this training?

8.2 What training or skills would you like to develop?

### 9. Supervision & HRD

9.1. What are your impressions on the frequency and quality of feedback you receive from:
- Project Manager
- National office
- International offices?

9.2. Do you have a copy of the CCF's Personnel Manual, job description?
9.3. Do you receive performance evaluations? If so when was he last evaluation
9.4. Do you have regular staff meetings?

### 10. MIS

10.1. Describe the system you have to measure progress towards reaching project objectives.
10.2. Describe how you use monitoring data for quarterly and annual planning.
10.3. Describe your involvement in:
- KPC surveys
- HFA survey
- Other assessment activities

10.4. Describe other MIS systems and approaches employed by CCF.

## 11. Technical/ administrative support

11.1. Describe the technical assistance you have received from:

- Field office
- National office
- International offices

11.2. Describe your involvement in planned technical assistance activities.

11.3. What are your impressions of these technical assistance activities?

11.4. What technical assistance would you like (list and prioritize)?

## 12. Partnerships with NGOs/PVOs (IEF-CCF; CCF-CCF)

12.1. In your opinion what are the elements needed for effective partnership relationships?

12.2. Who do you feel are your priority partners, list and prioritize?

12.3. What are the strengths and weakness of these partnerships?

12.4. What can be improved, and how can improvements be made?

13. *Communications*:

*13.1.* Are the communications regular between offices? Do you feel you have received all information needed to your work? Has information been delivered on a timely basis? What do you think could be changed or improved? *(If no, write specifics of why. If yes, tell what particularly was helpful)*

*14. Technical Assistance:*

14.1. Have your requests for technical assistance been satisfactorily answered for you? If a request for technical assistance was not advised/approved, please explain why? Do you feel you have received the support to run the project effectively?

**B. In-depth Interview –Zonal and Woreda Level (Council, DPPC, Social Affairs, Health Department)**

**In-depth Interview with Zonal Council**

1. Do you know about the existence of the CCF child survival project? To what extent do you know about it? Can you tell me what the project does, basically?

2. What kind of feedback from any government partners have you had – both positive and negative? Please share details.

3. How complementary do you think the project is in relation to the government programs? Are there areas you feel are not complementary? Please explain.

4. Do you feel that the project has targeted priority problems of the beneficiary community?

5. Where you involved in the planning review of the project? Do you feel the project has responded to you input in activity review meetings? Please elaborate why?

6. What do you think could help make approval of projects go more quickly? What roles would you office play? What roles could the CCF office play?

7. How would you describe your relationship with the project? (consultations, frequent contact? Etc.) Do you have regular meetings with the CCF project? Receive regular reports?

8. What do you think are the strengths of this project? What do you feel are he weakness or constraints they operate under?

9. Do you and/or your office benefit from this project? How?

10. Did you have the chance to attend a CCF sponsored training? Was it useful? How? How much did the skills you brought back to the project help the management process? Please explain.

11. How valuable do you feel are the CCF trainings given at the different levels of health workers and the community leaders/members and volunteers?

12. Separate from the trainings, what new experience have you gained from the project to adapt or use by your facilities in the future? Have you made changes already, if so what where they?

13. What expectations do you have from the project?

14. Do you feel certain aspects (or all aspects) of the project should be replicated? What? And how?

15. Do you feel the auxiliary health workers (CHAs and DHs) are assisting the health workers serving in your facilities? Please explain their role and how your facilities may be benefiting.

16. What is your opinion concerning the continuation of the project?

17. Do you feel the government partners can take over the activities started by the project? Do you think the project results can be sustained beyond the life of the project? If so, how? What steps should the government take? What steps should the NGO take in order to sustain critical activities?

18. If no, what arrangements do you feel should be made?

20. What recommendations do you have about the nature of the project in the future?

**<u>In-depth Interview with Zonal Health Department and Zonal DPPC</u>**

1. Do you know about the existence of the CCF child survival project? To what extent do you know about it? Can you tell me what the project does, basically?

2. Are you happy with the project?

3. What kind of feedback from any government partners have you had – both positive and negative? Please share details.

4. How complementary do you think the project is in relation to the government programs? Are there areas you feel are not complementary? Please explain.

5. Do you feel that the project has targeted priority problems of the beneficiary community?

6. Where you involved in the planning review of the project? Do you feel the project has responded to you input in activity review meetings? Please elaborate why?

7. What do you think could help make approval of projects go more quickly? What roles would you office play? What roles could the CCF office play?

8. How would you describe your relationship with the project? (consultations, frequent contact? Etc.) do you have regular meetings with the CCF project? Receive regular reports?

9. What do you think are the strengths of this project? What do you feel are he weakness or constraints they operate under?

10. Do you and/or your office benefit from this project? How?

11. Did you have the chance to act as a resource person at a CCF sponsored training? Was it useful? How?

12. How valuable do you feel are the CCF trainings given at the different levels of health workers and the community leaders/members and volunteers?

13. Separate from the trainings, what new experience have you gained from the project to adapt or use by your facilities in the future? Have you made changes already, if so what where they?

14. What expectations do you have from the project?

15. Do you feel certain aspects (or all aspects) of the project should be replicated? What? And how?

16. Do you feel the auxiliary health workers (CHAs and DHs) are assisting the health workers serving in your facilities? Please explain their role and how your facilities may be benefiting.

17. Are there are some NGOs projects that you feel it would be worthwhile for CCF to view their activities to learn from their activities? And visa versa? How would you recommend the transfer of skills to take place?

18. What is your opinion concerning the continuation of the project?

19. Do you feel the government partners can take over the activities started by the project? Do you think the project results can be sustained beyond the life of the project? If so, how? What steps should the government take? What steps should the NGO take in order to sustain critical activities?

20. If no, what arrangements do you feel should be made?

21. What recommendations do you have about the nature of the project in the future?

## In-depth Interview with Woreda Council

1. Do you know about the existence of the CCF child survival project? To what extent do you know about it? Can you tell me what the project does, basically?

2. Are you happy with the project?

3. What kind of feedback from any government partners have you had – both positive and negative? Please share details.

4. How complementary do you think the project is in relation to the government programs? Are there areas you feel are not complementary? Please explain.

5. Do you feel that the project has targeted priority problems of the beneficiary community?

6. Are you involved in the planning, implementation monitoring and evaluation of the project? How have you been involved? Is this worthwhile?

7. What do you think could help make approval of projects go more quickly? What roles would your office play? What roles could the CCF office play?

8. How would you describe your relationship with the project? (consultations, frequent contact? Etc.) do you have regular meetings with the CCF project? Receive regular reports?

9. What do you think are the strengths of this project? What do you feel are he weakness or constraints they operate under?

10. Do you and/or you office benefit from this project? How?

11. Did you have the chance to act as a resource person at a CCF sponsored training? Was it useful? How?

12. How valuable do you feel are the CCF trainings given at the different levels of health workers and the community leaders/members and volunteers?

13. Separate from the trainings, what new experience have you gained from the project to adapt or use by your facilities in the future? Have you made changes already, if so what where they?

14. What expectations do you have from the project?

15. Do you feel certain aspects (or all aspects) of the project should be replicated? What? And how?

16. Do you feel the auxiliary health workers (CHAs and DHs) are assisting the health workers serving in your facilities? Please explain their role and how your facilities may be benefiting.

17. What is your opinion concerning the continuation of the project?

18. Do you feel the government partners can take over the activities started by the project? Do you think the project results can be sustained beyond the life of the project? If so, how? What steps should the government take? What steps should the NGO take in order to sustain critical activities?

19. If no, what arrangements do you feel should be made?

20. What recommendations do you have about the nature of the project in the future?

## In-depth Interview with Woreda Health Office *Specify Woreda*

1. Do you know about the existence of the CCF child survival project? To what extent do you know about it? Can you tell me what the project does, basically? Are you happy with the project?

2. What kind of feedback from any government partners have you had – both positive and negative? Please share details.

3. How complementary do you think the project is in relation to the government programs? Are there areas you feel are not complementary? Please explain.

4. Do you feel that the project has targeted priority problems of the beneficiary community?

5. Are you involved in the planning, implementation monitoring and evaluation of the project? How have you been involved? Is this worthwhile?

6. What do you think could help make approval of projects go more quickly? What roles would your office play? What roles could the CCF office play?

7. How would you describe your relationship with the project? (consultations, frequent contact? Etc.) Do you have regular meetings with the CCF project? Receive regular reports?

8. What do you think are the strengths of this project? What do you feel are he weakness or constraints they operate under?

9. Do you and/or you office benefit from this project? How?

10. How valuable do you feel are the CCF trainings given at the different levels of health workers and the community leaders/members and volunteers? And have the trainings been valuable for you? If so, how?

11. Separate from the trainings, what new experience have you gained from the project to adapt or use by your facilities in the future? Have you made changes already, if so what where they?

12. What expectations do you have from the project? Should those expectations be parts of the project that are continued? Explain why.

13. Do you feel the auxiliary health workers (CHAs and DHs) are assisting the health workers serving in your facilities? Please explain their role and how your facilities may be benefiting.

14. Do you feel there are certain aspects of the project that should be replicated? What and how?

15. Do you feel the government partners can take over the activities started by the project? Do you think the project results can be sustained beyond the life of the project? If so, how? What steps should the government take? What steps should the NGO take in order to sustain critical activities?

16. If no, what arrangements do you feel should be made?

17. What recommendations do you have about the nature of the project in the future?

18. If an unimmunized child came to you at the age of 8 months, what antigens you are going to give him?

19. What is the protocol for Vitamin A capsules (IU) for post-partum mothers?

20. What are two danger signs of diarrhea requiring referral for medical care that you tell your patients?

21. What key messages do you provide mothers about breastfeeding newborns?

22. When do you recommend to mothers to start additional foods after exclusive breastfeeding? Which foods should be given? And how much?

## Health Facilities /Head

Name of interviewer: Date:
Name of interviewer: Position:

Introduction to interview.

How many years have you been in your position?

Where did you work before this posting?

What are your expectations of he evaluation underway?

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1. Can you tell me about the CCF-CS project?

2. What is the relationship of your facility with the program? What is your role in the project? Have you been involved in the major CCF activities such as the KPC survey, planning, training activities, etc.? Explain how.

3. Is the health facility supporting activities from the project appropriate, adequate and received in timely manner?

4. What type of joint CCF/MOH monitoring and supervision mechanism is in place to over-see your facility? How frequently are these visits made? Describe the purpose the visits?

5. Are there any other contacts with the Woreda office, such as training, review and planning meetings? How frequent are these? How long do these meetings take?

6. What is the relationship of CHAs and Depot Holders with the facility in relation to the project? Are these relationships worthwhile? Do they enforce your work? How? Do you want to continue this relationships? Would you like to suggest any changes?

7. Do you think your relationship with CCF-CS project was useful? Describe how?

8. What major changes occurred in the services since the introduction of the project as a describe result of the interaction with CCF? Please specify.

9. Do you believe that CHAs and Depot holders are helpful in providing some of the health services to the communities? Explain your responses.

10. Do you currently supervise CHAs and Depot holder? How often per year? How do you envision your role in supervising these people? Do you have any concerns about it? Will there be any constraints to do so? What additional support you may need to be involved in supervision?

11. Do you feel that CHAs have to supervise Volunteer mothers? Do you have a checklist to ask CHAs about their work? Does it include questions about the supervision of voluntary mothers? Can you show the checklist?

12. Did you receive any training from the CCF-CS project? How many times? On which topics? Were they useful? Were they adequate? Did they help you learn and use new skills? Are you using these skills in your work? Describe them.

13. What are your expectations of the project?

14. What steps need to be taken to further promote relationship?

15. Do you want the project to continue? Do you think activities started continue without CCF support? Explain how.

16. Do you feel you have adequate supplies, materials and equipment to operate successful services? If not, list your priority needs.

17. If an unimmunized child came to you at the age of 8 months, what antigens you are going to give him?

18. How much Vitamin A capsules (IU) should be given to post-partum mothers?

19. Name two danger signs of diarrhea requiring referral for medical care?

20. What key messages do you provide mothers about breastfeeding newborns?

21. What age is the best time to start additional foods to breast? Why do you think so? Which foods should be given? And how much?

## Health Workers Nurses and Health Assistants at Health Facilities

Name of interviewer: Date:
Name of interviewer: Position:

Introduction to interview.

How many years have you been in your position?

Where did you work before this posting?

What are your expectations of he evaluation underway?

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1. Can you tell me about the CCF project?

2. What is your role in the project? Describe the activities you undertake. Have your been involved in the major CCF activities such as the KPC survey, planning, training activities, etc.? Explain how.

3. What are the major constraints in undertaking your duties?

4. Have you received additional training from the CCF project? Please describe. Was the training useful and do you feel there are skills missing in your training? Please describe.

5. What are the monitoring and supervision mechanisms used to supervise your activities? Describe them and who provides them. How frequently is M/S done or visits made? Describe the purpose, and are they supportive?

6. What is your role in relation to CHAs and Depot Holders? Describe what you do on a routine basis.

7. Do you currently supervise CHAs and Depot holder? How often per year? How do you envision your role in supervising these people? Do you have any concerns about it? Will there be any constraints to do so? What additional support you may need to be involved in supervision?

8. Do you feel that CHAs have to supervise Volunteer mothers, and Depot Holders? Do you have a checklist to ask about their work? Does it include questions about the supervision of voluntary mothers and Depot Holders? Can you show the checklist?

9. How good are your relationships with CHAs and Depot Holders? Are the relationships useful? Do you have suggestions for improving relationships and role? How?

10. Do you think joint work with CCF was useful? Can you describe changes in service delivery since the introduction of the project? Describe what.

11. Did CCF support assist you in completing your duties? Describe.

12. Do you believe that CHAs and Depot Holders are helpful in providing services to the communities. Explain your response.

13. What are your expectations of the Project?

14. What do you think should be the approach to strengthen your performance in the future?

15. Do you want the project to continue?

16. Do you feel you have adequate supplies and materials to do your job?

17. An un-immunized child came to you at the age of 8 months, what antigens you are going to give him?

18. How much Vitamin A capsules (IU) should be given to post-partum mothers?

19. Name two danger signs of diarrhea requiring referral for medical care?

20. What key messages do you provide mothers about breast-feeding newborns?

21. What age is the best time to start additional foods to breast? Why do you think so? Which foods should be given? And how much?

## CHA – Volunteers

Name of interviewer: Date:
Name of interviewer: Position:

Introduction to interview.

How many years have you been in your position?

Where did you work before this posting?

What are your expectations of he evaluation underway?

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1. What can you tell me about the CCF-CS project?

2. What are your roles in the project? Describe the activities you undertake.

3. What is your role in mobilizing communities to participate in project activities?

4. Have you received training from the CCF project? Please describe. Was the training useful and do you feel there are skills missing in your training? Please describe.

5. What motivated you to join the project? How were you selected to be a CHA?

6. What are the difficulties you encounter in your work? Please describe.

7. Are you visited by health persons (MOH and or CCF) how often? Are supervision visits useful? Describe how. Do visits help you solve your problems? Please describe.

8. What is your relationship with Kebele, health facility, and CCF project? Do you receive adequate support? Please describe.

9. What is your relationship with communities and households? How do think communities feel about your services? Please describe.

10. What support do you receive from Kebele, health facility, and CCF? Is it adequate? Explain.

11. What support do you receive from your communities? Is it adequate? Explain.

12. What are your expectations of the Project?

13. Do you want the project to continue?

14. If you encounter an un-immunized child what do you do??? If this child was 8 months old, what antigens does he need?

15. How much Vitamin A capsules (IU) should be given to post-partum mothers?

16. Name two danger signs of diarrhea requiring referral for medical care?

17. What key messages do you provide mothers about breast-feeding newborns?

18. What age is the best time to start additional foods in addition to breast milk? Why do you think so? Which foods should be given? And how much?

**Depot Holders – Volunteers**

Name of interviewer: Date:
Name of interviewer: Position:

Introduction to interview.

How many years have you been in your position?

Where did you work before this posting?

What are your expectations of he evaluation underway?

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1. What can you tell me about the CCF-CS project?

2. What are your roles in the project? Describe the activities you undertake.

3. Have you received training from the CCF project? Please describe. Was the training useful and do you feel there are skills missing in your training? Please describe.

4. What motivated you to join the project? How were you selected to be a Depot Holder?

5. What are the difficulties you encounter in your work? Please describe.

6. Are you visited by health persons (MOH and or CCF) how often? Are you visited by CHAs and how often? Are supervision visits useful? Describe how. Do visits help you solve your problems? Please describe.

7. What is your relationship with Kebele, health facility, CCF project, and CHAs? Do you receive adequate support? Please describe.

8. What is your relationship with communities and households? How do think communities feel about your services? Please describe.

9. What support do you receive from Kebele, health facility, CCF, and CHAs? Is it adequate? Explain.

10. What supplies do you receive, how frequently, and from where?

11. What support do you receive from your communities? Is it adequate? Explain.

12. What are your expectations of the Project?

13. Do you want the project to continue?

14. What do you do when you encounter a child with diarrhea?

15. If you do not have sachets, what do you do?

16. Name two danger signs of diarrhea?

17. How much Vitamin A capsules (IU) should be given to post-partum mothers?

18. What key messages do you provide mothers about breast-feeding newborns?

19. What age is the best time to start additional foods in addition to breast milk? Why do you think so? Which foods should be given? And how much?

**Individual In-depth Interview (III) with Kebele Leaders**

1. What are the main problems (health and related) in this community? Do you believe that the project addresses the priority problems of your community? Explain your response.

2. Do you know the existence of the child survival project? To what extent do you know about it? Can you tell me what the project does? How did you know about it, i.e., what are your sources?

3. What benefits did the project bring to the community members? Tell us in more detail about it? Probe for the various benefits – health, monetary, etc.

4. To what extent did the project helped the community members to establish healthy behaviors for children ? Were health related messages given adequately? Were they useful? Was the approach acceptable?

5. What kinds of barriers exist to prevent members of the community from benefiting from the program?

6. Are you satisfied by the project activities and why do you think you are satisfied? Are residents of this community satisfied? What are the reasons for your response?

7. How do you generally feel about the project? Is it good? Do you like it? Do you have any reservations about it? Please explain your answers.

8. What did you expect the project to do for the community? How far do you think these expectations are met by the project? Please tell me about it in more details.

9. Do you think that community members have to be involved in the project activities? Why do you think so? How should be people be involved? Please, explain in detail.

10. What kinds of community mobilization activities have been undertaken by the project? What was the role of the kebele in the community mobilization activities?

11. How far did the residents of this community (including kebele officials) respond to the community mobilization (involvement) activities undertaken by the project? (Probe for – involvement in the various management functions. Also probe for the various contributions made by the residents – such as time, ideas, labor, money, infrastructure, etc.)

12. What kinds of barriers exist to prevent the members of the community from benefiting from the program?

13. Do you think that this project should continue operating in this area? Why do you think it should or not?

14. If it has to continue should it continue as it is or changes be made to it? What changes do you recommend? Please, explain your responses in detail.

**Additional questions to ask Kebele Leaders**

1. Is there currently a CHA posted in your Kebele?

2. Should CHAs be posted to Kebeles?

3. What do you want a CHA to do for you? (List roles and responsibilities).

4. How should/are CHAs be selected? (List criteria).

5. Who does/should supervise the CHA? (List answers).

## Questionnaire with Opinion Leaders

1. What are the main problems (health and related) in this community? Do you believe that the project addresses the priority problems of your community? Explain your responses.

2. Do you know the existence of the child survival project? To what extent do you know about it? Can you tell me what the project does? How did you know about it, i.e., what are your sources?

3. What benefits did the project bring to the community members? Tell us in more detail about it? Probe for the various benefits – health, monetary, etc.

4. To what extent did the project helped the community members to establish healthy behaviors for children? Were health related messages given adequately? Were they useful? Was the approach acceptable?

5. What kinds of barriers exist to prevent members of the community from benefiting from the program?

6. Are you satisfied by the project activities and why do you think you are satisfied? Are residents of this community satisfied? What are the reasons for your response?

7. How do you generally feel about the project? Is it good? Do you like it? Do you have any reservations about it? Please explain your answers.

8. What did you expect the project to do for the community? How far do you think these expectations are met by the project? Please tell me about it in more details.

9. Do you think that community members have to be involved in the project activities? Why do you think so? How should be people be involved? Please, explain in detail.

10. What kinds of community mobilization activities have been undertaken by the project?

11. How far did the residents of this community (including kebele officials) involve themselves in the project activities. (Probe for – involvement in the various management functions. Also probe for the various contributions made by the residents – such as time, ideas, labor, money, infrastructure, etc..)

12. What kinds of barriers exist to prevent the members of the community from benefiting from the program?

13. Do you think that this project should continue operating in this area? Why do you think it should or not?
14. If it has to continue should it continue as it is or changes be made to it? What changes do you recommend? Please, explain your responses in detail.

## Focus Group Discussion (FGDs) with Voluntary Mothers

1. What are the main problems (health and related) in this community? Explain your response.

2. Do you believe that the project addresses the priority problems of your community? Explain your response.

3. Are community members aware of the existence of the child survival project? To what extent do people know about it? Here probe discussion on the various interventions of the project? Can you tell me what the project does? How did people know about it, i.e., what are your sources?

4. To what extent did the project helped mothers to establish healthy behaviors for children? Were health-related messages given adequately? Were they useful? Was the approach acceptable?

5. What did mothers expect the project to do for the community? How far do you think these expectations are met by the project? What are the benefits obtained? Please tell me about it in more details.

6. Why do you think that community members should be involved in the project activities? Why do you think so? How far did residents of this community (including kebele officials) involve themselves in the project activities. (Probe for – involvement in planning, implementation, monitoring, evaluation. Also probe for the various contributions made by the residents – such as time, ideas, labor, money, infrastructure, etc...)

7. Does the project support you in anyway? If so, how? How frequently follow up visits were made by CCF staff? What was the purpose of the visits? Were these visits useful? Please discuss in detail.

8. Do community members consider your work useful? What made you say this?

9. What made you volunteer to take the assignment of teaching your fellow mothers in the community?

10. Discuss about your training – the strategy, how long was it, was it adequate, was it useful, did it prepare you enough for the job, etc? Did the training helped you to do new ways of doing things? Did it increase your knowledge/skills?

11. How do mothers/residents generally feel about the project? Is it felt as good? Do people like it? Do people have any reservations about it?

12. Do you think people would like to see the project continue? If it has to continue should it continue as it is or changes be made to it? What changes do you recommend? Please, explain your responses in detail.

**Elicit response from each mother and note number of mothers giving correct answers**

13. What is the importance with vaccinations? Do you believe it works? How many times your baby should come for vaccination before the age of one? If you don't have all the vaccinations why not?

14. Name two danger signs of diarrhea requiring referral for medical care?

15. Has your child taken this capsule? Do you know this capsule? Why is Vitamin A important (2 reasons) for health? What foods are rich in Vitamin A?

16. Why is it important to breastfeed right after birth, i.e., within 8 hours of birth? List all possible responses.

17. What age is the best time to start giving solid foods? Why do you think so?

## FGD with Beneficiary Mothers

1. What are the main problems (health and related) in this community? Explain your response.

2. Do you believe that the project addresses the priority problems of your community? Explain your response.

3. Are community members aware of the existence of the child survival project? To what extent do people know about it? Here probe discussion on the various interventions of the project? Can you tell me what the project does? How did people know about it, i.e., what are your sources?

4. To what extent did the project helped mothers to establish healthy behaviors for children ? Were health related messages given adequately? Were they useful? Was the approach acceptable?

5. What did mothers expect the project to do for the community? How far do you think these expectations are met by the project? What are the benefits obtained? Please tell me about it in more details.

6. Why do you think that community members should be involved in the project activities? Why do you think so? How far did residents of this community (including kebele officials) involve themselves in the project activities. (Probe for – involvement in planning, implementation, monitoring, evaluation. Also probe for the various contributions made by the residents – such as time, ideas, labor, money, infrastructure, etc...)

7. How do mothers/residents generally feel about the project? Is it felt as good? Do people like it? Do people have any reservations about it?

8. Do you think people would like to see the project continue? If it has to continue should it continue as it is or changes be made to it? What changes do you recommend? Please, explain your responses in detail.

**Elicit response from each mother and note number of mothers giving correct answers**

9. What is the importance of vaccinations? Do you believe it works? How many times your baby should come for vaccination before the age of one? If you don't have all the vaccinations why not?
10. Name two danger signs of diarrhea requiring referral for medical care?
11. Has your child taken this capsule? Do you know this capsule? Why is Vitamin A important (2 reasons) for health? What foods are rich in Vitamin A?
12. Why is it important to breastfeed newborns right after birth, i.e., within 8 hours of birth? List all possible responses.
13. What age is the best time to start giving solid foods? Why do you think so?

## Questionnaire: Knowledge

**Health workers: Health facility head/ Other workers/ CHAs**

Name of interviewer: Date: Area:

Circle type of respondent: Health facility head/ other health worker/ CHA

1. If an un-immunized child aged 8 months came to you, what antigens would you give him/her?
   Check off responses BCG ___, DPT ___, Polio ___, measles ___
   Circle: correct/ incorrect.

2. How much vitamin A (VAC) should be given to post-partum mothers?
   State in either number capsules or IUs
   Circle: correct/ incorrect.

3. By when (no later than) should a mother receive a VAC?
   State answer

   Circle: correct/ incorrect

4. Name two danger signs of diarrhea requiring referral to medical care?
   List answers

   Circle: correct/ incorrect

5. What key messages do you provide mothers about breast feeding newborns?
   List answers:

   Circle correct/ incorrect

6. At what age is the best time to start additional foods in addition to breast milk?
   List answer:

   Circle correct/ incorrect

7. What foods should be given? And how much should be given?
   List answers:

   Circle: correct/ incorrect

## Questionnaire: Knowledge

**Voluntary mothers and Beneficiary mothers**

Name of interviewer: Date: Area:

1. Do you have a child under five years of age? Yes / No
2. Do you have a health cards for the child? Yes/ No
3. What is the importance of vaccinations? List all answers.
4. How many times should your baby come for vaccinations before the age of one year?
5. Should mothers receive vaccinations? Yes/ No
6. Do you know what this is? Show a VAC Yes/ No
7. Has your child taken this capsule in the past 6 months? Yes/ No
8. Have you ever taken this capsule? Yes/ No
9. Why is vitamin A important? List all answers
10. What foods are rich in vitamin A? List all answers
11. Name two danger signs if diarrhea requiring referral to medical care?
12. Why is it important to breast feed right after birth, i.e., within 8 hours of birth? State answers.
13. What are is best time to start giving solid foods? List all answers.
14. Why do you think so?

## Annex F. Major Outputs: Training Workshops Conducted

| Course title | Purpose & Expected Output | Course Duration | No. of Persons attended | Target Trainees |
|---|---|---|---|---|
| 1) TOT on EPI for MOH staff | - EPI management at Health Facility & community level | - March 22-29/99 | 15 | - MOH staff (Nurses & HA) |
| 2) TOT on EPI for MOH staff | - EPI management at Health Facility & community level | - Sep. 20-24/99 | 10 | - MOH staff (Nurses & HA) |
| 3) Hearth | - Child feeding improvement at house hold level using the positive deviance approach | - May 23-25/2000 | 15 | - Volunteer Mothers |
| 4) Hearth | - Child feeding improvement at house hold level using the positive deviance approach | - June 30-July 1/00 | 19 | - Volunteer Mothers |
| 5) 1st Round refresher training for CHW | - Refresher training of CHA's & TBAs | - Feb. 22 - 29/99 | 24 | - CHW (Community Health Workers) |
| 6) 2nd Round refresher training for CHW | - EPI, DCM, Nutrition Vitamin 'A' & Breast Feeding promotion implementation and management at health facilities and community level. | - June 26-July 4/00 | 13 | - MOH staff (Nurse & HA) |
| 7) Introduction to all intervention | - Training of Kebele Health Committee members (2nd round) | July 3-5/2000 | 129 | - Kebele Health Committee |
| | - Training of Women & Youth | July 6-7/2000 | 84 | - Women & Youth Ass. members |
| | | July 12-14/2000 | 100 | - School club members |

| | | | | |
|---|---|---|---|---|
| | Association Members (2nd round)<br>- Training School Club Members (1st round)<br>- Training of Depot Holders (2nd round) | Aug 14-18/2000 | | - Depot Holders |

## Major Outputs (Training Workshops Conducted)

| Course title | Purpose & Expected Output | Course Duration | No. of Persons attended | Target Trainees |
|---|---|---|---|---|
| 1) 1st round TOT on DCM, BF and Nutrition/Vitamin A | - To train MOH-mid level health workers (nurses and health assistants) who could in turn take part in subsequent community health workers (CHAs, TBAs and Depot-holders) training as a trainer | - July 19-23, 1999 | 11 | - MOH mid-level health workers in the two Woredas (Debrebirhan and Basonaworena) |
| 2) 2nd round TOT on DCM, BF and Nutrition/Vitamin A | - To train MOH-mid level health workers (nurses and health assistants) who could in turn take part in subsequent community health workers (CHAs, TBAs and Depot-holders) training as a trainer | - August 16-20, 1999 | 15 | - MOH mid-level health workers in the two Woredas (Debrebirhan and Basonaworena |
| 3) 1st round Kebele Health Committee (KHC) training | - To enhance Kebele Health Committee members awareness on the project's interventions such as: DCM, EPI, BF and Nutrition/Vitamin 'A' | - July 2-4, 1999 | 9 | - KHC members, one from each Kebele in Debrebirhan Woreda |
| 4) 2nd round Kebele Health Committee (KHC) training | - To enhance Kebele Health Committee members awareness on the project's interventions such as: DCM, EPI, BF and Nutrition/Vitamin 'A' | - Sep. 22-24, 1999 | 30 | - KHC members, one from each kebele in Debrebirhan Woreda and from 21 Kebeles in Basonaworena Woreda |
| 5) 3rd round Kebele Health Committee (KHC) training | - To enhance Kebele Health Committee members awareness on the project's interventions such as: DCM, EPI, BF and Nutrition/Vitamin 'A' | - Jan. 17-19, 2000 | 10 | - KHC members in Debrebirhan Woreda |
| 6) 3rd round Kebele Health committee (KHC) training | - To enhance Kebele Health Committee members awareness on the project's interventions such as: DCM, EPI, BF and Nutrition/Vitamin 'A' | - Jan. 26-28, | 22 | - KHC members |

| | | | | |
|---|---|---|---|---|
| 7) 1st round integrated refresher training<br><br>8) Training of Kebele Health Committee Members (1st round) | - To expedite the knowledge and skills of health workers, so as to improve quality of care (at health facility level) on the area of DCM, EPI, BF and Nutrition/Vitamin A<br><br>- To enhance the role of KHC members in organizing and leading preventive child health endeavors in general, and on project's interventions such as: EPI, DCM, BF and nutrition/vitamin A in particular. | 2000<br><br>- April 17 - 26, 2000<br><br>- April 5-7, 2000 | 15<br><br>93 | selected from 21 Kebeles in Basonaworena Woreda<br><br>- MOH mid-level health workers in the two Woredas (Debrebirhan and Basonaworena)<br>- Selected members of KHC from nine Kebeles in Debrebirhan Woreda. |

| Course title | Purpose & Expected Output | Course Duration | No. of Persons attended | Target Trainees |
|---|---|---|---|---|

| | | | | |
|---|---|---|---|---|
| 9) Community mobilization & sensitization | - To review the two Woredas community sensitization programs, and to introduce sound community sensitization programs and mobilization methods | March 30 - 31, 2000 | 10 | - The two Woredas (Debrebirhan and Basonaworena) health office staff |
| 10) Training of kebele leaders | - To highlight on major childhood health problems (with due emphasis on project's interventions) and the role kebele leaders in community mobilization and sensitization | March 27 and 28, 2000 | 39 | - Nine kebele leaders in Debrebirhan Woreda, and 25 kebeles in Basonaworena. |
| 11) Training of women and youth association members (1st round) | - To enhance the members' knowledge on the project's interventions such as DCM, EPI, BF and Nutrition- vitamin A. Besides, efforts have been made to maximize members' contribution on community health activities at their vicinities. | March 27 and 28, 2000 | 88 | - Members of the two associations in Debrebirhan and Basonaworena Woreda |
| 12) Depot-holders training (1st round) | - To equip with key message of project's interventions so as to create health promoters at a grass root level | March 27 to 29, 2000 | 107 | - Selected community members from each kebeles in Debrebirhan and Basonaworena Woreda |
| 13) Training of kebele health committee members | - To refresh members on the project's interventions such as DCM, EPI, BF and Nutrition/Vitamin A. | July 6-8, 2000 | 127 | - KHC members from all kebeles at Debrebirhan and Basonaworena Woredas. |
| 14) Training of kebele health committee | - To review health endeavors in the respective kebeles and, therefore, to improve grass root participation in their health endeavors. | July 12-14, 2000 | 39 | - KHC members from kebeles in Debrebirhan |
| 15) Communication skills and | | June 10 to 11, 2000 | 22 | |

| | | | | |
|---|---|---|---|---|
| utilization of communication materials<br><br>16) Training to CHAs | - To introduce the concept of communication and communication strategies, so as to improve the participants' knowledge and skills in communication & the use of communication materials.<br><br>- To train auxiliary health workers who can give service at community level | Feb. 7 to May 10, 2000 | 22 | and Basonaworena Woredas<br><br>- Zonal and Woreda MOH staff, teachers and Woreda council members<br><br>Nine from each kebeles in Debrebirhan Woreda, and the remaining 13 form Basonaworena Woreda |

## Annex G Evaluation of the Evaluation Process*

Number of responses = 9 (core evaluation team did not participate)

**1. What comments do you have about the evaluation approaches?**

*-Approach was good. Tried to involve all levels (zone, woreda, kebele)*
*-Can be taken as an example to other NGOs*
*It enabled the team to know:*
*a) What has been accomplished;*
*b) Roles of the stakeholders;*
*c) Level of community participation;*
*d) Relationships of the project.*

2. **What have you learned from the evaluation process?**

*Learned techniques of the evaluation process: data collection, compilation, flipchart analysis, affinity charts etc. also learned more about the project objectives. Learned priority problems of the community; needs and expectations. Evaluation skills that can be use in my own work.*

3. **Do you believe that the evaluation process has utilized all possible ways to look into all aspects of the project efforts?**

*Yes (all respondents) It has compared many issues: training partnerships, resources allocation, skills and knowledge. It has also included the different levels of community organization (zone--- to-- community)*

4. **Do you believe that the methods used in this evaluation were appropriate? How?**

*Yes appropriate methods (all respondents). Included people at all levels, it asked knowledge questions to the trainees, questions were clear, affinity chart helped a lot. Approach was participatory among stakeholders, starting from orientation through data gathering, compilation and preliminary analysis*

**5. Was the evaluation period adequate?**

*Yes, timing was adequate, Team were comfortable with the days doing the field activity. More or less, all of the sample groups were covered*
*One respondent noted time was short.*

**6. Was the evaluation well planned? Was it well coordinated?**

*Yes. Activities were undertaken exactly as per the proposed timetable. Organized teams were active. Included all partners so as to employ the various*

*expertise. In many of the sample areas, people were readily available to facilitate the process. One respondent noted that is was okay but some of the team members were not included in the planning workshop (with the core team) in Addis with the core team, making it difficult to say whether or not it was well planned.*

***Additional Note***: Feedback from CCF staff – Skills to do PAR significant transfer of evaluation process (tools). Dr. Tadesse – learned well the limitations of the project especially networking levels in the community – enabled to elaborate future steps. Very comfortable with process and evaluation.

Tabulated by Dr. Tadesse (IEF/CCF)

Annex H Summary of CCF/Ethiopia Strategic Plan

# THE NEW DIRECTIONS AND STRATEGIES OF CCF Inc.

## ETHIOPIA

## VISION, AND MISSION OF CCF INC. ETHIOPIA


**CCF Inc. Ethiopia aspires to see all children of Ethiopia grow up in a situation where their developmental needs are met and become productive adults that ensure the growth and development of successive generations.**

## MISSION:

**CCF Inc. Ethiopia is dedicated to Promote and enhance the well being of disadvantaged children in various regions of Ethiopia as much as resource permits by improving access to health, education and economic development services through one to one sponsorship and non-sponsorship program, in the context of the family and community On the basis of developmental approaches of national and area based indigenous partners.**

## STRATEGIES

**The Aim/Purpose of The New Strategies:**

To position CCF Inc Ethiopia advantageously to fully realize its mission and Goals by strategically tackling existing and emerging internal and external challenges.

*Major Considerations:*

⇒ Government policies and guidelines and other external environment within which CCF Inc. Ethiopia & its projects operates

⇒ The needs and expectation of stakeholders,

⇒ The internal environment within which CCF Inc. Ethiopia & its projects operates

**Direction:**

⇒ Improving effectiveness, cost efficiency, credibility, publicity, etc, of CCF Ethiopia as whole.

⇒ A paradigm shift, giving due emphasis to integrated area development programs, is an essential element in development efforts.

⇒ Curtail certain programs that are not sustainable and do not entail significant impact, and also fail to win the appreciation of government partners and project participants/ communities.

Goal 1: *Enhanced Organizational capacity and management system of CCF Inc. Ethiopia in child, family and community development programs.*

- Establishing clear organizational arrangement and functional relationships and roles for the Advisory Board, National Office, Project Offices (Project Committee and Project Administrators)
- Building the capacity of the National office and projects by putting in place resourceful staff, efficient management system and appropriate facilities.
- Establishing appropriate human resource development system: motivation, performance appraisal, promotion, salary enhancement, training, etc
- Establishing clear extension modality and service delivery system (that will enable CCF to get closer to the community and target the beneficiaries more, and sharing costs of development interventions with counterparts.)
- Establishing standard financial policies and procedures that ensure, efficiency, accountability, cost effectiveness, financial control and transparency
- Establishing appropriate planning, monitoring, evaluation, reporting and re-planning system for program quality improvement.
- Establishing appropriate information management and communication system.(to make sure that information will be properly documented and be accessible whenever needed.)

- Establishing appropriate Phase–in and phase-out strategies/ procedures (Phase-in and Phase-out in CCF's context will have three levels namely: Area,- Program and Child)
- Developing and implementing appropriate modality for strategic partnering with GOs and NGOs to facilitate its operation.

*Goal 2: Reach more needy children and communities*

- Raise total number of enrolled children (20,500 25,000) →
- Improve quality and efficiency of sponsor relation services.
- Establish diversified fund raising strategies

*Goal 3: Improved health and nutrition status of children and beneficiary families*

- Improving immunization coverage of children and mothers.
- Improve coverage of environmental health services and practices.
- Improve access to MCH and FP service.
- Raise knowledge and awareness of community on HIV/ AIDS prevention, and control and prevention of malaria
- Improving accessibility to basic health facilities/ services
- Improve access to proper nutrition

*Goal 4 Improved educational status and quality of children and beneficiary families.*

- Improve access to basic education
- Enhance functional literacy for Adolescents and adults
- Raise the level of awareness of families and children on the right of a child
- Improve efficiency and quality of basic education.
- Promote the girl child education by Providing special educational support for enrolled girls their female siblings to eliminate gender disparity in education

*Goal 5: Improved food security status of children and beneficiary families.*

- Enhance crop and livestock production capacity of rural community
- Enhance effective utilization available water resources in rural area.
- Promote soil and water conservation practices in rural areas.
- Improve preparedness and response to Emergency Situation

*Goal 6 Improved income and livelihood_status of beneficiary families.*

- ✞ Enhance income generation Capacity of families of enrolled children through MSE
- ✞ Enhance income generation capacity of enrolled older youth through skill training and start-up financial support

## Goal 7: Ensure growth, development and learning of Children

- ✞ Improve access to early child hood care and development (ECCD) services
- ✞ Educate/train parents on appropriate child care.
- ✞ Implement cost effective community centers with innovative and flexible programs
- ✞ Capacity building of traditional pre schools

## Annex I Project Pipeline And Expenditures

(Insert electronically)

PVO/COUNTRY: ETHIOPIA

DATE SUBMITTED TO USAID

Cooperative Agreement No. FAO-A-00-99-00018-00

# PIPELINE ANALYSIS: PART C - HEADQUARTERS/FIELD

E:\Program Areas\Avoid Blindness\CS-VA\Ethiopia\Budget\Pipeline2

*(Inclusive expenditure Eritrea and Ethiopia)*

| | | Actual Expenditures to Date 09/30/95 to 06/30/00 | | | Projected Expenditures Against Remaining Obligated Funds 07/01/00 to 09/29/00-12/29/00 | | | Total Agreement Budget (Columns 1 & 2) 09/30/95 to 09/29/99-12/29/00 | | |
|---|---|---|---|---|---|---|---|---|---|---|
| I. DIRECT COSTS | | AID | PVO | TOTAL | AID | PVO | TOTAL | AID | PVO | TOTAL |
| A. PERSONNEL (salaries, wages, fringes) | 1. Headquarters-wages/salar | 68,314 | 12,745 | 81,059 | -19,275 | 17,409 | -1,866 | 49,039 | 30,154 | 79,193 |
| | 2. Field, Technical Personnel-wages/salaries | 23,724 | 15,702 | 39,426 | 0 | 0 | 0 | 23,724 | 15,702 | 39,426 |
| | 3 Field, Other Personnel-wages/salaries | -943 | -1,000 | -1,943 | 943 | 1,000 | 1,943 | 0<br>0 | 0<br>0 | 0 |
| | 4. Fringes - Headquarters + | 26,512 | 7,124 | 33,636 | -8,083 | 5,193 | -2,890 | 18,429 | 12,317 | 30,746 |
| | SUBTOTAL - PERSONNEL | 117,607 | 34,571 | 152,178 | -26,415 | 23,602 | -2,813 | 91,192 | 58,173 | 149,365 |
| B. TRAVEL/PER DIEM | 1 Headquarters - Domestic | 2,861 | 858 | 3,719 | 2,828 | 3,585 | 6,413 | 5,689 | 4,443 | 10,132 |
| | 2. Headquarters - Internation | 15,048 | 7,080 | 22,128 | 13,853 | 0 | 13,853 | 28,901 | 7,080 | 35,981 |
| | 3. Field - in country | 9,492 | 0 | 9,492 | 0 | 0 | 0 | 9,492 | 0 | 9,492 |
| | 4. Field - International | 6,253 | 2,433 | 8,686 | -478 | 1 | -477 | 5,775 | 2,434 | 8,209 |
| | SUBTOTAL - TRAVEL/PER D | 33,654 | 10,371 | 44,025 | 16,203 | 3,586 | 19,789 | 49,857 | 13,957 | 63,814 |
| C. CONSULTANCIES | 1. Evaluation Consultants - F | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | 2. Other Consultants - Fees | 5,525 | 0 | 5,525 | -2,525 | 0 | -2,525 | 3,000 | 0 | 3,000 |
| | 3. Consultant travel/per diem | 3,255 | 175 | 3,430 | 0 | 0 | 0 | 3,255 | 175 | 3,430 |
| | SUBTOTAL - CONSULTANCI | 8,780 | 175 | 8,955 | -2,525 | 0 | -2,525 | 6,255 | 175 | 6,430 |
| D. PROCUREMENT (provide justification/explan narrative) | 1. Supplies | | | | | | | | | |
| | a. Headquarters | 63 | 834 | 897 | 1,832 | -115 | 1,717 | 1,895 | 719 | 2,614 |
| | b. Subgrants CCF | 256,000 | 222,306 | 478,306 | 462,802 | -12,786 | 450,016 | 718,802 | 209,520 | 928,322 |
| | c. Field - Other | 1,838 | 615 | 2,453 | 0 | 0 | 0 | 1,838 | 615 | 2,453 |
| | 2 Equipment | | | | | | | | | |
| | a. Headquarters | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | b. Field | -595 | 3,513 | 2,918 | 595 | -595 | 0 | 0 | 2,918 | 2,918 |
| | 3 Training | | | | | | | | | |
| | a. Headquarters | 1,038 | 87 | 1,125 | -38 | -75 | -113 | 1,000 | 12 | 1,012 |
| | b. Field | 1,275 | 0 | 1,275 | 0 | 0 | 0 | 1,275 | 0 | 1,275 |
| | SUBTOTAL - PROCUREMEN | 259,619 | 227,355 | 486,974 | 465,191 | -13,571 | 451,620 | 724,810 | 213,784 | 938,594 |
| E. OTHER DIRECT COSTS (provide justification/explana narrative) | 1. Communications | | | | | | | | | |
| | a Headquarters | 200 | 1,980 | 2,180 | 840 | 3,865 | 4,705 | 1,040 | 5,845 | 6,885 |
| | b. Field | 1,747 | 0 | 1,747 | 0 | 0 | 0 | 1,747 | 0 | 1,747 |
| | 2 Facilities | | | | | | | | | |
| | a. Headquarters | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | b. Field | 14,005 | 4,200 | 18,205 | 0 | 0 | 0 | 14,005 | 4,200 | 18,205 |
| | 3. Other | | | | | | | | | |
| | a. Headquarters | 132 | 165 | 297 | 7,368 | 0 | 7,368 | 7,500 | 165 | 7,665 |
| | b. Field | 13,464 | 5,340 | 18,804 | -4,858 | -3,600 | -8,458 | 8,606 | 1,740 | 10,346 |
| | SUBTOTAL - OTHER DIRECT | 29,548 | 11,685 | 41,233 | 3,350 | 265 | 3,615 | 32,898 | 11,950 | 44,848 |
| TOTAL - DIRECT COSTS | | 449,208 | 284,157 | 733,365 | 455,804 | 13,882 | 469,686 | 905,012 | 298,039 | 1,203,051 |
| II. INDIRECT COSTS | | | | | | | | | | |
| A. INDIRECT COSTS | 1. Headquarters | 36,980 | 8,230 | 45,210 | -6,266 | 5,591 | -675 | 30,714 | 13,821 | 44,535 |
| | 2. Field (if applicable) | | | | | | | | | |
| TOTAL - INDIRECT COSTS | | 36,980 | 8,230 | 45,210 | -6,266 | 5,591 | -675 | 30,714 | 13,821 | 44,535 |
| GRAND TOTAL (DIRECT AND INDIRECT | | 486,188 | 292,387 | 778,575 | 449,538 | 19,473 | 469,011 | 935,726 | 311,860 | 1,247,586 |

# Combined IEF and CCF Expenditure