C-CHANGE
COMMUNICATION FOR CHANGE

C-CHANGE ETHIOPIA

FINAL REPORT

September 2013

USAID
FROM THE AMERICAN PEOPLE

ETHIOPIANS AND AMERICANS IN PARTNERSHIP TO FIGHT HIV/AIDS

CDC
USAID
FROM THE AMERICAN PEOPLE
President's Malaria Initiative

C-CHANGE ETHIOPIA

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ACKNOWLEDGMENTS

C-Change Ethiopia worked with the following governmental and non-governmental partners to support the project's objective to bring about social and behavior change using communication programs for malaria prevention and control activities and for increased uptake of ANC, PMTCT, and MNCH practices.

Government Partners

Federal Ministry of Health (FMOH)
Amhara Regional Health Bureau (ARHB)
Oromia Regional Health Bureau (ORHB)

Sub-Grantees

EFDA
MCMDO
Save Your Generation

FBOs

Ethiopian Orthodox Tewahedo Church

NGO Partners

CARE Ethiopia
Fayaa Integrated Development Organization (FIDO)
Integrated Family Health Program (IFHP)
UNICEF
Malaria Consortium
Anti-Malaria Association (AMA)
The Carter Centre
CRDA/Core Group Ethiopia
International Centre for AIDS Care Program (ICAP)
Ethiopian Malaria Control Professionals Association
Coalition Against Malaria in Ethiopia (CAME)
Research Triangle Institution (RTI)
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Integrated Family Health Program (IFHP)
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ACRONYMS

AA	Associate Award
AED	Academy for Educational Award
ARHB	Amhara Regional Health Bureau
ANC	Ante-natal Care
AIDS	Acquired Immune Deficiency Syndrome
CBO	Community Based Organization
CC	Community Conversation
CJTF-HOA	Combined Joint Task Force – Horn of Africa
DHS	Demographic Health Survey
EMA	Essential Malaria Actions
EOTC	Ethiopian Orthodox Tewahedo Church
FIDO	Fayaa Integrated Development Organization
FMOH	Federal Ministry of Health
GoE	Government of Ethiopia
HIV	Human Immune Virus
HDA	Health Development Army
HEW	Health Extension Worker
HSDP	Health Sector Development Plan
IRS	Indoor Residual Spraying
ITN	Insecticide Treated Net
JHU/CCP	John Hopkins University Center for Communication Programs
LLIN	Long-lasting Insecticide Treated Net
LQAS	Lot Quality Assurance Survey
LWA	Leader With Associates
M&E	Monitoring and Evaluation
MIS	Malaria Indicator Survey
MNCH	Maternal Newborn Child Health
MSH	Management Sciences for Health
NGO	Non-governmental Organization
NMCST	National Malaria Control Support Team
OHRB	Oromia Regional Health Bureau
PCV	Peace Corps Volunteer
PEPFAR	President's Emergency Plan For AIDS Relief
PMI	President's Malaria Initiative
PMTCT	Prevention of Mother to Child Transmission (of HIV)
RHB	Regional Health Bureau
SBCC	Social and Behavior Change Communication
TBA	Traditional Birth Attendant
TOT	Training of Trainers
TWG	Technical Work Group
vCHW	Voluntary Community Health Worker
WASH	Water, Sanitation, and Hygiene

THE C-CHANGE ETHIOPIA STORY

Introduction

In September 2008, USAID/Ethiopia awarded a four-year Associate Award (AA) to Communication for Change (C-Change)[1] under a Leader-with-Associates (LWA) Award. Funding support was received from the President's Malaria Initiative (PMI) and the President's Emergency Plan for AIDS Relief (PEPFAR). The C-Change Ethiopia AA was awarded a one-year extension through September 27, 2013 to finalize its SBCC interventions.

Over its five years of operation, C-Change Ethiopia, through FHI 360 and core partners CARE International and Internews, has provided support to the Federal Ministry of Health (FMOH) by bringing a mix of skills, experience, and creativity to the design and implementation of high impact communication strategies. Its work involved the use of mass media, interpersonal communication, community engagement, and participatory training to empower Ethiopian families to take malaria prevention and antenatal care/maternal and child health/prevention of mother-to-child transmission of HIV (ANC/MNCH/PMTCT) actions that have helped improve health status.

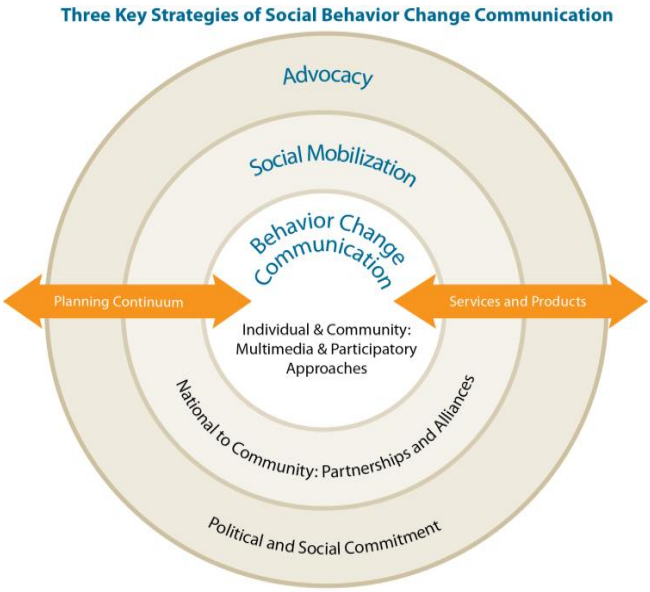
C-Change worked to streamline formative research and pre-testing methods and developed numerous easy-to-use, frontline teaching tools and short skills-based trainings that could be managed by *woreda* and *kebele* level teams and which were also used by other implementers working on related interventions. C-Change has strengthened the capacity of regional, *woreda*, and *kebele* structures to create affordable and sustainable interventions that resonate with key audiences to achieve USAID's objectives, including:

- Establishing and sustaining a culture for long-lasting insecticidal nets (LLINs), including increased demand for LLINs, increased LLIN ownership and correct and consistent use, especially among the most vulnerable groups (pregnant women and children under five);
- Increasing community awareness about the effectiveness of indoor residual spraying (IRS) and facilitating reduced re-plastering;
- Improving treatment-seeking behavior for malaria (e.g., timeliness, appropriateness)
- Increasing community knowledge regarding malaria diagnosis, treatment, prevention, and control;
- Integrating HIV/AIDS programming with the activities of the PMI in Ethiopia to increase uptake of PMTCT services by boosting ANC visits and enrolling women in PMTCT services in Amhara and Oromia; and
- Increasing capacity and involvement of local NGOs in malaria prevention and control.

[1] The C-Change Leader was a five-year cooperative agreement with the USAID Bureau for Global Health, which began on September 25, 2007 and completed on December 31, 2012. C-Change provided state-of-the-art support to USAID Missions and their partners in designing, planning, implementing and evaluating communication activities and ensuring that communication innovations, best practices, and lessons learned were developed and disseminated.

The Role of Health and Development Communication

The field of health and development communication has evolved over time. Programming in this area encompasses a broad range of activities and approaches which focus on the individual, community, and environmental influences on behavior and social change. Projects spanning three decades in various sectors have worked to reduce fertility; decrease morbidity and mortality of women, infants and children; reduce risky behaviors; improve agricultural production; promote democracy and civil society; and protect the environment.



SOURCE: Adapted from McKee, N. Social Mobilization and Social Marketing in Developing Communities (1992)

Terms such as information, education and communication (IEC), health education, behavior change communication (BCC), social marketing, health communication, communication for social change (CFSC), and **social and behavior change communication (SBCC)** have been used to describe this field. It defines the art and practice of informing, influencing, and motivating individuals, communities, institutional and public audiences about important health and development issues. As a key component of public health and other development areas, the field has evolved to use measurable objectives and evaluation methods, and is fed by multiple disciplines. As part of this evolution, behavior change has moved away from the linear expert-learner or sender-receiver paradigm to transfer information, and seeks to engage audiences in ongoing and meaningful dialogue where influence flows in both directions. Popular BCC methodologies emphasize persuasion and negotiation with the individual or community for changes affecting knowledge, attitudes, behaviors, and practices. An alternate framework for intervention, CFSC emphasizes focusing on empowerment of community members through dialogue and problem-solving. This approach locates individual behavioral risks and vulnerabilities within the broader community and social context.[2] As a combination of both approaches, **SBCC** makes a conscious and consistent effort to address social factors that influence health and development within a socio-ecological framework. While change often starts with an individual, it needs to be manifested in social norm change, group change, policy or structural change in order to be sustainable. This is achieved through communication oriented towards advocacy in the political and cultural domain, social and community mobilization to expand participation and foster collaboration, and communicating in relation to individual risk and vulnerability.[3]

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[2] Figueroa, M E, D L Kincaid, M Rani, & G Lewis. 2002. *Communication for Social Change: An Integrated Model for Measuring the Process and Its Outcomes. New York: the Rockefeller Foundation.*

[3] C-Change. 2012. *C-Modules: A Learning Package for Social and Behavior Change Communication (SBCC).* Washington DC: C-Change/FHI 360.

C-Change's Strategic Approach

From September 2007, the C-Change Project has been a key partner in USAID's efforts to provide leadership across sectors in the field of **SBCC**. C-Change, through it Leader and Associate Awards across the globe, including C-Change Ethiopia, has articulated and promoted this approach which recognizes that the determinants of behavior and social change exist on multiple levels and need to be addressed beyond the individual to include macro-influencers of behavior. This report details the research, implementation, and capacity strengthening activities and interventions in Ethiopia, which has resulted in improved systems and processes to facilitate the application of SBCC and ensure its sustainability.

Over the past five years, C-Change Ethiopia has applied the key SBCC strategies of advocacy, social motion and behavior change communication that have enabled it to produce effective communication materials and tools, provide multi-tiered trainings, and establish productive partnerships to reach many targeted communities with SBCC interventions.

At the core of the strategic approach the project followed six sub-strategies. These strategies included:

Strategy 1: Use research to inform and guide problem analysis, strategy development, and programmatic design.

Strategy 2: Actively engage the community by leveraging existing structures and community Health Extension Workers (HEWs) and volunteer community health workers (vCHWs) and/or Health Development Army (HDAs) volunteers to mobilize communities for action to control malaria and increase uptake of ANC/PMTCT and MNCH services.

Strategy 3: Reinforce interpersonal interventions with the of use mass media to promote essential actions to families and foster interpersonal messages in all aspects of malaria prevention and control and ANC/MNCH and PMTCT; use integrated messaging (i.e. malaria and ANC/MNCH/PMTCT) in line with the Ethiopian national communication strategy, and, where appropriate, reinforced through community level action.

Strategy 4: Strengthen capacity in communication by continuing to provide SBCC training at all levels of the Oromia Regional Health Bureau (ORHB), Amhara Regional Health Bureau (ARHB), Southern Nations and Nationalities People's Region (SNNPR) and other Regional Health Bureaus (RHBs) structure, emphasizing practical communication applications and establishment of a mentoring relationship.

Strategy 5: Strengthen partnership and the linkages among stakeholders (e.g. health centers, HEWs, vCHWs, local organizations, schools, and individual families) to build a cohesive, comprehensive effort to boost ANC/MNCH service utilization and to prevent MTCT of HIV as well as malaria control.

Strategy 6: Ensure the sustainability of prevention and control after project completion through robust capacity building at the local, regional and federal levels. This involves the transfer of knowledge and the training of a critical mass of in-country SBCC experts, support in message development and preparation of SBCC materials and tools. The aim is to develop the expertise along with advocacy and social mobilization and the ultimate transfer of ownership of the intervention effort to the local leadership, service providers, and the community.

MALARIA PREVENTION INTERVENTION

Introduction: Malaria in Ethiopia

It is estimated that approximately 68% of the Ethiopian population, approximately 62 million people, live in areas below 2,000 meters, and thus are at risk of malaria. Historically, the unstable nature of malaria transmission has been characterized by frequent focal and cyclical epidemics which reach national scale at irregular intervals of five to eight years.

In the Ethiopian highlands, several large-scale epidemics have been documented since 1958. That year, an estimated 150,000 people died during a widespread epidemic of malaria and several major epidemics have been reported since that time. Increasing numbers of cases were reported in the highlands and highland-fringe areas in 1988 and 1991–92 time periods, associated with abnormally high temperatures. In 1997-1998, widespread epidemics also occurred in the highlands. In the most recent national scale epidemic of 2003-2004, more than 2 million clinical malaria cases and 3,000 deaths were reported from 3,368 villages in 211 districts.

A review of the Ethiopian National Malaria Indicator Survey (MIS) 2011[4] indicates that there were significant gains in prevention and control, while also showing that considerable gaps still remained. According to FMOH, in 2009-2010, malaria was among the ten leading causes of inpatient deaths among children under the age of five.

Implementing malaria prevention and control intervention

Initially, C-Change Ethiopia's malaria prevention program was designed to assist vulnerable communities to protect themselves from malaria transmission by gathering data about the knowledge, attitudes, and practices related to malaria communication in the Oromia Region of Ethiopia. Ethiopia has a diverse population with the vast majority of people living in rural areas. In addition to broad cultural diversity, there are relatively low literacy levels and limited access to professional health care throughout the country, with many areas remote and inaccessible. Although literacy and access to health care are rapidly improving as a result of accelerated national development, circumstances vary from place to place.

[4] Ethiopian Health and Nutrition Research Institute. *Ethiopia National Malaria Indicator Survey 2011*. September 2012. http://www.unicef.org/ethiopia/ET_MIS_2011_Report.pdf

With a view to an effective use of limited resources, C-Change and the Oromia Regional Health Bureau (ORHB) selected and prioritized areas with highly vulnerable populations as the primary targets of its interventions. C-Change's preliminary research within the target communities produced the findings that formed the basis for its strategy and activities. The research showed that most community members were aware of (i.e., had knowledge of) the causes, symptoms, mode of transmission, and prevention methods of malaria, although there were many members with misconceptions about its cause, transmission, and treatment. For example, some people believe malaria is transmitted via cooking utensils, breathing, and eating certain types of food.

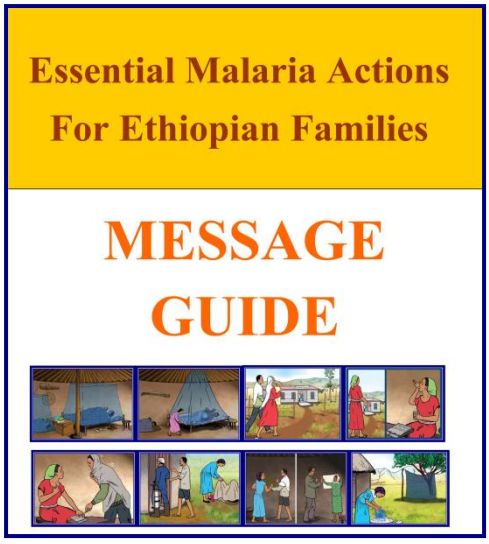
The **Family Health Sticker** is displayed on the entry door to the household and shows that the family has successfully carried out the 4 doable actions to prevent malaria.

While almost all who were surveyed knew about the benefits of insecticide-treated nets (ITNs)—reported by 74% of respondents as the most important method of malaria prevention—and indoor residual spraying (IRS); incorrect use of ITNs, fear of the side effects of IRS, and re-plastering after spraying were contributing factors to reduced effectiveness of malaria prevention activities. The majority of respondents (62.7%) were also aware that malaria was transmitted through mosquito bites and that mosquitoes usually bite people at dusk or during the night. Some 80% of participants reported that malaria is a preventable disease.

A significant finding was that one of the most common causes of delay in seeking early treatment is the tendency to resort to traditional remedies such as herbal medicines and holy water or going to traditional healers. On the other hand, the most commonly mentioned and trusted sources of information were health workers.

Message Harmonization

C-Change moved to next steps and developed the messages it would deliver to the communities it aimed to reach. The messages had to be crafted to create awareness as well as doable actions for malaria prevention and control that could be carried out easily by the targeted households.



EMA Message Guide developed by C-Change for use by Ethiopian families.

C-Change was aware that its own program interventions would be one of many and that reaching consensus and harmonization of messages among key stakeholders was critical to the overall effectiveness of the national effort to tackle malaria.

At the time, there were several ongoing communication activities; however, it was apparent campaigns were not originating from a common set of key messages. There were communication guidelines for

malaria that can assist or guide partners in developing messages. Following a micro-planning workshop with key stakeholders, it was recommended that members collect, analyze existing messages, and develop standards for developing messages.

To that end, C-Change organized a two-day workshop in November 2008 to streamline the process and maximize the impact of malaria communication activities. Workshop participants included members of the National Malaria Control Support Team (NMCST) and key PMI-supported partners involved in malaria prevention and control activities across Ethiopia.

Following the workshop, C-Change assisted with the establishment of a National Communication Taskforce. The taskforce was chaired by the FMOH and worked closely with the Oromia Regional Health Bureau and other stakeholders. In February 2009, C-Change conducted a final message harmonization workshop, during which the taskforce identified and validated malaria health actions at the family and community level. The team identified and prioritized eight Essential Malaria Actions (EMAs), which are crucial to malaria prevention and control.

Following the workshop, these EMA messages with draft illustrations were pre-tested in different areas of the country. Findings were analyzed and presented to the Malaria Communication Taskforce during a Message Finalization Workshop in April 2009.

During that workshop, participants provided further comments on the eight messages and illustrations. The outcome was a final draft with illustrations and messages, which were again pre-tested. The resultant EMA messages and guidance were published as the *EMAs for Ethiopian Families Message Guide*.

Meeting the Challenge

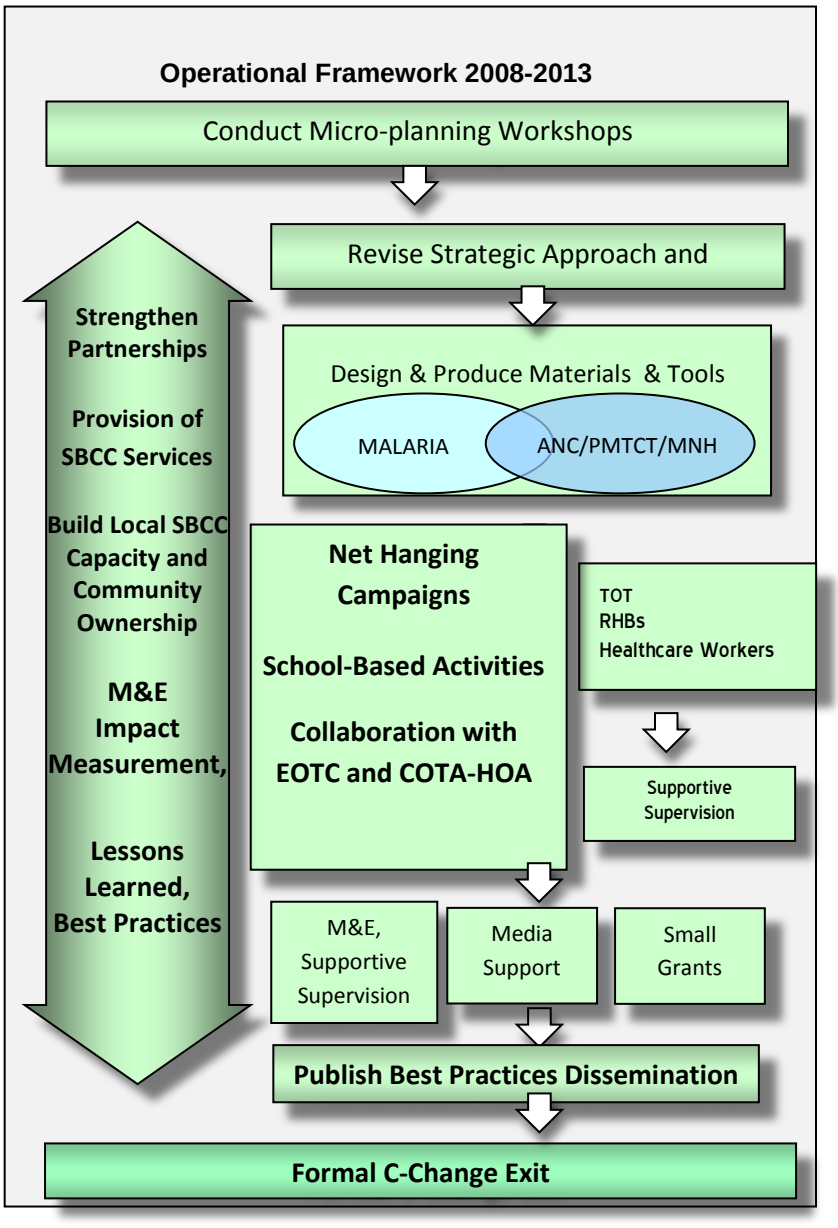
C-Change Ethiopia's strategy was centered on the application of SBCC, using three key strategies: advocacy, social and community mobilization, and behavior change communication to influence social conditions and individual behaviors. This process includes a comprehensive, socio-ecological model to identify effective tipping point for change that include a number of elements, e.g., the active engagement of the community, strengthening interpersonal communication at the service delivery level, ensuring sustainability by strengthening capacity in communication, and the establishment of linkages and collaboration among partners and stakeholders.

C-Change developed an operational framework to guide the implementation plan and achieve the strategic objectives. A wide range of SBCC materials and tools were prepared, based on the essential malaria actions, to deliver the messages that had been developed. Materials were developed for use at the household and community level, during interpersonal communication (IPC), and community conversations (CC), while other materials were designed for training purposes and for use at health facilities. The materials included flipcharts used for group presentations; malaria posters, malaria scorecards and stickers for household use; leaflets on LLIN use and maintenance, and a training-of-trainers (TOT) facilitator's guide. All materials were developed in the respective languages of the communities and included Amharic, Oromiffa, and Tigrigna.

The next step was to reach the communities, households, and other stakeholders such as health facilities, to create awareness, assist effective implementation, and build national and local capacity for a sustainable effort to prevent and control malaria.

C-Change Ethiopia Operational Framework

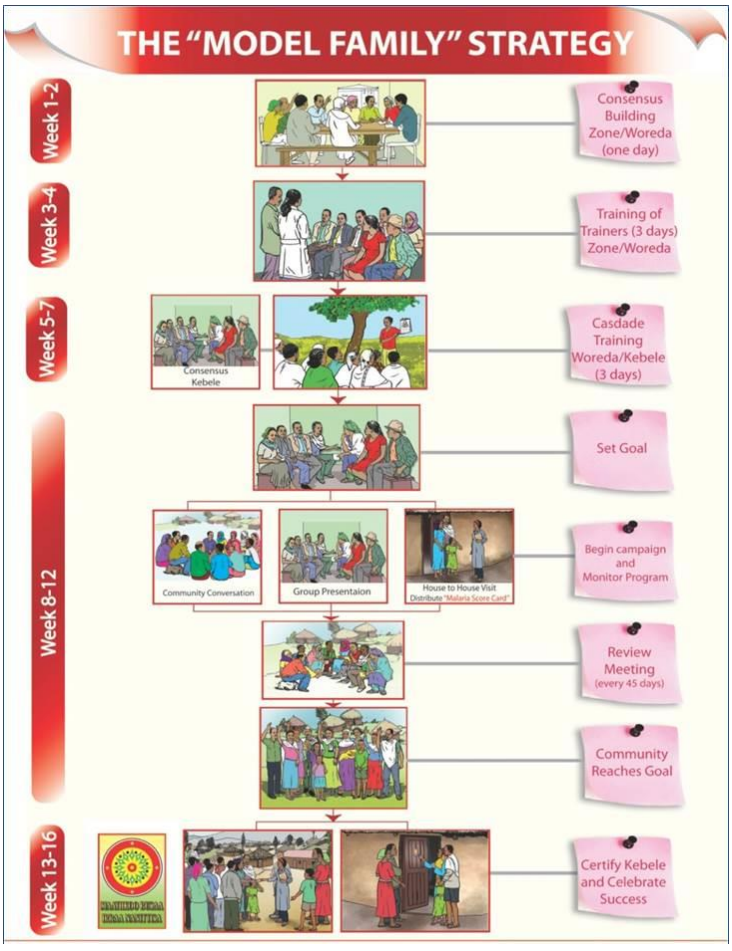
C-Change applied a multi-faceted operational framework that operates at various levels to maximize the reach, impact, and sustainability of its SBCC program. The various facets of this approach were incorporated into a rapid scale-up scheme that enabled the project to operate in a concerted manner to achieve the strategic objectives within the project lifetime. The main feature of the rapid scale-up is the integration and concentration of the SBCC effort within the FMOH's Health Extension Program (HEP).



In addition to extending the reach and impact of SBCC activities, C-Change also designed a structured exit strategy working to transfer knowledge, skills, and ownership of the process to governmental health structures and partner organizations.

The main elements of the multi-faceted approach were as follows:

1. Developing a strategic framework that takes into account all relevant contextual factors – social, cultural, and institutional – as well as research-based situational analysis.
2. Building consensus and obtaining buy-in from stakeholders ranging from government officials and community leaders to partners as a starting point for most activities.
3. End-to-end intervention: providing support at all service delivery levels down to the target population. C-Change primarily works with government, community organizations, health facility workers, HEWs, and vCHWs and or HDAs.
4. Establishing a working relationship and coordinating with various partners, both those directly engaged in C-Change activities and those with whom other synergies were beneficial.
5. Developing simplified and clearly articulated messages (such as Essential Malaria Actions) that the targeted beneficiaries can easily put to practice. C-Change also integrated malaria and ANC messages where appropriate.
6. Using the Model Family strategy (see graphic at right) to encourage communities to actively engage in prevention and control activities, and using a branded approach to communication to have longer-lasting impact and evoke positive action by beneficiaries.
7. SBCC capacity building at the local level and the transferring of ownership for continued prevention to ensure sustainability.
8. Conducting supplementary activities and exploiting incidental opportunities to reinforce and enhance effectiveness of SBCC activities. Examples include the distribution of localized support materials in ITN packages (illustrated local language net-hanging instructions), net-hanging campaigns, and the distribution of SBCC materials outside C-Change target areas through mechanisms like the World Malaria Day mobile van.



To implement malaria prevention and control activities, C-Change carried out community level and school-based activities supported by mass media campaigns.

Implementing Malaria Prevention and Control Activities:

Community Level Activities

C-Change applied the Model Family strategy to implement and roll out malaria prevention and control activities at the community level. This strategy was designed in line with the GOE's Model Family and Community' structure to incentivize families at the household level to learn about and follow malaria prevention and control practices. In each *kebele*, the 16 week-campaign was implemented with five major phases, each aimed at achieving a specific objective.

Consensus Building

The consensus-building step involved explaining to, and obtaining buy-in from, the zonal and *woreda* health offices about the C-Change SBCC rollout strategy. The first 2-week phase involved the gathering of community leaders and other stakeholders at the zonal and *woreda* levels in order to build consensus around the malaria prevention control activities to be carried out. During this meeting, stakeholders and leaders discussed the malaria situation in their community and built consensus around how to roll out the Model Family strategy.

Training of Trainers (TOT)

Subsequent to the consensus building phase, C-Change carried out a training of trainers (TOT) to *woreda* health officials, which took 3 to 4 weeks to finalize. The TOT was provided by C-Change staff to selected *woreda* health workers to become trainers, who in turn cascaded training to HEWs working at the community and household levels. Trainees were provided with necessary SBCC materials including data collection tools, which were later collected by C-Change.

Cascade Training

Trainings are cascaded down to HEWs by health officials. The trained HEWs in turn cascaded training down to vCHWs or HDAs, who were responsible for educating the community. During the training, volunteers and HEWs set goals for their respective communities and made sure they were adequately equipped with the materials and tools required to meet their objective.

Campaign

Once training was concluded, volunteers kicked off the SBCC campaign. The campaign comprised a wide range of activities, including community conversations, group presentations, and house-to-house visits using IPC.

During the house-to-house visits, health workers distributed malaria prevention scorecards and encouraged household members to adhere to the doable malaria action messages. Families were monitored periodically to determine their progress in achieving the campaign's goals. Once volunteers determined that families were adhering to the four doable actions, families were awarded malaria

protection stickers, which were affixed to their door in recognition of successfully carrying out the malaria action messages.

Review Meetings

As part of the Quality Assurance process, three review meetings (every 45 days) were carried out where experience sharing, addressing challenges, and reviewing of activity reports were conducted.

Supportive Supervision, Monitoring, and Quality Assurance

The objective of the supportive supervision, conducted by zonal coordinators and C-Change training supervisors immediately following TOTs and cascade trainings, was to ensure that the health workers and volunteers (HEWs, k*ebele* chairpersons, school representatives, and religious leaders) were making effective use of the skills and toolkits provided for the benefit of the communities in which they were working.

Monitoring and Quality Assurance were conducted in a structured manner using standardized forms that were used to track activities and outcomes at all stages of implementation. The M&E and QA also checked on the SBCC workers' effective use of the toolkits and the skills they had learned.

School-Based Activities

The School-Based Activities Campaign was another innovative C-Change malaria prevention and control intervention that produced positive outcomes. C-Change recognized the importance of implementing malaria prevention and control awareness in schools, where students would learn health behaviors that would be transferred to their families when they went home and that would become lifelong habits as they became adults. The campaign was a central piece of a small grants' program, through which C-Change awarded grants to three local NGOs to conduct malaria prevention and control activities in schools.

The campaign targeted students, 5-8 years old, attending 60 selected public schools in Oromia Region. In order to promote malaria activities among school children, it adapted the EMA messages and developed interactive SBCC materials and tools using language and illustrations suitable for children. The grantees were oriented with the materials and trained on how to use the tools and conduct the school campaign effectively. The small grants were also used to train club leaders and support existing anti-malaria clubs, to broadcast malaria messages through a school's loudspeaker system, to provide a number of "*Mimi wins a Prize*" storybooks to school libraries, and to establish discussion groups among peers. Portions of the grant money were used for further local training and maintenance of mini-media equipment.

School children use the C-Change developed materials to learn about preventing malaria.

School children play a version of chutes and ladders as they learn about preventing malaria.

Mass Media

To support the ongoing community activities, C-Change produced and aired a number of radio programs to provide support to the frontline workers (i.e., HEWs, vCHWs) to help reinforce key malaria action messages.

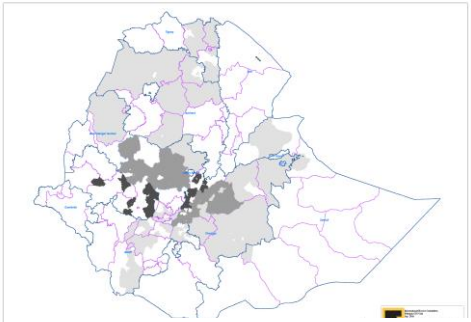
Rebadaw Mender

In Year 2, C-Change aired the radio drama series *"Rebadaw Mender"* in Amharic and Afan Oromo on two stations with national coverage, Ethiopian Radio and Fana Radio for a period of six months. The program was a 12-episode drama revolving around HEWs and a community where malaria is prevalent.

Variety Show

In year 3, C-Change in collaboration with Radio Fana launched a 20-minute variety show, which aired on a weekly basis. The show was designed and developed to outline and discuss malaria prevention and control issues affecting the community. The program was aired in both Amharic and Afan Oromo. To support and promote the show, one-minute trailers in Amharic and Afan Oromo were aired twice a week. To further reiterate key malaria messages, 52 one-minute PSAs (in Amharic and Afan Oromo) were produced. The PSAs were broadcast during high and low malaria transmission seasons.

Figure 1. Geographical coverage of PMI-supported SBCC activities



Note. **Light grey areas**: Pathfinder IFHP implementation areas, which C-Change is leveraging to distribute SBCC materials. **Medium grey areas**: areas where C-Change and its partners are implementing a range of community-level activities, including community conversation, household-level visits and focus group discussions. **Dark grey areas**: FIDO implementation areas, which C-Change is leveraging to distribute SBCC materials. All areas are reached by IEC/BCC messages disseminated via mass media.

Challenges and Opportunities

Over the five-year life of the project, the C-Change Ethiopia project achieved its goals and created real value in a constantly changing environment and scope of work. Originally conceived as a project targeting households with programming to influence the behavior of households with respect to malaria and ANC/PMTCT service uptake, the project changed gears to a rapid scale-up strategy which applied a capacity and technical support scheme to be able to reach more households than originally planned. This was as a result of discussions undertaken by ORHB and USAID.

With a directive to scale-up, C-Change Ethiopia needed to expand to reach 11 zones in Oromia and 6 zones in Amhara targeting over a million households. To achieve these new targets, C-Change Ethiopia had to retool its approach to focus more on building the capacity of governmental and non-governmental stakeholders, implementers, and partners to cascade down the program of work via a mix of delivery mechanisms, tools, and methods. To achieve its targets C-Change Ethiopia completely integrated the C-Change Ethiopia approach into the FMOH's Health Extension Program (HEP). Instead of direct outreach to households, C-Change Ethiopia concentrated on training of HEW and community volunteers whom then took responsibility and leadership in conducting outreach and behavioral change communication activities at the household level.

In Year One of the project, C-Change Ethiopia began by leading the creation of the Essential Malaria Actions and rolling out the Model Family strategy (see final technical report for details on the Model Family strategy) at the household level in some initial *woredas* and *kebeles*. In Year Two and Three administrative directives from the FMOH limiting partner involvement in the community, delayed implementation activities. Despite these challenges, the project achieved 85% of its intended target by end of Year 5.

The other major challenge was the inability of the zonal and *woreda* offices to keep to the schedule and to show up at already-planned workshops. This happened repeatedly and delayed the implementation of activities.

Accomplishments

Over the life of the project, C-Change developed and conducted several SBCC campaigns to achieve specific objectives in line with its strategic framework. The program was able to cover 11 zones and 100 *woredas* in Oromia region through its malaria prevention and control activities. Activities were carried out in close collaboration and coordination with government and NGO partners, community leaders, health workers, and other stakeholders. C-Change provided SBCC training to more than **36,000 local staff** and played a significant role in building the capacity of health workers in the targeted regions. Specifically, C-Change, through its malaria prevention activities, targeted 972,872 households in Oromia and reached more than 85% of them or **824,603 households**.

These trainings and communication interventions had impact. The 2011 Malaria Indicator Survey (MIS) showed a significant increase of 73.2% in knowledge of malaria prevention and control from 32% in 2007. This statistic is also supported by the C-Change evaluation report, which shows increased LLIN utilization among households especially by pregnant women and children under age 5.

Findings from 2012 showed the percent of households sleeping under LLINs increased significantly, in C-Change Ethiopia operational areas, to 31.4 % (2012) from 14.8% (2009) (**See Table 1**). Although findings cannot all be attributable to C-Change Ethiopia, there was also a positive shift in net utilization among pregnant women and children under age five According to in-depth interviews carried out with health workers, there was a significant change in attitude and practice when it came to malaria prevention and control among the community. Unlike previous years, families were more aware and did seek care at the onset of fever especially for children under age five. Focus group discussions with households also showed that people were more aware of the benefits of complying with anti-malarial drugs.

Table 1: Household members' mosquito net use and treatment seeking behavior for fever for by study arm in Oromia Region

Characteristics	Baseline	Endline
Total number of household members enumerated	10,624	3661
Number (%) of household members slept under mosquito net the previous night in all surveyed households[1]	1569 (14.8)	1093 (31.4)
Total Household Members	*10624*	*3479*
Number (%) of household members slept under mosquito net the previous night in households that owned at least one net	1569 (16.8)	1071 (49.7)[2]
Total in Households with Nets	*9350*	*2153*
Number (%) of under-five children slept under mosquito net the previous night in all surveyed households	402 (22.9)	186 (33.7)
Total Children Under 5	*1759*	*552*
Number (%) of under-five children slept under mosquito net the previous night in households that owned at least one net	402 (25.8)	184 (54.4)
Total Children Under 5 in Households with Nets	*1560*	*338*
Number (%) of pregnant women slept under mosquito net the previous night in all surveyed households	38 (18.9)	22 (29.3)
Total Pregnant Women	*201*	75
Number (%) of pregnant women slept under mosquito net the previous night in households that owned at least one net	38 (20.8)	21 (53.8)
Total Pregnant Women in Households with Nets	*183*	39

Note: Please see Baseline/Endline Evaluation Study for complete findings.

[1] The Baseline/Endline Evaluation Study did not report which household members spent the previous night in the household, so all calculations are based on the total household members. The calculations are based on the household members that spent the previous night.

[2] In the Baseline/Endline Evaluation Study, the number sleeping under mosquito nets in all surveyed households and in households that owned at least one net are the same for all groups, as would be expected. However, in the endline survey, there were instances where the demographic survey reported household members slept under a mosquito net the previous night, however, there were no nets in the household.

According to the evaluation study, net utilization among pregnant women also increased from 20.8% to 53.8% and use by children under age 5 increased from 25.8% to 54.4%. These changes are also reflected

Table2: Practices of indoor residual spraying for malaria prevention by study arm in Oromia Region

Use of IRS	Baseline	Endline
No. (%) of households sprayed in the past 12 months	734 (38.7)	378 (58.2)
Total	*1899*	*650*
House sprayed by:		
Government/MCP	639 (88.6)	362 (95.8)
Private company	43 (6.0)	3 (0.8)
Household member	25 (3.5)	1 (0.3)
Other	14 (1.9)	12 (3.2)
Number of months since house was sprayed		
Less than one month	135 (18.9)	24 (6.3)
1-3 months	19 (2.7)	9 (2.4)
4-6 months	121 (17.0)	26 (6.9)
7-12 months	438 (61.4)	319 (84.4)
Average in months	7.68	9.46
No. (%) of households replastered or painted after spraying in the past 12 months	175 (9.2)	57 (15.1)
Total	*734*	*378*
Duration of re-plastering in months after spraying	8 (4.8)	2 (3.5)
Less than one month	53 (31.5)	19 (33.3)
1-3 months	66 (39.3)	17 (29.8)
4-6 months	41 (24.4)	19 (33.3)
7-12 months	4.81	5.42
Average in months		
Total	*175*	*57*
Main reasons cited for not spraying houses		
Service not available	768 (68.3)	177 (65.1)
Not at home	100 (8.9)	36 (13.2)
New house constructed	n/a	14 (5.1)
Do not want it	10 (0.9)	1 (0.2)
It is useless	4 (0.4)	0 (0.0)
Don't know	n/a	36 (13.2)
Other	243 (21.6)	8 (2.9)
Total	*1165*	*272*

Note: Please see Baseline/End Line Evaluation Study for complete findings.

in the number of households undergoing Indoor Residual Spraying (IRS), which increased to 58.2% (2012) from 38.7% (2009). Focus group discussions also show that families cooperate with sprayers as a result of education they receive from the community and do refrain from re-plastering their walls after spraying (**See Table 2**).

Additional results can be found in the Baseline/Endline Evaluation Study.

ANTENATAL CARE/MATERNAL, NEWBORN AND CHILD HEALTH/PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HIV INTERVENTION

ANC/MNCH/PMTCT Situation in Ethiopia

When mothers are malnourished or ill, their newborns face a higher risk of disease and premature death. According to the FMOH, 472,000 Ethiopian children die each year before their fifth birthday. Fifty-seven percent of children die of malnutrition while 11% are associated with HIV infection.[5] The quality of care that both mother and newborn receive during pregnancy, at delivery, and in the early postnatal period is essential to ensuring women remain healthy and that children get a strong start. Traditionally, pregnant women are cared for by relatives at home and give birth with the assistance of traditional birth attendants (TBAs). Maternal health services are only sought in emergency situations or for curative purposes when the expectant mother feels sick.[6] Studies in Ethiopia have shown a direct correlation between a low level of education and low awareness of the importance of preventive measures such as PMTCT during pregnancy to prevent HIV.[7]

Although the Demographic and Health Survey (DHS) study showed a slight improvement in the utilization of ANC by pregnant women between 2005 and 2011, findings reveal that there is low uptake of ANC, which impacts infant and child health and PMTCT services.[8]

With this information, C-Change designed an approach and overarching strategy for its ANC/MNCH/PMTCT SBCC intervention that was similar to, and integrated with, the malaria prevention intervention. The strategic objectives, the message development, the targeted population, and, to some extent, the SBCC materials and toolkits, were specific to this intervention. The entire ANC/ MNCH/ PMTCT/ campaign and activities were carried out under the "*Mesenado*" (*Getting Prepared*) brand to minimize any confusion and create a more cohesive, easy-to-grasp campaign.

C-Change Approach:

C-Change worked to strengthen the linkages among stakeholders (i.e., health centers, HEWs, vCHWs, local organizations, and families) to build a cohesive, comprehensive effort to boost ANC/MNCH/PMTCT services. C-Change also worked in collaboration with the FMOH, Regional Health Bureaus (RHBs) and existing structures/projects to ensure the consistency of messages coupled with outreach efforts to address barriers related to seeking ANC-related services. Primary implementation partners for implementation of the ANC/MNCH/PMTCT programs were IntraHealth, Management Sciences for Health (MSH), and Integrated Family Health Program (IFHP).

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[5] National Strategy for Child Survival in Ethiopia, Family Health Department Federal Ministry of Health, Addis Ababa, Ethiopia, 2005

[6] AED-LINKAGES, Prevention of Mother to Child Transmission (PMTCT), Baseline Survey, April 2004.

[7] Prime II, IntraHealth International Save the Children UK, HAREG PROJECT: Preventing Mother to Child Transmission of (PMTCT) of HIV/AIDS in Ethiopia.

[8] Ethiopia Demographic Health Survey 2005. Addis Ababa, Ethiopia and Calverton, Maryland, USA: Central Statistics Authority and ORC Macro.

Implementing the ANC/MNCH/PMTCT Intervention

Qualitative and quantitative research that C-Change undertook in 2008-2009 indicated that knowledge about when to initiate ANC and perception and practices around ANC differed between the urban and the rural communities and between the educated and the uneducated. The research showed that urban and educated community members appeared to have better knowledge and to make better use of ANC services than rural and uneducated community members. The main barriers for PMTCT service utilization included misconceptions about PMTCT, fear of discovering having been infected with HIV, and difficulty with telling that news to their spouses.

An ANC visit for a current pregnancy was reported by 63.3% of the pregnant women in the study. Health centers and health posts were the main facilities visited for ANC follow-up. Institutional delivery for the last pregnancy was reported by only 10% of the women. Voluntary Counseling and Testing (VCT) services during the current pregnancy were sought by 27% of the pregnant women. The major barriers cited were the distance to the health facilities and lack of transportation.

The target populations for the C-Change ANC/MNCH/PMTCT intervention were expectant mothers, new mothers, and husbands. To reach these targets, C-Change developed materials for health care workers, community volunteers, and traditional birth attendants (TBAs), and provided capacity building to assist them in using the materials.

Mesando logo for the radio mass media component of the ANC/PMTCT campaign

Crafting the Message

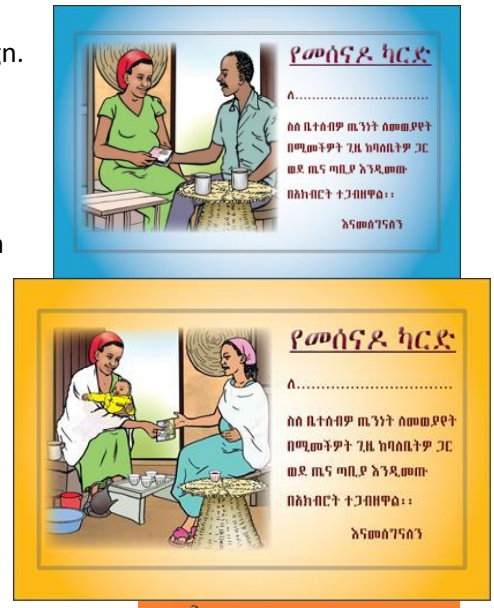
In March 2009, similar to the malaria message harmonization process, C-Change worked with partners JHU-CCP, IntraHealth, MSH, and other stakeholders on key ANC Action Messages. Unlike malaria prevention and control, several messages were developed by various partners for the promotion of ANC uptake and PMTCT promotion. Therefore, C-Change identified six messages that would underpin and address the barriers in this area. The six messages targeted mothers, pregnant women, and husbands about the actions and care they should take during pregnancy to prevent mother-to-child transmission of HIV at delivery and soon after birth.

Using the findings in the baseline study as well as extensive pretesting, C-Change produced a variety of SBCC materials and tools for this intervention and shared them with partners, stakeholders and implementers. Materials included the ANC Booklet with six ANC Action Messages on the benefits of ANC/PMTCT, safe delivery, malaria prevention and postnatal care services. In addition to the colorful illustrations promoting the six action messages, the booklet contained six perforated referral cards for use by the pregnant women. For every visit, a pregnant woman was encouraged to give this to the

health post or facility she was visiting. In addition to helping HEWs keep track of attendees, the tracking cards were also used as a data collecting tool.

Another key material was the ANC Invitation Card, which encouraged the pregnant woman to refer other pregnant women in her neighborhood, as she herself was referred by a community volunteer, to attend ANC appointments. The ANC Certificate was awarded to a new mother and her family upon completing the specific ANC actions. Other ANC materials included the Husband Invitation Card and an ANC Poster for display in health centers, community gathering places, and *kebele* offices, which supported the overall campaign.

C-Change Ethiopia developed a communication approach that worked with the government health structures and the health workers (HEW and vCHW and HDAs) who were already working with the communities on ANC and PMTCT. C-Change provided a two-day skills building workshop to the health workers to equip them on how to use the C-Change developed SBCC materials when visiting individual households. These health workers went house-to-house and worked through existing community groups to educate pregnant women and promote ANC attendance.



Examples of SBCC materials developed by C-Change for the ANC/PMTCT intervention in Amhara and used by all government health workers.

The ultimate goal was to refer women and their partners to the health center to seek ANC, PMTCT, and postnatal services. The health center was responsible for tracking a woman's progress, which was highlighted with the awarding of the Safe Motherhood Certificate, which recognized that a mother and her husband had carried out key ANC actions: 1) Attend a minimum of four ANC visits, 2) Get tested for HIV with respective partner and or utilize PMTCT services, 3) Plan for an institutional delivery, and 4) Attend at least one postnatal visit. The certificate was a way to recognize a woman as a model to be emulated in her community and among their peers and also to encourage other mothers to do the same.

Integrated ANC/WASH Messages

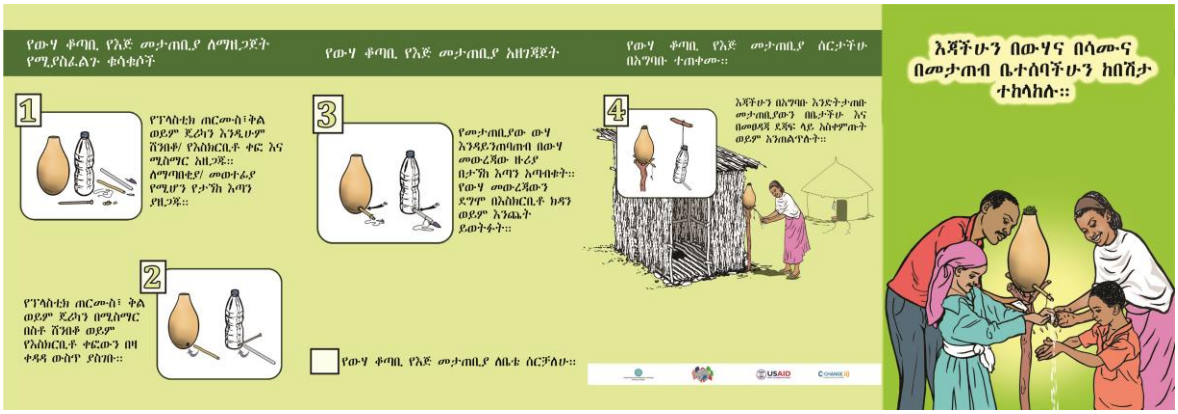
C-Change received additional funding to incorporate WASH (water, sanitation and hygiene) messages into the ANC/PMTCT intervention. To that end, C-Change revised the ANC Safe Motherhood card into a comprehensive 20-page ANC booklet with integrated WASH messages.

With the additional WASH funding, C-Change also developed standalone WASH messages in the form of a scorecard, highlighting the proper times family members should wash their hands. The scorecard was

ANC/WASH Message Guide

based on the doable action messages and focused on handwashing practices: 1) before food preparation, 2) before eating, 3) before handling babies or breastfeeding, and 4) after using the latrine and changing soiled diapers.

C-Change also developed a WASH training manual which outlined ways to build a “Tippy Tap” out of



WASH Scorecard

gourds or used jerry cans. Tippy taps are simple technologies that are easily developed with available materials. They are placed outside latrines and inside the home to facilitate handwashing with minimal contamination.

Mass Media

To further strengthen the ANC/MNCH/PMTCT activities, C-Change launched radio programs to increase ANC attendance at PMTCT sites.

“Mesenado” Radio Programming and Listening Group

In its first year of operation, C-Change launched a radio listening group designed to encourage pregnant women to attend ANC at PMTCT sites. These listening groups proved to be highly effective in motivating and educating women in various communities. Pregnant women and partners were encouraged to attend listening groups in 10 *woreda*s of Amhara region. The radio listening group, which ran for four-weeks at a time, was key in promoting the importance of ANC/PMTCT and, in particular, encouraged VCT testing and linked activities with health facilities to be able to assess impact of promotion.

Although the Ethiopian Demographic Health Survey (EDHS) data of 2011 indicate relative limited radio listenership, especially among women, our experience has demonstrated vigorous participation by those audiences who are reached through our ANC radio programs. C-Change also developed an interactive 15-episode radio program, *Mesenado*, which targeted pregnant women and their partners, promoted the importance of ANC attendance, and provided useful information on PMTCT, safe delivery, and postnatal care and the opportunity for call-ins by listeners. An average of 30 callers followed up after each show, mostly with specific questions around ANC and PMTCT achievements.

Table 13: Reproductive history and ANC service seeking behavior for currently pregnant women by study arm, Amhara Region

Reproductive History and ANC services	**Baseline**	**End line**
No. of women who are currently pregnant	69	41
Respondents who attended ANC services during the current pregnancy	35 (50.7)	33 (80.5)
Number of ANC visits during the current pregnancy		
None	33 (47.8)	8 (19.5)
Once	7 (10.1)	9 (22.0)
2-3 times	24 (34.8)	20 (48.8)
4+	5 (7.2)	4 (9.8)
Tested for HIV/AIDS during ANC visit in the current pregnancy	23 (33.3)	28 (68.3)
Spouse encouraged them to attend ANC in the current pregnancy	n/a	21 (51.2)
Spouse encouraged them to deliver at a health facility in the past two years	n/a	24 (58.5)
Total	*69*	*41*
Place of delivery of the last baby		
At home	47 (88.7)	32 (80.0)
Health facility (HP, HC, Gov. Hosp, Pvt hospital/clinic)	6 (11.3)	8 (20.0)
Total	*53*	*40*
Place for attending ANC for the current pregnancy		
Health post	10 (27.8)	13 (39.4)
Health center	20 (55.6)	17 (51.5)
Govt. hospital	1 (2.8)	1 (3.0)
Private hospital/ clinic	3 (8.3)	2 (6.1)
Other	2 (5.6)	0 (0.0)
Total	*35*	*33*

Please see Baseline/End Line Evaluation Study for complete findings.

Through its ANC/MNCH/PMTCT activities, C-Change reached 6 zones and 31 *woredas* of the Amhara region achieving 86% of its set target.

According to the C-Change final evaluation report, which looks at initial baseline findings (2009) to final endline study (2012), there was a marked increase in women currently attending ANC. Although findings cannot be entirely attributed to C-Change's efforts alone, the report showed a significant increase in women attending ANC during their current pregnancy from 50.7% to 80.5%. Similarly, the evaluation report indicated a noticeable increase of women getting tested for HIV/AIDs during their pregnancy from 33.3% to 68.3%. According to in-depth interviews with health workers, women are more aware of

the benefits of attending antenatal care services during their pregnancy. Unlike previous years, women do understand the importance of getting tested for HIV/AIDS during their pregnancy. Focus group discussions with households also showed a significant difference in attitude and practice among interviewed families especially male partners. According to findings, women were willing and wanted to deliver their babies at the nearest health facility and or hospital.

Partnerships

Since 2008, C-Change has established a significant number of productive partnerships with Ethiopian Government entities, NGOs and other in-country stakeholders.

Among the key collaborators were the federal government's HEWs, Regional Health Bureaus, and community leaders working at the community and household levels, as well as vCHW.

Other partners and stakeholders that worked in close collaboration with C-Change included the Federal Ministry of Health (FMOH), Fayya Integrated Development Organization (FIDO), Research Triangle Institute (RTI), UNICEF, Peace Corps, and the U.S. Combined Joint Task Force for the Horn of Africa (CJTF-HOA).

CARE International

As a prime partner of C-Change Ethiopia, CARE implemented SBCC activities from 2008 until July 2012. The CARE intervention followed C-Change's strategic approach and implemented community activities in malaria prevention and control in the Oromia region. Over the four-year implementation, CARE carried out activities in four *woreda*s covering 73 malarious *kebeles*.

The core component of the malaria prevention and control intervention was the use of the 'community conversation' to engage communities and or *kebeles* to discuss malaria prevention and control. To support this program, CARE utilized C-Change's SBCC materials and tools. In addition to their direct intervention with the community, CARE actively collaborated with C-Change in capacity building and supportive supervision.

'Hang Up, Keep Up':

The 'Hang Up, Keep Up' malaria mosquito net campaign was a collaborative effort by C-Change that combined net hanging efforts with SBCC interventions to increase ownership and active use of nets. The campaign was a collaboration by UNICEF, the U.S. Combined Joint Task Force for the Horn of Africa (CJTF-HOA), PMI, C-Change, and Ethiopian HEWs. UNICEF provided the mosquito nets and members of the CJTF-HOA distributed the nets working alongside HEWs. C-Change conducted the training and provided SBCC materials and the net hanging accessories (nails and ropes).

PMI obtained permission from the Oromia Regional Health Bureau (ORHB) and local health officials for the project, and together with CJTF-HOA and C-Change met to discuss the project goals, share SBCC resources, and ensure a common approach. It was agreed that at least one or two LLINs be distributed per household and that pregnant women and children under 5 years of age would be given priority, which was in keeping with FMOH policy. Over a period of three years, the intervention covered 13 *woreda*s and distributed over 500,000 LLINs in Oromia.

To further understand the effectiveness of this intervention, C-Change carried out a pre- and post-assessment survey in three *woreda*s using a simple questionnaire on malaria net ownership, utilization, and retention levels.

Implementation

The campaign began with C-Change providing training at the various *kebele*s, which were attended by the *kebele* chairman, *kebele* manager, local religious leaders, HEWs and 13-14 CJTF-HOA campaigners. The training comprised proper net hanging and maintenance techniques, malaria prevention and control guidelines, and the use and distribution of C-Change-developed SBCC materials. CJTF-HOA staff also practiced hanging nets before going to the field.

Task Force members and local residents work to distribute malaria nets

In the next phase of the campaign, CJTF-HOA staff, accompanied by HEWs, went house to house to distribute SBCC materials and mosquito nets, demonstrated and helped hang the mosquito nets, and taught members of the households about the importance of hanging nets for protection from malaria. To carry out distribution in remote communities and households, the team used donkeys and porters to carry the supplies.

As the participants in the campaign reported, and the post-campaign assessment survey indicated, the campaign was a success on a personal as well as a statistical level. The CJTF-HOA participants, many of whom had competence in conversational Amharic, were well received and trusted by the members of the communities they assisted. People were impressed that foreigners would go to such lengths to help them, and many said that it motivated them to help themselves. Together this successful partnership of health extension workers and CJTF-HOA participants distributed over 500,000 nets in 13 *woreda*s from 2010-2013.

Achievements

A post-assessment study carried out 12 month after net distribution showed increased utilization of nets and confirmed the benefits of combining an SBCC intervention with a strong community-based effort. Following are some of the study results:

- Before the campaign, 33.4% of households interviewed had at least one bed net; post-campaign, 90.5% of households had a least one bed net.
- Bed net hang-up before the campaign was carried out by 46.7% of users; post-campaign, it was 69.2%.
- Pre-campaign, 23% of pregnant women slept under a net; post-campaign, 73% slept under a net.
- Pre-campaign, 14% of children under 5 slept under a net; post-campaign, 54% slept under a net.

An objective of the campaign was to convey the importance of proper and consistent use of nets and that was achieved. Moreover, this low-cost, high-impact intervention showed that coupling a net hanging campaign with an SBCC intervention can achieve behavior change, and that collaboration like this one is a model that can be adapted by other social organizations and community networks.

Additionally, the study revealed that the source of bed nets for the majority of the respondents (86.7%) was the "Hang Up/Keep Up" campaign. Only 13.3% of the respondents reported receiving nets from other sources.

C-Module Training

As a vehicle for establishing strengthening partnership with key stakeholders, C-Change used a high-level SBCC training program, the *C-Module Learning Package*. One of the most innovative and effective components of the C-Change program has been the introduction of the "C-Modules" learning package. C-Modules is part of a training program to strengthen capacity in the successful application of SBCC planning, programming, and evaluation. Ethiopia is one of 10 countries where the C-Modules has been successfully implemented.

C-Change created this learning package for facilitated, face-to-face and online courses in SBCC. The package includes a series of six modules for communication practitioners. A facilitator's guide accompanies each module.

The C-Modules contain the following downloadable documents[9]:

- Practitioners' handbook for each of the six modules (0–5)
- Facilitators' guide for each module with tips and examples for preparation
- Additional resources

The Introduction Module, numbered 0, outlines the overall SBCC framework, including the five steps of C-Planning for SBCC. Each of the next five modules focuses on one distinct step of the SBCC planning process:

[9] https://www.c-changeprogram.org/focus-areas/capacity-strengthening/sbcc-modules

Module 0: Introduction Module
Module 1: Understanding the situation
Module 2: Focusing and designing
Module 3: Creating
Module 4: Implementing and monitoring
Module 5: Evaluating and re-planning

C-Change Ethiopia has carried out C-Module workshops for multiple organizations. Prior to taking the workshop, participants were assessed with the C-Change Capacity Assessment Tool (CAT), which helped tailor the training program to fit the specific needs of the participants.

Adapted from National Cancer Institute: Health Communication Program Cycle (1989); AED: Tool Box for Building Health Communication Capacity (1995); Parker, Dalrymple, and Durden: The Integrated Strategy Wheel (1998); McKee, Manoncourt, Chin, Carnegie: ACADA Model (2000); Health Communication Partnership, P-Process Brochure (2008).

C-Change carried out these training workshops at the federal, regional and zonal level of Amhara and Oromia regions including Peace Corps Volunteers (PCV). The training addressed all aspects of SBCC, from situation analysis, to planning, to execution, to monitoring and evaluation designed to strengthen the capacity of participants to plan and carry out SBCC activities for their organization or regions. This approach supports FMOH's decision to develop regional office capacity to plan and execute effective SBCC campaigns.

C-CHANGE FORMAL EXIT AND HANDOVER

In accordance with the overarching C-Change strategic framework, C-Change carried out closeout workshops in key *woreda*s and zones in the Amhara and Oromia regions. The main objective of the closeout workshop was to hand over activities and provides *woreda* health offices with the necessary tools to enable them to continue implementing activities. C-Change provided each *woreda* with a handover packet that included hard and soft copies of SBCC materials, including studies carried out in their respective area.

Conclusion and Lessons Learned

The five years of operation by C-Change have been successful and instructive on what works for implementing for positive outcomes. Among the various successes C-Change achieved, foremost was its ability to reach a vast number of households in carrying out the plan under the strategic framework, and operating at various levels in a coordinated manner. At the core of the strategic framework was an approach to SBCC that operated at three levels: advocacy, social and community mobilization, and behavior change communication that enabled C-Change to produce effective communication materials and tools, provide multi-tiered trainings, and establish productive partnerships to reach many targeted communities with SBCC interventions.

One of C-Change's contributions to public health intervention in Ethiopia was the proactive role it played in coordinating and establishing partnerships with key stakeholders in government and non-government entities. Key in this effort was the development of agreed upon Essential Malaria Actions and the

subsequent message harmonization that involved a number of partners including the Federal Ministry of Health.

C-Change established many partnerships that led to active engagement in community outreach, including the highly effective net distribution campaign in collaboration with the CTJF-HOA. C-Change was also instrumental in building partnerships with various organizations such as the Ethiopian Orthodox Tewahido Church (EOTC) in the implementation of community-level activities including distribution of key SBCC materials and tools. C-Change also worked closely with its prime partner CARE in providing support for the implementation of community-level activities in Oromia.

C-Change implemented activities from 2008 to 2013, a time during which Ethiopia was implementing a new government structure and was experiencing constant change in the health sector. C-Change responded by adapting an operational framework which allowed it to implement activities within the already existing Health Extension Program (HEP) to provide capacity building including technical support to health officials at a higher level, who in turn adapted the strategy and cascaded activities to their respective communities.

Consistent Capacity Building

The strategic framework allowed the project to reach vast numbers of households with key action messages. C-Change's experience demonstrates that this approach not only build the capacity of health officials at all levels but also enables sustainability of the interventions by local personnel because they have been part of the process.

Collaboration among Stakeholders

Effective collaboration among stakeholders was also imperative to make sure activities were implemented efficiently and to avoid duplication of efforts, thus ensuring the best outcomes for the communities and the people and families in those communities.

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