COMMUNITY ASSESSMENT AND PLANNING
FOR MATERNAL AND CHILD HEALTH
PROGRAMS:
A PARTICIPATORY APPROACH IN ETHIOPIA

March 1997

Karabi Bhattacharyya
John Murray
Peter Winch

BASICS Technical Directive Number: 020-ET-02-025
USAID Contract Number: HRN-6006-Q-02-3032-00
# TABLE OF CONTENTS

## ACRONYMS

## EXECUTIVE SUMMARY ...................................................... 1

## I. PREVIOUS BASICS/ESHE PROJECT ACTIVITIES ................................. 3

## II. BACKGROUND TO THE COMMUNITY ASSESSMENT .............................. 4
   A. Maternal and Child Health Emphasis Behaviors: A Framework for Planning Community Interventions ........................................... 4
   B. Areas Selected for Community Level Activities .......................... 7

## III. SURVEY DESIGN AND METHODS ............................................. 7
   A. Design Overview .................................................. 7
   B. Objectives ....................................................... 9
   C. Methods .......................................................... 9

## IV. CONDUCTING THE SURVEY .................................................. 11
   Phase 1: Identifying partners and building partnerships ......................... 11
   Phase 2: Selecting 3-5 Emphasis Behaviors .................................. 14
   Phase 3: Exploring Reasons for the Behaviors ................................ 17
   Phase 4: Developing Intervention Strategies and Next Steps ................. 19

## V. RESULTS AND DISCUSSION .................................................. 21
   A. Indicators ....................................................... 21
   B. Priorities and Strategies ......................................... 27

## VI. REVIEW OF THE PARTICIPATORY PLANNING PROCESS ...................... 30

## APPENDIXES

Appendix A Map of the SNNPR
Appendix B Survey Teams
Appendix C Training Timetable
Appendix D Example of a Social Map
Appendix E Survey Questionnaires
Appendix F One-page Summaries for In-depth Analysis of Emphasis Behaviors
Appendix G Summary of Community Action Plans
Appendix H Team Evaluations
LIST OF TABLES

Table 1. The emphasis behaviors ................................. 6
Table 2: Focus zones, woredas, kebeles and estimated populations in the SNNPR ......... 7
Table 3: Community assessment at a glance ...................... 11
Table 4: Children’s health problems listed and ranked by men in Konteb ............. 14
Table 5: Matrix ranking to prioritize behaviors in Konteb: men’s and women’s groups .. 16
Table 6: Matrix ranking of weaning foods by women in Konteb .......................... 17
Table 7: Reasons for getting and not getting measles vaccination in Konteb ........... 19
Table 8: Strategies for measles immunization coverage in Konteb .................... 20
Table 9: Summary of actions to be taken in Alaba .................................. 21
Table 10: Results of free-listing and ranking .................................... 28
Table 11: Selected behaviors by communities .................................... 28
ACRONYMS

SNNPR  Southern Nations and Nationalities People's Region
BASICS Basic Support for Institutionalizing Child Survival Project
ESHE Essential Services for Health in Ethiopia
HMIS health management information system
PHC primary health care
ARI acute respiratory infection
NGO nongovernmental organization
MOH Ministry of Health
CHA/CHW community health agent/community health worker
TBA traditional birth attendant
AIDS acquired immune deficiency syndrome
TT tetanus toxoid immunization
ANC antenatal care clinic
EXECUTIVE SUMMARY

Purpose
The purpose of this trip was to test and implement a participatory approach to community assessment in five focus communities in the focus zones in SNNPR, Ethiopia. The purpose of the assessment was for health facilities and the communities they serve to jointly identify maternal and child health problems and work together to solve them. The process (1) collects important information to identify health problems and serve as a baseline for monitoring the progress of solving those problems, and (2) promotes and facilitates community involvement in planning of both community and facility health activities which is critical to the sustainability of health programs.

Design and Methods
The process begins with a list of emphasis or key behaviors which have been shown scientifically to decrease child morbidity and mortality. The emphasis behaviors are used as a “menu” from which communities and health facilities jointly decide which of these behaviors are a priority and could be changed. This then forms the basis for the joint action plan. The methodology combines both participatory and qualitative methods with a structured household survey. The process is conducted in a community over 7-10 days.

Field-testing
Activities were conducted in five woredas in the Southern Nations and Nationalities People’s Region (SNNPR). Ministry of Health staff were trained in the methodology for one week. The participants included staff from the regional level, four zones, and five districts in SNNPR, for a total of 16 people. The group then broke into five teams and went to selected communities in the five districts for 8-9 days where the four phases were completed. The size of the communities ranged from 726 to 1187 households. At the end of the fieldwork, the group came back together to develop detailed implementation plans and identify next steps.

Results and Products
The information collected is used at several different levels. The health staff and community teams use the data immediately to develop action plans for their community. The data from the household survey is aggregated at a regional level to provide baseline indicators for monitoring and evaluation. The qualitative data can be used to develop communication materials that address a range of community situations. In Ethiopia, the process resulted in (1) five community action plans in five districts; (2) baseline data on key behaviors for monitoring and evaluation; and (3) trained staff at regional, zonal and district levels (in five districts).
I. PREVIOUS BASICS/ESHE PROJECT ACTIVITIES

This community assessment and planning approach builds on a number of previous activities undertaken by the BASICS/ESHE project in Ethiopia. Taken together, these assessment, planning and training activities are seen as crucial to improving the quality of maternal and child care at both health facilities and in the community. A key objective of all of these activities has been to improve the capacity of local staff at all levels to plan and develop primary health care programs themselves. Previous work has resulted in a number of implementation strategies that are currently underway or planned to improve the health management and information system (HMIS), the drug and vaccine logistics and supply system, and the quality of child care at peripheral health facilities using an integrated supervisory approach. The community-level activities have allowed implementation plans to be developed in each of the focus communities. Updated community health worker training and health education materials will be completed in May 1997. Past activities that have been essential to the development of implementation strategies are

- Health Facility Survey in the SNNPR, August 1995 (Dr. Paul Freund)
- Community Demand Study for the BASICS/ESHE Project, June 1995 (Dr. Karabi Bhattacharyya)
- Health Management and Information System (HMIS) in the SNNPR: Review and Recommendations for a Re-Design, June 1995 (Dr. Eckhard Kleinau)
- Ethiopia Health Systems Design Activity: Report of a Health System Baseline Survey, June 1995 (Drs. Sjoerd Postma, Mahari Woldeab Tecle, Kidanemariam Woldeyesus Abashe)
- Planning for Basic and Continuing Education for PHC in SNNPR, April 1996 (Dr. Dennis Carlson)
- Training of Trainers in the Development of Community-Based Materials and Methods, July 1996 (Dr. Dennis Carlson)
- Zonal Planning Meetings and Selection of Focus Woredas, July 1996 (Dr. Rose Macauley)
- Ethiopian Health Facility Assessment: Using local planning to improve the quality of child care at health facilities in the Southern Nations and Nationalities People’s Region, October 1996 (Drs. John Murray and Serge Manoncourt)
II. BACKGROUND TO THE COMMUNITY ASSESSMENT

A. Maternal and Child Health Emphasis Behaviors: A Framework for Planning Community Interventions

In order to have a measurable impact on childhood morbidity and mortality in developing countries, public health programs need to focus on health-related behaviors, in particular the behavior of child caretakers. Many public health programs are facility-based, because facilities provide an organized structure, a recognizable system, and trained health workers. However, health facilities often see only a small proportion of all sick children in a community and are therefore unable to have an impact on overall childhood morbidity and mortality. In order to have a greater impact on child health, programs must improve the management of children in the home by their caretakers and families. This assessment and planning approach focuses on improving both the prevention and the management of childhood illness in the home by changing the behavior of the caretakers and families responsible for young children.

Good data available from many developing countries now suggest that at least 70 percent of all childhood mortality is the result of five major conditions: diarrheal diseases, acute lower respiratory tract infections (ARI), malnutrition, malaria, and measles. The evidence suggests that children often have multiple conditions at the same time; managing just one of these conditions may not prevent death from other underlying conditions. In addition, there is a great deal of evidence that malnutrition, even mild malnutrition, can increase the likelihood of mortality from a number of different disease entities. In order to improve the health of children in developing countries, therefore, programs need to focus on all five of the most common causes of morbidity and mortality, including malnutrition, at the same time.

The emphasis behavior concept has been developed for public health programs that want to improve child health in communities by changing caretaker behavior, but that do not have the resources to undertake extensive background research or to implement large and complex programs. Emphasis behaviors are those caretaker behaviors that have already been demonstrated to have a public health impact and that can be feasibly changed in a relatively cost-effective manner. A multidisciplinary team of child survival and behavioral specialists selected a shortlist of emphasis behaviors by developing and considering five criteria. These criteria were based on both epidemiological and programmatic considerations.

The criteria used to select the emphasis behaviors were

- broad public health importance by having an impact on multiple disease areas
- documented to reduce childhood morbidity and mortality
- have an impact on the most important health problems in developing countries
• measurable
• changeable by public health interventions already demonstrated as feasible and cost-effective

A final list organizes sixteen emphasis behaviors into four categories: (1) reproductive health practices, (2) infant and child feeding practices, (3) immunization practices, (4) home health practices, and (5) care-seeking practices. Each of these categories is believed to be important in order to maximize program effectiveness. Some overlap exists among these categories, but it was felt important programmatically to separate home-feeding and immunization practices from other categories of household behavior in order to highlight their importance. The emphasis behaviors were used as a framework for planning and conducting all community-level planning activities.

The emphasis behaviors are presented by category in Table 1
Table 1. The emphasis behaviors

**REPRODUCTIVE HEALTH PRACTICES:** Women of reproductive age need to practice family planning and seek antenatal care when they are pregnant.

1. For all women of reproductive age, delay the first pregnancy, practice birth spacing and limit family size.
2. For all pregnant women, seek antenatal care at least two times during the pregnancy.
3. For all pregnant women, take iron tablets.

**INFANT AND CHILD FEEDING PRACTICES:** Mothers need to give age-appropriate foods and fluids.

4. Breastfeed exclusively for about 6 months.
5. From about 6 months, provide appropriate complementary feeding and continue breastfeeding until 24 months.

**IMMUNIZATION PRACTICES:** Infants need to receive a full course of vaccinations; women of childbearing age need to receive an appropriate course of tetanus vaccinations.

6. Take infant for measles immunization as soon as possible after the age of 9 months.
7. Take infant for immunization even when he or she is sick. Allow sick infant to be immunized during visit for curative care.
8. For pregnant women and women of childbearing age, seek tetanus toxoid vaccine at every opportunity.

**HOME HEALTH PRACTICES:** Caretakers need to implement appropriate behaviors to prevent childhood illnesses and to treat them when they do occur.

*Prevention*

9. Use and maintain insecticide-treated bed nets.
10. Wash hands with soap at appropriate times.
11. For all infants and children over 6 months, consume enough vitamin A to prevent vitamin A deficiency.
12. For all families, use iodized salt.

*Treatment*

13. Continue feeding and increase fluids during illness; increase feeding after illness.
14. Mix and administer ORS, or appropriate home-available fluid, correctly.
15. Administer treatment and medications according to instruction (amount and duration).

**CARE-SEEKING PRACTICES:** Caretakers need to recognize a sick infant or child and need to know when to take the infant or child to a health worker or health facility.

16. Seek appropriate care when infant or child is recognized as being sick (i.e., looks unwell, not playing, not eating or drinking, lethargic or change in consciousness vomiting everything, high fever, fast or difficult breathing).
B. Areas Selected for Community Level Activities

Four focus zones have been chosen by the SNNPR for all BASICS project activities (Hadiya, KAT, North Omo and Sidama). From these zones, five focus woredas were selected for implementation of all low-level project activities. The focus woredas were selected by zonal committees using a number of criteria including public health need (high incidence and prevalence rates of childhood diseases); larger population size and density (to maximize public health impact); functional health facilities available (to allow facility-based activities to be implemented); and limited NGO activity. While intensive project implementation will initially occur in these five focus woredas, it is hoped that these woredas will form the basis from which successful primary health care activities can be disseminated throughout the zones. In the longer term, it is hoped that trained staff from these focus areas can become trainers of other staff.

Within each focus woreda, one community or kebele was chosen for the initial implementation of community-level activities. These communities were selected by woreda committees. The focus zones, woredas and kebeles are summarized in Table 2. The population of zones and woredas is estimated from 1990 census figures and the number of households in each kebele from taxation and land-ownership records. A map of the SNNPR and focus woredas is attached in Appendix A.

Table 2: Focus zones, woredas, kebeles and estimated populations in the SNNPR

<table>
<thead>
<tr>
<th>Focus Zone</th>
<th>Woreda</th>
<th>Kebele</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hadiya</td>
<td>Konteb</td>
<td>Shurmo-Adel</td>
</tr>
<tr>
<td>N=1,089,518</td>
<td>N=320,274</td>
<td>HH=1,080</td>
</tr>
<tr>
<td>KAT</td>
<td>Alaba</td>
<td>Ashoka</td>
</tr>
<tr>
<td>N=835,813</td>
<td>N=198,274</td>
<td>HH=750</td>
</tr>
<tr>
<td>North Omo</td>
<td>Boloso-Sore</td>
<td>Dola</td>
</tr>
<tr>
<td>N=3,150,518</td>
<td>N=334,853</td>
<td>HH=935</td>
</tr>
<tr>
<td></td>
<td>Bonke</td>
<td>Demle-Leda</td>
</tr>
<tr>
<td></td>
<td>N=136,902</td>
<td>HH=726</td>
</tr>
<tr>
<td>Sidama</td>
<td>Dale</td>
<td>Wicho</td>
</tr>
<tr>
<td>N=3,537,500</td>
<td>N=320,567</td>
<td>HH=1,187</td>
</tr>
</tbody>
</table>

III. SURVEY DESIGN AND METHODS

A. Design Overview

The design of this community assessment responds to a number of trends in public health planning. Throughout the world and especially in Africa, there is a trend for primary health care
program planning to be decentralized to the district level and away from the national level. This approach requires that health planners collect local information to develop strategies and allocate resources. Along with decentralization, there is a trend towards “integration” of maternal and child health programs. Integrated approaches are designed to manage all of the most important maternal and child health problems at the same time. More and more countries are choosing to implement programs at health facilities which train health workers to provide all essential services every day (such as sick child care, immunization and antenatal care). This assessment is an integrated approach to planning community-level programs. It collects and uses information on maternal and child health behaviors and is designed for district and sub-district program planners and health staff.

There is still little attention given to developing tools which could be used by local level health staff who often work with limited technical and financial resources. Health staff need assistance with how to form a working group with community representation, how to engage in a dialogue with their communities to understand their needs and constraints, and to plan interventions that target the people most in need at the times when they are most in need. With the decentralization of planning and decision-making in a number of countries, it is even more urgent that health facility staff begin to engage the communities they serve in an on-going dialogue. The goal of the community assessment described here is for the health staff and the communities they serve to jointly identify and prioritize health problems and work together to solve them.

The important features of this assessment are

- Focuses on a limited number of maternal and child health behaviors that are critical to the prevention and management of the most important causes of childhood morbidity and mortality.
- Uses an integrated household survey that measures indicators on all the major causes of childhood morbidity and mortality.
- Combines participatory and qualitative approaches with a quantitative survey.
- Is conducted by the MOH staff who are responsible for implementing health programs and a team of community volunteers, not an outside research team.
- Produces joint action plans for both the community and health facility as well as household-level data.
- Balances activities imposed on the community by the MOH and requests from the community which fall outside the MOH domain (e.g., wells, roads) by using the emphasis behaviors as a “menu” to guide planning.
Encourages community members and health staff to use and analyze information immediately.

Teaches a simple methodology that does not require extensive time or resources so that it is potentially replicable at the district level or below.

Collects data that can be used at multiple levels: at the community level to develop an action plan; at the district, zonal, regional and project levels for project monitoring and evaluation.

B. Objectives

The community assessment had four main objectives:

1. To develop a community implementation plan with full participation and consensus of communities.

2. To develop a community implementation plan based on primary health care behaviors which are documented to impact on maternal and child health.

3. To collect key indicators for monitoring and evaluation of community and household activities.

4. To build capacity of local staff and communities to develop and evaluate community programs.

Although all four objectives were equally important, the need to build local capacity heavily influenced the design and methodology of this approach. Every attempt was made to make the process time and resources efficient. The only materials required for the field work were copies of the household survey (six copies per community), a small notebook, and a pencil. The household survey results were all hand-tabulated.

C. Methods

The community assessment and planning activity was conducted in five communities in the Southern Nations and Nationalities People’s Region (SNNPR). Ministry of Health staff were trained in the methodology for one week between January 27 and 31, 1997, in Awassa. A total of 17 participants were trained, including staff from the region, four zones, and five districts in the SNNPR. The group then broke into five teams and went to the five selected communities for 8-9 days. All field work was conducted between February 1 and February 9, 1997. At the end of the fieldwork, the groups returned to Awassa where detailed implementation plans and next steps were developed and discussed between February 10 and 12, 1997. Survey teams and participants are summarized in Appendix B.
The methodology in the community included both participatory and qualitative methods with a structured household survey. For the qualitative and participatory procedures (public meeting, social mapping, free listing, matrix ranking, semi-structured interviews), a suggested checklist of topics or issues was provided which was modified both during the training and in the field. The household survey was developed, pre-tested and translated into Amharic in advance. During the training, minor changes were made on the questionnaire and standard definitions were agreed upon. The qualitative and participatory methods were conducted in 6-7 days and the household survey was conducted in 2 days, so the entire process required 8-9 days in each community. The planning process was conducted in four phases as described below.

**Phase 1: Identifying Partners and Building Partnerships** This emphasized the establishment of working relationships between the health staff and community team members. The health staff were introduced to the community at a public meeting. It was emphasized to the community that teams were there to listen while THEY (the community) drew a map of their community and listed their own health priorities.

**Phase 2: Selecting the Emphasis Behaviors** This involved the use of a simple household survey which collected information on the key child health behaviors in a sample of households. The teams tabulated the data by hand. The behaviors shown to be at unacceptable levels by the survey were ranked by groups of men and women according to the importance of the behavior and the feasibility of changing the behavior. Based on the community ranking, 3-5 priority behaviors were selected.

**Phase 3: Exploring Reasons for the Behaviors** This involved the use of a variety of participatory research techniques, including semi-structured interviews, seasonal calendars, and matrix ranking, to explore the reasons behind the practices of the 3-5 selected behaviors. For each behavior, a list of suggested topics and methods for understanding the behavior more fully were provided to each team.

**Phase 4: Developing Intervention Strategies** This involved the development of interventions based on the reasons people were doing or not doing the selected behaviors. The intervention strategies were suggested by community members and the health staff. During a public meeting, a plan for implementing the strategies was developed. The action plan included the identification of resource needs and allocation of responsibilities.

The following table summarizes the schedule for the activity:
Table 3: Community assessment at a glance

<table>
<thead>
<tr>
<th>Phase</th>
<th>Number of Days</th>
<th>Activities/Procedures</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase 1: Identifying Partners, Building Partnerships and Making a Map</td>
<td>Completed in advance</td>
<td>Logistics Finalization of forms, schedules</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Completed in advance</td>
<td>Selection of focus community Visits to focus community Formation of community team</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5 days: Monday-Friday: Jan 27-31</td>
<td>Training in household survey PRA methods</td>
<td>Awassa</td>
</tr>
<tr>
<td></td>
<td>1 day: Monday, Feb 3</td>
<td>Public meeting Social mapping Free listing and ranking of child illnesses Team Meeting</td>
<td>Focus Communities</td>
</tr>
<tr>
<td>Phase 2: Selecting the Emphasis Behaviors</td>
<td>2 days: Tuesday, Wednesday Feb 4,5</td>
<td>Household survey Hand tabulation Prioritize behaviors (3-5) based on indicators and health impact Matrix Ranking / Scoring Seasonal calendars Team Meeting</td>
<td>Focus Communities</td>
</tr>
<tr>
<td>Phase 3: Exploring the reasons for the behaviors</td>
<td>3 days: Thursday, Friday, Saturday Feb 6,7,8</td>
<td>In-depth interviews Prepare for public meeting</td>
<td>Focus Communities</td>
</tr>
<tr>
<td>Phase 4: Developing intervention strategies and next steps</td>
<td>1 day: Sunday Feb 9</td>
<td>Public meeting Team meeting</td>
<td>Focus Communities</td>
</tr>
<tr>
<td></td>
<td>2 days: Monday, Tuesday Feb 10-11</td>
<td>Further analysis of data and experience Next steps in all districts including follow-up visits by regional staff and district teams</td>
<td>Awassa</td>
</tr>
</tbody>
</table>

IV. CONDUCTING THE SURVEY

Phase 1: Identifying partners and building partnerships

Site selection: Focus districts in each of the project Zones were selected in advance. Within each of the focus districts, health teams selected communities for the initial implementation of project
activities. Criteria used to select these communities included public health need, the absence of NGOs, accessibility, and the availability of a functional health facility. District staff negotiated with communities to arrive at a final selection.

**Forming Ministry of Health and community teams:** Ministry of Health staff from each zone, district and, where possible, local health facilities, were involved in all community planning activities. Local health staff, therefore, represented implementation teams in their own areas. In each selected community, a community action committee was identified to participate in all planning activities. In many cases, this committee already existed, either formally or informally, and was usually composed of the kebele chairman and secretary (elected to be administrative heads of each kebele), schools teachers, agricultural extension workers, community health agents (CHAs), trained birth attendants (TBAs) and village elders. Preliminary visits to each community allowed community committees to be identified and notified about the planning activity and the need for full community involvement.

**Training:** The training was conducted in English and Amharic. Each method was discussed with the group and then practiced using small group exercises and role-plays. The structured household questionnaire was reviewed and consensus reached on the interpretation of each question. All procedures were practiced in the field during the training week. The training timetable is summarized in Appendix C. (Detailed participant guidelines for the training are available from the authors.)

**Public meeting, social mapping, free listing:** The first day in the focus communities was spent building rapport through informal conversations and meetings with community leaders, the community team and traditional healers. In addition, health facility staff and the community team were oriented to the assessment and their roles in the assessment. A meeting was held with as many people from the community as possible and facilitated using the suggested checklist which is summarized below:

**Suggested public meeting checklist**

- Introductions by everyone
- Explanation of purpose: health facility trying to improve services, wants to understand community problems and improve relations with the community, focus on child health
- Explanation of the need for ideas from all community members
- Explanation of what the community can expect from us, including confidentiality
- Introduction of community interviewers and district team and discussion of their roles
- Overview of schedule while in village
Setting the time and place to meet at end of stay to present the information collected and develop an action plan.

After the public meeting, groups of 6-8 men and 6-8 women (two separate groups) were formed to draw a social map of their kebele*. This allowed the outsiders to get an overview of the community as well as to show the community members that the outsiders were interested in learning from them. After the map was drawn on the ground, it was transferred to paper either by community members or the MOH team. A number of pieces of information about the resources, community groups and infrastructure available to the community were obtained by drawing the social map. An example map is attached in Appendix D.

**Suggested checklist for social mapping**

- Overall layout of village
- Water sources
- Roads in and out of village, markets
- Main sources of health care and medicines
- Main ethnic groups and location within the village
- Main socio-economic groups and location within the village, especially the very poor
- "Public goods" such as schools, churches, mosques
- "Parts" or sections of the village, e.g., katana

After the social maps were completed, the same groups of men and women were asked to do a free listing and ranking of children’s health problems. The participants were asked the following questions:

- Can you tell me all health problems that young children have in this community? List all you can think of. (Probing questions: What are the main reasons that children die in this community? What symptoms cause you to worry?)

*Note that a kebele translates to English as a peasant association, which is the lowest administrative unit in Ethiopia. Some kebeles consist of one or more katanas, which represent a traditional social grouping of people or "village".*
Use the matrix of health problems to score the symptoms and illnesses. Place 1-5 beans in each box to show how common or severe the illness or symptom is. The more beans, the more severe or common.

End by asking: Out of all these problems, which one is the most common? Which one is the most severe? If you could be free of any one illness or symptom, which one would it be? Mark these in a special way (e.g., a leaf).

An example of the final outcome of a free-listing and ranking exercise in the Konteb district is summarized in the table below. Each focus community produced a summary of this type, using the same process.

<table>
<thead>
<tr>
<th>Name of Illness or Symptom</th>
<th>How common is this? (5=most common)</th>
<th>How severe is this? (5=most severe)</th>
</tr>
</thead>
<tbody>
<tr>
<td>diarrhea (watery or bloody)</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>sorkopha (swelling of mouth)</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>keke (whooping cough)</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>jenjena (rash on legs that won't heal)</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>scabies (kosha)</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>&quot;Amoeba&quot;</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>swelling of glands in neck</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>pneumonia (sambamich) - “Want to be free of pneumonia because it kills the most”</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>malaria</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>ear discharge (aje)</td>
<td>4</td>
<td>0</td>
</tr>
</tbody>
</table>

Phase 2: Selecting 3-5 Emphasis Behaviors

1. Household survey

Sampling: In each community, 42 households were randomly selected from taxation and land-ownership records using random number tables. Community members were confident that household lists were complete. A lot quality assurance sampling method was used to make decisions about indicators in each community. For this reason, a relatively small number of
households could be sampled. A total of 42 households was selected since it was logistically feasible and was thought to be large enough to allow an estimate of the acceptability of most indicators with reasonable degree of accuracy (10%) and level of confidence (95%).

**Conduct of the survey:** Surveyors conducted the household survey in teams of two. A household was defined as a group of individuals sharing the same cooking pot. Each randomly selected household was visited and only households with children 0-23 months of age were included in the sample. If there were no children 0-23 months of age, then surveyors moved to the next, adjacent house, and repeated this process until a house with a child in this age range was identified. At every household the questionnaire was administered to the primary caretaker of the child. If the primary caretaker was not present at the time of the household visit, then surveyors arranged a time to return to conduct the interview. All questionnaire questions were coded at the end of each day by the team supervisors with survey teams. When all 42 households had been visited, coded data were hand tallied to summarize the performance for each indicator. Questionnaires are attached in Appendix E.

**Using the lot quality assurance technique:** This survey used a lot quality assurance technique to determine whether each of the indicators reached a pre-determined standard. This method classified each indicator as “acceptable” or “not acceptable”. If an indicator was classified as “acceptable”, then it was assumed that the community health program did not need to concentrate program activities on this indicator. If an indicator was classified as “not acceptable”, then it was assumed that additional programmatic resources would be required in order to improve this indicator. This method allowed results from all selected communities to be combined in order to calculate aggregate proportions for each indicator across all communities.

**Upper threshold**

For this survey, an upper threshold of 80 percent was set for every indicator. This was the desired target for each indicator in each community. For example, if 80 percent or more of the infants between birth and 6 months of age in a community were exclusively breastfed, then performance for this indicator would be “acceptable”.

**Lower threshold**

For this survey, a lower threshold of 50 percent was set for every indicator. This was the lowest desirable level for each indicator in each community. For example, if 50 percent or less of children who had been sick in the previous two weeks were given oral medications correctly, then performance for this indicator would be “not acceptable”.

**Deciding whether each indicator was “acceptable” or “not acceptable”**

For each indicator, the number of unacceptable responses required in order to decide that the performance for that indicator was not acceptable was calculated. The number of unacceptable
responses required before calling the performance for the indicator not-acceptable is called the “decision value”. Decision values for a range of different sample sizes have been calculated using an X formula. This formula uses the sample size and pre-determined thresholds to estimate the probability that a certain number of unacceptable responses will occur. Each decision value is selected to produce results with a 90-96 percent level of confidence. For example, if a total of 10 children were selected, the decision value would be three. This means that if more than three children with unacceptable performance were seen in the sample, then the indicator would be classified as being “not acceptable”. If three or fewer children with unacceptable performance were seen, then the indicator would be classified as being “acceptable”. Each team took a decision value table for sample sizes between 7 and 42.

2. Matrix ranking

Behaviors which were not acceptable were presented to groups of men and women (6-8 men or women in each group) and prioritized using matrix ranking. Matrix ranking was done on the ground, using locally available materials as symbols for each behavior, and maize, sticks or berries to rank the importance of the behaviors and the feasibility of changing them. Decisions about the feasibility of changing certain behaviors were based on local perceptions about the complexity of the behavior as well as the resources required to make a change. Based on the information from the matrix ranking, 3-5 of the emphasis behaviors were prioritized. An example of matrix ranking in one community is shown in the table below.

| Table 5: Matrix ranking to prioritize behaviors in Konteb: men’s and women’s groups (Ethiopia Community Assessment and Planning, Jan. 1997) |
|-----------------|-----------------|-----------------|
| Behavior         | Importance | Feasibility | Total |
| **Complimentary feeding** | M 1       | M 2       | W 1     | W 2     | M 1       | M 2       | W 1     | W 2     |
| **Measles vaccination at 9 months** | 4         | 4         | 4       | 5       | 5         | 5         | 4       | 3       | 34   |
| **Antenatal care and tetanus toxoid vaccination** | 5         | 2         | 5       | 5       | 6         | 5         | 5       | 5       | 38   |
| Appropriate care-seeking | 3         | 2         | 4       | 5       | 5         | 5         | 5       | 5       | 34   |
| Use a modern method of contraception | 4         | 3         | 3       | 5       | 3         | 5         | 5       | 1       | 29   |
| Wash hands with soap at appropriate times | 5         | 5         | 1       | 5       | 3         | 1         | 3       | 1       | 24   |
| **Store/transport water in narrow-necked, covered containers** | 4         | 3         | 3       | 4       | 4         | 5         | 4       | 5       | 32   |

**Selected Behaviors
Phase 3: Exploring Reasons for the Behaviors

The major barriers to performing the 3-5 prioritized behaviors were further investigated. A suggested checklist for conducting in-depth interviews and focus groups was developed for each behavior and these were further modified in the field. An example of a checklist used for exclusive breastfeeding is shown on the next page. One-page summary checklists for each behavior are summarized in Appendix F.

Different qualitative and participatory procedures were used to further explore barriers to practicing the priority behaviors. These procedures included semi-structured interviews, free listing, matrix ranking, seasonal calendars and bean counting. For example, one of the behaviors selected in Konteb zone was “From 6-24 months, provide appropriate complimentary feeding”. To understand more about this behavior, a group of 6-8 women with young children was brought together and asked to list all the foods that children under 2 eat (free-listing). After a complete list was developed, the women were asked what was good about some of the different foods in order to develop criteria for comparing the different foods. Using the list of foods and the criteria, all the weaning foods were scored using a matrix. The results are shown in the table below:

<table>
<thead>
<tr>
<th>Table 6: Matrix ranking of weaning foods by women in Konteb (Ethiopia Community Assessment and Planning, Jan. 1997) (10 means more fat, nutrition etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fatty</strong></td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>Fatty</td>
</tr>
<tr>
<td>Replaces milk</td>
</tr>
<tr>
<td>Gives energy</td>
</tr>
<tr>
<td>Nutritious</td>
</tr>
<tr>
<td>Easy to digest</td>
</tr>
<tr>
<td>Easy to prepare</td>
</tr>
</tbody>
</table>

*Ereta* is a local weaning food made of several grains, legumes, and butter all mashed together.

When the matrix scoring was complete, the women were then asked about the seasonal variations in the foods that they had listed. During this discussion, the women mentioned that not all women know how to prepare the local food *ereta* and that women would like to learn this from other women, so the link between understanding more about the behavior and developing strategies was easily made.
**Guidelines to understand more about: “Breastfeed exclusively for about six months”**

What are people doing now?
- Are mothers initiating breastfeeding within a couple hours after birth?
- Are children under 3 months given any supplemental teas, milks or other liquids?
- Are children under 4-6 months given any supplemental teas, milks, liquids or solids?
- Are children fed on demand, including night feeding?

What are the reasons for doing the behaviors?

What are the reasons for not doing the behaviors?
- What do mothers do if they perceive their milk is not enough for the baby?
- What do mothers do if they have to be separated from the infant for more than half a day?

**Suggested Methods**

Beans with key informants (grandmothers, TBAs, mothers of children under 6 months)
- The total pile of beans is all children under 6 months old
- How many beans are exclusively breastfed?
- Of the beans not exclusively breastfed, what are the main reasons for not exclusively breastfeeding?

Interviews with women exclusively breastfeeding and not exclusively breastfeeding child under 6 months (can be identified from the survey)
- Interviews with health care providers, traditional healers

<table>
<thead>
<tr>
<th>Common reasons why people do not do these behaviors</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Concerns of the mother</strong></td>
</tr>
<tr>
<td>&quot;Child is always hungry&quot;—Mother believes she does not have enough milk for the child</td>
</tr>
<tr>
<td>&quot;I don't know what to do&quot;—There is no family member or friend who can help the mother when she has a problem with breastfeeding.</td>
</tr>
<tr>
<td>&quot;The weather is very hot&quot;—Concern that the child needs additional fluids on hot days; breastmilk is not sufficient.</td>
</tr>
<tr>
<td>Family members and friends want to help mother, look after child much of the day, mother does not get chance to breastfeed.</td>
</tr>
<tr>
<td>If mother is sick, she should stop breastfeeding or sickness will be transmitted to her child.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Concerns of the father</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual relations not allowed if mother is breastfeeding, so father does not encourage mother to breastfeed.</td>
</tr>
<tr>
<td>Mother spends too much time breastfeeding, neglects other duties such as agricultural work, care of other children.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Health care providers and traditional healers</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother advised not to breastfeed if child has diarrhea.</td>
</tr>
<tr>
<td>Health care providers do not know what to tell mother if she has trouble breastfeeding</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Environmental/ Economic</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Women do not take their infant to the field, market, or workplace and hence cannot breastfeed.</td>
</tr>
<tr>
<td>A mother may not sleep with her infant, making night feeding difficult.</td>
</tr>
</tbody>
</table>
The results of the semi-structured interviews and other methods were analyzed by listing the reasons why people were doing and not doing the selected behavior. An example for measles vaccination from one community is shown below:

Table 7: Reasons for getting and not getting measles vaccination in Konteb (Ethiopia Community Assessment and Planning, Jan. 1997)

<table>
<thead>
<tr>
<th>Reasons for doing the behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge of benefits</td>
</tr>
<tr>
<td>Children in school remind and educate mothers</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reasons for not doing the behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of awareness</td>
</tr>
<tr>
<td>Not convinced that vaccination works (belief that vaccinations prevent scabies, AIDS, and other diseases)</td>
</tr>
<tr>
<td>Fear of side effects</td>
</tr>
<tr>
<td>Husbands don’t motivate mothers to take the child</td>
</tr>
<tr>
<td>Vaccinations offered only on Tuesdays</td>
</tr>
</tbody>
</table>

Phase 4: Developing Intervention Strategies and Next Steps

Intervention strategies were developed with the community health committee, using information collected during semi-structured interviews and group discussions. Strategies were usually suggested by community members and a few came from the MOH team. An example of strategies proposed for improving measles vaccination coverage is shown in the table below. Note that these strategies relate very closely to the reasons for getting or not getting measles vaccine summarized above. Intervention strategies were developed in every community for each of the prioritized behaviors.
Table 8: Strategies for measles immunization coverage in Konteb  
(Ethiopia Community Assessment and Planning, Jan. 1997)

<table>
<thead>
<tr>
<th>Strategies—Health Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Offer vaccination services every day</td>
</tr>
<tr>
<td>2. Health education on which diseases are vaccine preventable</td>
</tr>
<tr>
<td>3. Health workers to explain and counsel on side effects</td>
</tr>
<tr>
<td>4. Check vaccination status during sick child visits</td>
</tr>
<tr>
<td>5. Orientation of health workers on contraindications and reduce fears of wastage and use</td>
</tr>
<tr>
<td>of the steam sterilizer</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Strategies—Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. One person in each village to disseminate the message and check vaccination status</td>
</tr>
<tr>
<td>2. Motivate school children to bring brothers and sisters for vaccination</td>
</tr>
<tr>
<td>3. Raise awareness of the community on their right to get child immunized any time</td>
</tr>
<tr>
<td>during working hours</td>
</tr>
</tbody>
</table>

**Public meeting:** On the final day of the community assessment, another public meeting was called to present the selected behaviors and the strategies proposed for improving them. Community members were encouraged to ask questions and to contribute ideas or suggestions for improving the intervention strategies. An action plan for all follow-up activities was then developed and discussed with community members. During this process, it was made clear that responsibilities for all implementation activities would need to be split between the community, the Ministry of Health staff, and the BASICS project. In some communities, the action plan was presented to the community as a “contract” which was signed by all persons in attendance. An example of an action plan from one community is shown below.
Table 9: Summary of actions to be taken in Alaba
(Ethiopia Community Assessment and Planning, Jan. 1997)

**Community**
- Collect 3 Birr from each household within one week to establish a revolving drug fund.
- Form health committee to administer the revolving drug fund.
- Mohammed Ribato will start working again as a CHA once the health post has been repaired.
- Men will help women after birth (fetching water, market) so they can exclusively breastfeed for six months.
- Mothers will prepare complementary foods for their young children as demonstrated at the public meeting.
- Mothers will continue feeding during illness with breastmilk, food-based home-made ORT, and small amounts of the regular food given frequently.

**Health department**
1) Procure drugs from Pharmid in Awassa, using money collected from the community (zone).
2) Provide certain drugs, such as vitamin A and ORS, which are in zonal stores free of charge. Assess other potential sources of free drugs such as the Catholic Missions (zone).
3) Supervise revolving drug fund (woreda).
4) Participate in community-based training. Schedule and content will be prepared in the woreda office.
5) Provide outreach (vaccination, antenatal/postnatal care and family planning) at the kebele health post (woreda).

Planning next steps: After completing planning work in communities, teams returned to Awassa where each community action plan was presented and discussed. Aggregate household indicators were calculated and follow-up responsibilities for Ministry of Health and BASICS staff were planned. Each district/community implementation team was linked with a local BASICS staff member who will be responsible for providing long-term follow-up and support. At the end of the planning process, each district/community implementation team had a clear action plan for the focus community, with a set of prioritized next steps. Arrangement had been made with the BASICS support staff for follow-up visits.

V. RESULTS AND DISCUSSION

A. Indicators

A summary of the status of the indicators for each community is presented below:
Infant and child feeding practices

| Indicator                                                      | Ashoka | Wicho | Dola | Demble | Shurmo | Overall*** proportion |
|                                                               |        |       |      |        |        |                     |
| Infants and children 0-6 months exclusively breastfed         | 4/14   | 4/13  | 5/14 | 2/21   | 6/9    | 35% (N=71)           |
|                                                               | NA*    | NA    | NA   | NA     | NA     |                     |
| Children 7-23 months receiving 3-5 complementary feeds in addition to breastfeeding | 1/29   | 24/29 | 18/28 | 15/21  | 10/33  | 52% (N=140)          |
|                                                               | NA     | A**   | NA   | A      | NA     |                     |
| Children 0-23 months with a growth monitoring card            | 3/42   | 14/42 | 4/42 | 26/42  | 10/42  | 25% (N=210)          |
|                                                               | NA     | NA    | NA   | NA     | NA     |                     |
| Children 0-23 months with a growth card weighed in the last four months | 0/3    | 0/14  | 1/4  | 0/26   | 4/10   | 9% (N=57)           |
|                                                               | NA     | NA    | NA   | NA     | NA     |                     |

*NA=Not Acceptable, **A=Acceptable, ***Weighted for sample size

**Comments:** A relatively low proportion of infants are exclusively breastfed in these communities. A number of reasons for the lack of exclusive breastfeeding were identified during in-depth interviews and focus groups, including a lack of awareness of the importance of exclusive breastfeeding, the belief that breastmilk is not enough for a growing child, and the lack of time available for mothers to breastfeed when they are also attending to household chores and agricultural work. Strategies to improve exclusive breastfeeding focused on improving awareness and removing barriers which prevent women from breastfeeding.

Half of the caretakers in these communities report giving an adequate number of complementary feeds in addition to breastfeeding. There is considerable seasonal variation in the quality and quantity of foods given. Barriers to effective complementary feeding included the lack of adequate foods and lack of awareness of the importance of giving certain foods to children. For example, a local food called Ereta, composed of several grains, legumes and butter is likely to be a good, energy-dense weaning food. However, in some communities it was not perceived as an appropriate weaning food for children; even where it was considered the best weaning food, many mothers didn’t know how to make it. In addition, there is a general lack of awareness of the importance of active feeding to encourage food intake; in many communities children are fed passively and left to “fend for themselves” at meal times. Approaches to improving complementary feeding included improving community awareness of the importance of weaning foods and developing strategies for improving feeding in the home. In some communities,
APPENDIXES
APPENDIX A

MAP OF THE SNNPR
women’s groups expressed a need for “nutrition support groups” to help train women with young children to feed correctly.

A relatively low proportion of children had a growth monitoring card, and had been weighed in the previous four months. In all communities, there was a lack of awareness of the importance of nutrition and body weight as a marker of nutritional performance. The most frequent barrier to improving growth monitoring was the performance of health workers; health workers often did not distribute child health cards and, even when a child had a health card, health workers did not weigh and plot these children. There is a lack of awareness among health facility staff about the importance of nutrition. This finding fits with the results of the health facility assessment conducted in September 1996 in the same woredas; only 4 percent of sick children attending facilities during this survey had their nutritional status examined and only 9 percent were weighed.

**Immunization practices**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Ashoka</th>
<th>Wicho</th>
<th>Dola</th>
<th>Demble</th>
<th>Shurmo</th>
<th>Overall*** proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children 12-23 months who have received measles vaccine (card only)</td>
<td>0/3</td>
<td>9/20</td>
<td>1/13</td>
<td>3/10</td>
<td>5/23</td>
<td>24% (N=69)</td>
</tr>
<tr>
<td>Children 0-23 months with an immunization card</td>
<td>3/42</td>
<td>20/42</td>
<td>4/42</td>
<td>26/42</td>
<td>10/42</td>
<td>30% (N=210)</td>
</tr>
<tr>
<td>Women currently pregnant or with a child 0-11 months who have received TT2+ (card only)</td>
<td>3/28</td>
<td>10/19</td>
<td>2/28</td>
<td>9/19</td>
<td>8/21</td>
<td>35% (N=115)</td>
</tr>
<tr>
<td>Mothers with a maternal health card</td>
<td>5/42</td>
<td>18/42</td>
<td>5/42</td>
<td>27/42</td>
<td>4/42</td>
<td>27% (N=210)</td>
</tr>
</tbody>
</table>

*NA=Not Acceptable, **A=Acceptable, ***Weighted for sample size

**Comments:** Measles vaccine coverage (card only) is low in these communities, suggesting that health facilities are not routinely vaccinating infants, even if they have received a vaccination card. Only about one-third of all children 0-23 months had received a vaccination card. It is unlikely that children without vaccination cards in these communities have been vaccinated; none of the communities had received mass campaigns and outreach was often irregular or non-existent. A similar pattern was observed for TT vaccination for women. In-depth interviews and focus groups suggested that there are a number of possible reasons for the poor card and vaccine coverage. At the household level, caretakers often had a low level of awareness of the diseases prevented by vaccination and did not seek vaccination services, were afraid of side-effects such
as fever or post-vaccination abscesses, and thought that exposing a young child to other children at health facilities was dangerous (exposing children to the “evil eye”). Caretakers complained that they often were able to get vaccinated on only one day of the week. Health workers demonstrated an unwillingness to vaccinate every day due to vaccine wastage. Importantly, health workers had a low level of awareness of the importance of screening and vaccinating mothers and children at every opportunity and sometimes believed that there are false contraindications to vaccinate. These findings support those of the health facility assessment in September 1996 where it was found that only 15 percent of sick children visiting health facilities had their vaccination status checked at the time of this visit, while 0 percent of the mothers of these children had their vaccination status checked. Overall, only 10 percent of children had their vaccination card at the time of the sick child visit.

Strategies suggested for improving vaccination coverage included improving the awareness of caretakers through a variety of channels, including educating school children to educate their parents. In addition, a number of facility-based strategies were suggested, including training health workers to avoid missed opportunities to vaccinate and to provide vaccination services more frequently.

**Home health practices: prevention**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Ashoka</th>
<th>Wicho</th>
<th>Dola</th>
<th>Demble</th>
<th>Shurmo</th>
<th>Overall*** proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women who made at least 2 antenatal visits for the last pregnancy</td>
<td>5/42</td>
<td>12/42</td>
<td>3/42</td>
<td>11/42</td>
<td>17/42</td>
<td>23% (N=210)</td>
</tr>
<tr>
<td></td>
<td>NA*</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Women using a modern method of birth control</td>
<td>0/42</td>
<td>5/42</td>
<td>0/38</td>
<td>0/42</td>
<td>1/42</td>
<td>4% (N=206)</td>
</tr>
<tr>
<td></td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Households with soap available</td>
<td>21/42</td>
<td>28/42</td>
<td>7/42</td>
<td>22/42</td>
<td>21/42</td>
<td>47% (N=210)</td>
</tr>
<tr>
<td></td>
<td>NA</td>
<td>A**</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Households using covered, narrow-necked containers for storing and transporting water</td>
<td>6/42</td>
<td>8/42</td>
<td>0/42</td>
<td>1/42</td>
<td>6/42</td>
<td>10% (N=210)</td>
</tr>
<tr>
<td></td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
</tbody>
</table>

*NA=Not Acceptable, **A=Acceptable, ***Weighted for sample size

**Comments:** A low proportion of women reported having two or more antenatal visits for their last pregnancy. Reasons for the lack of antenatal care included lack of awareness of the importance of preventive screening visits during pregnancy, the belief that caretakers only had to worry if signs or symptoms were noticed, the belief that other family members of neighbors were able to provide support if required, and long distances from health facilities which were “too far”
for pregnant women to walk. Strategies for improving antenatal care-seeking included increasing community awareness of its importance through TBAs and community organizations, and improving the availability of antenatal services by linking them with vaccination outreach or by training community health workers to provide them.

A very low proportion of women of childbearing age were using a modern method of contraception. Communities were mixed in their attitudes towards contraception. In some communities, women stated that they did not want to limit family size in any way, while in others, they recognized that it was important (often because land availability was limited), and expressed a desire to learn more. Principal barriers to more widespread use of contraception included an absence of demand for these services, and, where a demand might have existed, a lack of information and services. In those communities believing that it was important to limit family size, there is a need for better education on options and approaches towards contraception.

Almost half of the households had soap available in the house. Although this survey did not allow a detailed analysis of handwashing behavior, the majority of communities reported that handwashing with soap was not practiced regularly. The primary barriers to handwashing included a lack of awareness of its importance, problems keeping hands clean when there were young children in the house, a lack of water for washing hands, and the cost of soap. It was acknowledged in some communities that hand washing could be done better with available resources by increasing awareness of its importance.

A low proportion of households stored and transported water in covered, narrow-necked water containers. Water was identified as an important issue in all communities, although there was very little awareness of the importance of storage and transport for improving water quality. In general, water is collected in open-necked containers and water is removed by dipping into these containers; young children often place their hands into water containers used for storage. Barriers to improving this practice included, the lack of suitable containers and their expense (an open-necked clay water container costs approximately 6 Birr while a plastic jerry can with a narrow mouth costs approximately 60 Birr), and a belief that it is important to regularly clean the inside of containers manually (impossible to do with a narrow-necked container). Possible strategies suggested for improving this practice were better education of families and the production of narrow-necked clay pots by local potters.
Home health practices: treatment

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Ashoka</th>
<th>Wicho</th>
<th>Dola</th>
<th>Demble</th>
<th>Shurmo</th>
<th>Overall*** proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children 0-23 months, sick in the last 2 weeks, given oral medications correctly</td>
<td>2/11</td>
<td>1/8</td>
<td>1/15</td>
<td>4/11</td>
<td>1/6</td>
<td>17% (N=51)</td>
</tr>
<tr>
<td></td>
<td>NA*</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Children 0-23 months, sick in the last 2 weeks, given fluids appropriately during the illness</td>
<td>3/37</td>
<td>2/26</td>
<td>10/36</td>
<td>3/33</td>
<td>2/36</td>
<td>11% (N=168)</td>
</tr>
<tr>
<td></td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Children 0-23 months, sick in the previous 2 weeks, given food appropriately during the illness</td>
<td>2/37</td>
<td>8/25</td>
<td>0/25</td>
<td>4/33</td>
<td>11/19</td>
<td>26% (N=139)</td>
</tr>
<tr>
<td></td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Children 0-23 months, sick in the previous 2 weeks, who received home treatment</td>
<td>11/37</td>
<td>5/26</td>
<td>17/36</td>
<td>10/33</td>
<td>12/36</td>
<td>41% (N=168)</td>
</tr>
<tr>
<td></td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
</tbody>
</table>

*NA=Not Acceptable, **A=Acceptable, ***Weighted for sample size

Comments: The caretakers of any child 0-23 months who had been sick in the two weeks before the survey were asked questions about the management of their child during the illness. In order to be included in the sample, children had to have had at least one of the following symptoms or diagnoses: fever/malaria, watery or bloody diarrhea, cough, fast or difficult breathing/pneumonia, measles. Caretakers were asked about the medication given for each illness and the dose described was compared to the national treatment guidelines for that medication. A low proportion of caretakers were giving or had given medication according to the national treatment guidelines. The most frequent problem noted was that courses were given for an insufficient number of days. Barriers to taking a full course included being given poor instructions by health workers, being unable to afford a full course of medications, and needing to save as much medicine as possible so that it could be used for the next illness.

In general, caretakers did not give fluids (including breastmilk) or foods appropriately during the illness. In order to be considered appropriate, fluids or breastmilk had to be increased during the illness and foods had to remain the same or be increased. Barriers to giving fluids or food included a perception that fluids and food should be reduced during the illness, lack of demand from infants and children, and a lack of awareness of the importance of this issue. Overall, only 41 percent of caretakers reported doing anything at all in the home for their child when s/he was recognized as being sick. There appears to be a low awareness of the potential importance of home management in the management of sick children. Strategies proposed to improve the
management of sick children included improving the awareness of simple home-management strategies for sick children by training community health workers to educate caretakers, and improving the prescription of drugs and counseling in how to take drugs at home by health workers. In some communities, pharmacists and drug sellers are important sources of medications and it was suggested that these groups could also be better trained to prescribe medications according to national treatment guidelines and to counsel caretakers in how to take them properly.

**Home health practices: care-seeking**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Ashoka</th>
<th>Wicho</th>
<th>Dola</th>
<th>Demble</th>
<th>Shurmo</th>
<th>Overall*** proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caretaker knowledge of at least 2 signs for seeking care for their children</td>
<td>39/42</td>
<td>22/42</td>
<td>42/42</td>
<td>33/42</td>
<td>34/42</td>
<td>78% (N=210)</td>
</tr>
<tr>
<td></td>
<td>A**</td>
<td>NA*</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td></td>
</tr>
</tbody>
</table>

*NA=Not Acceptable, **A=Acceptable, ***Weighted for sample size

**Comments:** Signs for care-seeking included fever, not playing, not eating or drinking, fast or rapid breathing, convulsions, drowsy or change in consciousness and looking unwell. Most caretakers were able to list at least two of these signs. It is less clear how this knowledge translated to actual care-seeking behavior. In-depth interviews and focus groups suggested that there are often other barriers to taking children to health facilities, even if the signs and symptoms of illness are recognized, including distance, lack of time to visit the health facility, and being unable to afford medications. Most communities proposed improving the availability of services to communities by providing more outreach and by re-activating community health workers.

**B. Priorities and Strategies**

The health problems and health behaviors prioritized by the communities and an overview of strategies proposed for addressing these problems in each community are summarized below. Communities identified similar priority child health problems. The most important health problems of children identified by communities are summarized in the table. In general, there was agreement between community members and health staff on the most important causes of mortality and morbidity.
Table 10: Results of free-listing and ranking (Ethiopia Community Assessment and Planning, Jan. 1997)

<table>
<thead>
<tr>
<th>Health Problem</th>
<th>Number of Communities Ranking Important</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diarrhea</td>
<td>5</td>
</tr>
<tr>
<td>Malaria</td>
<td>4</td>
</tr>
<tr>
<td>Malnutrition</td>
<td>4</td>
</tr>
<tr>
<td>Pneumonia, cough</td>
<td>3</td>
</tr>
<tr>
<td>Measles</td>
<td>2</td>
</tr>
<tr>
<td>Sorkopa, tonsillitis</td>
<td>2</td>
</tr>
<tr>
<td>Scabies, skin problems</td>
<td>1</td>
</tr>
<tr>
<td>Eye problems</td>
<td>1</td>
</tr>
</tbody>
</table>

A total of ten different behaviors were selected by the five focus communities. These are summarized in the next table.

Table 11: Selected behaviors by communities (Ethiopia Community Assessment and Planning, Jan. 1997)

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Number of communities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusive breastfeeding</td>
<td>4</td>
</tr>
<tr>
<td>Antenatal care</td>
<td>4</td>
</tr>
<tr>
<td>Measles vaccination at 9 months</td>
<td>3</td>
</tr>
<tr>
<td>Store/transport water in narrow-necked, covered containers</td>
<td>3</td>
</tr>
<tr>
<td>Administer treatment medicines according to instructions</td>
<td>3</td>
</tr>
<tr>
<td>Provide appropriate complimentary feeding</td>
<td>2</td>
</tr>
<tr>
<td>Continue feeding and increase fluids during and after illness</td>
<td>2</td>
</tr>
<tr>
<td>Use a modern method of contraception</td>
<td>1</td>
</tr>
<tr>
<td>Seek tetanus toxoid vaccination</td>
<td>1</td>
</tr>
<tr>
<td>Wash hands with soap at appropriate times</td>
<td>1</td>
</tr>
</tbody>
</table>
These results show that the methods are simple and streamlined enough to be a part of routine MOH work for many people.

Since this is the first time that this process has been field-tested, we will review the experience in detail to make modifications. We expect to field-test this approach in other countries as well. Some of the changes that we will consider include:

- revision of the household questionnaire
- revision of the one-page guidelines for each behavior so that they are in the form of actual checklists for each behavior
- revision and/or deletion of the summary forms
- development of streamlined participant guidelines which include too much text now
- checklist for reviewing the field experience with the participants
A summary of the most important health problems, prioritized health behaviors and strategies developed for each community is compiled in Appendix G. Communities and health staff were encouraged to develop action plans that were feasible using existing resources and structures. In general, approaches developed in communities focused on the household (the knowledge and behavior of caretakers), the broader community (supports required to sustain or enable household behaviors, such as the availability of soap or community health workers), and the health facility (health worker knowledge and practice, the availability of medications). The emphasis behaviors provided a focus for program planning, although there was considerable overlap between strategies and actions plans. For example, limited availability of services was a constraint for obtaining measles and TT vaccinations, antenatal care, medications, and sometimes appropriate care-seeking behavior. Availability was limited both because facilities were not geographically accessible and because some health facilities did not provide quality services.

Strategies developed by communities had a number of similarities. At the health facility level there was a recognition that there is a need for greater integration of services to reduce missed opportunities for immunization and ANC screening. Counseling and health education by health workers on several key primary health care topics was often raised as important. In communities, there is a need to involve community-based health workers and community groups to conduct health education and motivate community members to seek services. Both facility and community-based health workers need more training, especially in the areas of counseling and health education. Improved community organization and participation was recognized as important to support household behavior change. Most communities wanted to involve existing community groups such as churches, mosques and schools in health work. Some expressed a need for “support groups” such as health and nutrition groups.

The need to develop incentives for community health workers was raised in all communities and considered essential to sustain their performance. Community groups discussed the development of revolving drug funds, or central community funds for supporting community health workers, as well as non-monetary incentives such as regular training, and the provision of farming assistance for community health workers and their families. Other frequently raised issues included the need for community health posts for community health workers and the need for improved sources of safe water. Most community action plans included provisions to address these problems in a limited fashion; all construction activities were negotiated with communities so that labor and resource inputs were shared as much as possible.

An overall summary of all community strategies is presented below:

**Improved quality and availability of health services**

- Conduct ANC screening during vaccination sessions.
- Check immunization status of mothers and children during sick child visits.
- Improve patient-provider interactions.
- Improve prescribing practices.
- Identify TBAs and CHWs.
- Build community health post.

Training
- Train first-level health workers in key primary health care tasks.
- Train CHAs and TBAs in essential community-level tasks which focus on the emphasis behaviors.

Community Organization and Participation
- Form health committees and nutrition groups.
- Involve schools, churches and extension workers in health education.
- Establish a health fund to be administered by the peasant association.
- Men to assist women with chores.
- Contribution of labor and material for health post.
- Potters to produce narrow-necked water pots.

Health Education Topics
- Taking medication correctly.
- Vaccine-preventable diseases and vaccine side effects.
- Teaching and demonstration of local weaning foods.
- Importance of exclusive breastfeeding.
- Importance of ANC and TT.
- Dangers signs for appropriate care-seeking.

VI. REVIEW OF THE PARTICIPATORY PLANNING PROCESS

This participatory approach trained local Ministry of Health staff, including health workers, to use participatory methods to plan primary health care activities in communities. Both the community and the MOH teams felt a sense of ownership of the process and felt that the information collected was accurate. The fact that the process resulted in concrete action plans rather than simply a research report was critical to the success of this approach. These action plans enabled everyone, but especially the MOH and community teams, to respond to the question “What will you do with all this information you are collecting?”

During the field work it was found that much of the process was intuitive and easily internalized by both Ministry of Health staff and communities. At the end of the process, the MOH teams completed an evaluation of the activity. The complete results are attached in Appendix H. When asked if they could do the method on their own, at least half the participants felt they could do all except one (manual tabulation of indicators) of the procedures without any additional training, and most of the others felt they could do them with a little more help. For all the procedures, the vast majority of respondents reported that they expected to use them in their work in the coming months. Similarly, with the exception of matrix ranking and manual tabulation of indicators, more than half the respondents felt they could teach the methods to others without any assistance.
Figure 1: Southern Ethiopia Peoples' Region Geographical Location

KEY
- International boundary
- Regional boundary
- Zonal boundary
- Special woreda boundary
- Lakes
- Selected Districts

CAUTION - The delineation of boundaries on this map must not be considered authoritative.

ETHIOPIA

GAMBELA

GURAGUE

OROMIYA

NORTH OMO

SOUTH OMO

SUDAN

KENYA

Date: Jan 1994
Scale: 1:3,000,000

Southern Planning and Economic Devt Bureau

Date: Jan 1994
Scale: 1:3,000,000

CAUTION - The delineation of boundaries on this map must not be considered authoritative.
APPENDIX B

SURVEY TEAMS
Appendix B: Survey Teams

ALABA: Leul Seged Asfaw
       Abu Awol
       Sr. Workenesh Kereta
       Dr. Peter Winch

BONKE: Kassahum Belete
       Tomas Toina
       Wondimu Amdie
       Dr. John Murray

BOLOSOSORE: Oaulos Amenta
              Getachew Assefa
              Dr. Mengistu Asnake
              Melissa Woods

DALE: Kekebo Debake
      Ashenafi Argeta
      Dr. Solomon Worku
      Dr. Mulageta Betre
      Dr. Paul Freund

KONTEB: Tirfe Mesfin
        Belay Roma
        Dr. Tekeleab Kedamo
        Dr. Karabi Bhattacharyya
APPENDIX C

TRAINING TIMETABLE
## Appendix C: Training Timetable

<table>
<thead>
<tr>
<th>Day and Date</th>
<th>Activities</th>
</tr>
</thead>
</table>
| Monday January 27  | **Morning** Administration  
                   | Review of focus woredas and communities  
                   | Overview of the problem solving process and emphasis behaviors  
                   | **Afternoon** Discussion and exercises on community participation and communication |
| Tuesday January 28 | **Morning** Discussion of public meeting, social mapping and free listing/ranking  
                   | Practice social mapping and free listing/ranking in workshop  
                   | **Afternoon** Review of the household survey questionnaire  
                   | Role plays using household questionnaire |
| Wednesday January 29 | **Morning** Continued review of the household questionnaire  
                      | Practice social mapping, free listing and ranking, and household questionnaire in a nearby community  
                      | **Afternoon** Discussion of problems encountered during field exercise  
                      | Further discussion and practice of household questionnaire |
| Thursday January 30 | **Morning** Role play of household questionnaire  
                      | Review developing a checklist  
                      | Review semi-structured interviews  
                      | **Afternoon** Role play in groups to develop a checklist and conduct a semi-structured interview  
                      | Review the use of matrix ranking and scoring |
| Friday January 31  | **Morning** Continued practice of semi-structured interviews and matrix ranking  
                   | Development of a team contract  
                   | Teams prepare for field work  
                   | **Afternoon - with team leaders only** Review of overall process  
                   | Sampling procedures for qualitative and quantitative methods  
                   | Hand tabulation and analysis of household questionnaire  
                   | Selecting the behaviors  
                   | Developing the action plan |
APPENDIX D

EXAMPLE OF A SOCIAL MAP
APPENDIX E

SURVEY QUESTIONNAIRES
Appendix E: Survey Questionnaires

COMBINED HOUSEHOLD SURVEY (ARI, malaria, diarrhea, feeding, EPI)

<table>
<thead>
<tr>
<th>District</th>
<th>Name of village/community</th>
<th>Interviewer number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Date __/__/__

AT EVERY SELECTED HOUSEHOLD ASK HOW MANY CHILDREN LESS THAN 2 YEARS OLD LIVE IN THE HOUSEHOLD

COMPLETE ONE COLUMN FOR EACH CHILD LESS THAN 2 YEARS OLD

<table>
<thead>
<tr>
<th>Household number</th>
<th>Child’s name</th>
<th>Child’s number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. What is (Name’s) date of birth __/__/__

   Record date, or write DK if unknown
   If the date is known, go to 4.
   If the date is unknown, go to 3.

2. How old is (Name)?_______

   If less than 1 month old, record “<1 mo”
   If 1-23 months, record “_____mo”

4/6
### FEEDING

<table>
<thead>
<tr>
<th>Child’s name</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Child’s number</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. Since this time yesterday, has (Name) been breastfed? Yes or no

If YES, go to question 4.
If NO, go to question 5.

4. Since this time yesterday, did (Name) receive?

**Prompt for each item and tick if YES**

- a. Vitamins, mineral supplements
- b. Plain water
- c. Sweet or flavored water
- d. Fruit juice
- e. Tea
- f. ORS solution
- g. Bottled soft drinks
- h. Infant formula
- i. Tinned, powdered or fresh milk
- j. Solid or semi-solid food
- k. Other fluids (specify) __________

Is the child aged 6 months or less? Yes or No

**A. If aged between 0-6 months, has the infant been exclusively breastfed?**
Yes or No
<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. How many times a day do you feed (Name) with solid or semi-solid foods?</td>
<td></td>
</tr>
<tr>
<td>6. Are you giving your child any of the following foods every day?</td>
<td>a. Porridge, semolina, gruel</td>
</tr>
<tr>
<td></td>
<td>b. Carrot, squash, mango or papaya</td>
</tr>
<tr>
<td></td>
<td>c. Dark green leafy vegetables such as spinach</td>
</tr>
<tr>
<td></td>
<td>d. Meat or fish</td>
</tr>
<tr>
<td></td>
<td>e. Lentils, peanuts or beans</td>
</tr>
<tr>
<td></td>
<td>f. Eggs or yogurt</td>
</tr>
</tbody>
</table>

**Is the child aged 7-24 months?**

Yes or No

**B. If aged between 7-24 months, is the child receiving 3-5 complementary feeds in addition to breastfeeding?** Yes or No
# CHILD ILLNESS

<table>
<thead>
<tr>
<th>Child’s name</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Child’s number</td>
<td></td>
</tr>
</tbody>
</table>

7. Has (Name) had any of these symptoms or problems in the last 2 weeks?

*Prompt for each listed symptom and tick if YES*

- a. Illness with cough
- b. Blocked or runny nose
- c. Fever
- d. Watery diarrhea
- e. Bloody diarrhea
- f. Fast breathing
- g. Difficult breathing
- h. Measles

Were the symptom(s) fast breathing or difficult breathing due to a problem in the chest or a blocked nose?

<table>
<thead>
<tr>
<th>Chest</th>
<th>Nose</th>
<th>Chest and nose</th>
<th>Don't know</th>
<th>Other (specify)</th>
</tr>
</thead>
</table>

If "chest" or "don't know"; leave the tick by fast breathing and/or difficult breathing. Otherwise cross out the tick by these symptoms.

If any of the following are ticked, go to question 8:

**ILLNESS WITH COUGH, FAST BREATHING or DIFFICULT BREATHING**

**FEVER**

**DIARRHEA**

**MEASLES**

If none of the symptoms above are ticked, go to question 17
<table>
<thead>
<tr>
<th>8.</th>
<th>Did you do anything to treat (Name) in the home when they developed the illness. <em>Yes or No</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>If YES, go to question 9</td>
<td>If NO, go to question 10</td>
</tr>
<tr>
<td>9.</td>
<td>How did you treat (Name) in the home?</td>
</tr>
<tr>
<td>Enter the letter corresponding to the response. Specify if necessary</td>
<td></td>
</tr>
<tr>
<td>a. Antibiotic</td>
<td></td>
</tr>
<tr>
<td>b. Other medicine or drug</td>
<td></td>
</tr>
<tr>
<td>c. Traditional remedy</td>
<td></td>
</tr>
<tr>
<td>d. ORS</td>
<td></td>
</tr>
<tr>
<td>e. Home fluid</td>
<td></td>
</tr>
<tr>
<td>f. Other (Specify)</td>
<td></td>
</tr>
</tbody>
</table>

| C. Treatment given in the home | Total # a. b. c. d. e. f. |

<table>
<thead>
<tr>
<th>10.</th>
<th>Did you seek care outside of the home when (Name) developed the illness? <em>Yes or no</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>If YES, go to question 11</td>
<td>If NO, go to question 14</td>
</tr>
<tr>
<td>11.</td>
<td>Where or from whom did you seek care?</td>
</tr>
<tr>
<td>a. Traditional healer</td>
<td></td>
</tr>
<tr>
<td>b. Religious leader</td>
<td></td>
</tr>
<tr>
<td>c. Government hospital</td>
<td></td>
</tr>
<tr>
<td>d. Government health center or clinic</td>
<td></td>
</tr>
<tr>
<td>e. Private hospital</td>
<td></td>
</tr>
<tr>
<td>f. Private health center or clinic</td>
<td></td>
</tr>
</tbody>
</table>
11. (Cont) Where or from whom did you seek care?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>g. Community-based practitioner associated with the health system</td>
<td></td>
</tr>
<tr>
<td>h. Private physician/H.W.</td>
<td></td>
</tr>
<tr>
<td>i. Pharmacy</td>
<td></td>
</tr>
<tr>
<td>j. Drug seller (including store or market)</td>
<td></td>
</tr>
<tr>
<td>k. Relative or friend (outside household)</td>
<td></td>
</tr>
<tr>
<td>l. Other provider (specify)</td>
<td></td>
</tr>
</tbody>
</table>

D. Providers visited outside of the home

<table>
<thead>
<tr>
<th></th>
<th>a.</th>
<th>b.</th>
<th>c.</th>
<th>d.</th>
<th>e.</th>
<th>f.</th>
<th>g.</th>
<th>h.</th>
<th>i.</th>
<th>j.</th>
<th>k.</th>
<th>l.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

12. Was (Name) given an antibiotic, antimalarial or ORS/RHF for this illness?

Yes or no

If YES, go to question 13
If NO, go to question 14

50
13. If an ANTIBIOTIC or ANTIMALARIAL or ORS/RHF were given, record the name and form of each given (pill, syrup, capsule, injection). Ask to see the medication if it is available. If unknown, record “unknown”.

For each drug ask: Who advised/prescribed this drug? Write the code for the adviser/prescriber in the column

a=Traditional healer
b=Religious leader
c=Government hospital
d=Government health clinic
e=Private hospital
f=Private health center or clinic
g=Community-based practitioner associated with the health system
h=Private physician
i=Pharmacy
j=Drug seller
k=Relative or friend
l=self
m=Other provider (specify)

<table>
<thead>
<tr>
<th>E. Providers advising/prescribing the drug/medication</th>
<th>Total # a. b. c. d. e. f. g. h. i. j. k. l. m.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug #1</td>
<td></td>
</tr>
<tr>
<td>How many times a day did you give this drug/ORS?</td>
<td></td>
</tr>
<tr>
<td>How much of this drug/ORS did you give each time?</td>
<td></td>
</tr>
<tr>
<td>For how many days did you give this drug/ORS?</td>
<td></td>
</tr>
<tr>
<td>Drug correctly administered?</td>
<td></td>
</tr>
<tr>
<td>Yes or No</td>
<td></td>
</tr>
<tr>
<td>Drug #2</td>
<td>How many times a day did you give this drug/ORS?</td>
</tr>
<tr>
<td>---------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>How much of this drug/ORS did you give each time?</td>
</tr>
<tr>
<td></td>
<td>For how many days did you give this drug/ORS?</td>
</tr>
<tr>
<td>Drug correctly administered?</td>
<td>Yes or No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Drug #3</th>
<th>How many times a day did you give this drug/ORS?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>How much of this drug/ORS did you give each time?</td>
</tr>
<tr>
<td></td>
<td>For how many days did you give this drug/ORS?</td>
</tr>
<tr>
<td>Drug correctly administered?</td>
<td>Yes or No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Drug #4</th>
<th>How many times a day did you give this drug/ORS?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>How much of this drug/ORS did you give each time?</td>
</tr>
<tr>
<td></td>
<td>For how many days did you give this drug/ORS?</td>
</tr>
<tr>
<td>Drug correctly administered?</td>
<td>Yes or No</td>
</tr>
</tbody>
</table>

F. Were all oral medications prescribed correctly? Yes or No
<table>
<thead>
<tr>
<th>Child’s name</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Child’s number</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

14. During the illness, did (Name) drink much less (ML), about the same (S) or more total fluids (including breastmilk and formula) (M) than usual? **Enter ML, S or M**

15. During the illness did, (Name) eat much less (ML), about the same (S) or more food than usual (M)? **Enter ML, S or M**

16. After the illness did, (Name) eat much less (ML), about the same (S) or more food than usual (M)? **Enter ML, S or M**

G. Fluids given appropriately during the illness? (14 = M) Yes or No

H. Food given appropriately during the illness? (15 = S or M) Yes or No

I. Food given appropriately after the illness? (16 = S or M) Yes or No

**IMMUNIZATIONS**

17. Do you have an immunization card for (Name)? a. Yes b. Lost it c. Never had one

If YES, go to question 18
If NO, go to question 19

18. Has measles vaccination has been received (Yes or No) Use the card (C) if it available. If it is not available, ask the mother (H)
<table>
<thead>
<tr>
<th>Child’s name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child’s number</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Is the child between 12-23 months of age? <em>Yes or No</em></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>J. If the child is 12-23 months of age, have they received measles vaccine? <em>Yes or No</em></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>19. Does (Name) have a growth monitoring or promotion card?</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Yes  b. No  c. Lost card</td>
</tr>
</tbody>
</table>

If YES, go to question 20  
If NO, go to end

<table>
<thead>
<tr>
<th>20. Look at the growth monitoring card and record the following information:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Has the child been weighed in the last 4 months? <em>Yes or No</em></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>21. Has the child’s weight been entered on the growth monitoring chart in the last 4 months? <em>Yes or No</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>Question</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>1. Do you have a maternal health card?</td>
</tr>
<tr>
<td>If YES, go to question 2 If NO, go to question 3</td>
</tr>
<tr>
<td>2. Record the number of TT vaccinations received from the maternal health card:</td>
</tr>
<tr>
<td>3. Is the women currently pregnant or does she currently have a child 7-11 months of age?</td>
</tr>
<tr>
<td>4. K. If the woman is currently pregnant or has a child 7 - 11 months of age, has she received TT2+?</td>
</tr>
<tr>
<td>5. Does the card have space to record antenatal care visits? Yes or No</td>
</tr>
<tr>
<td>If YES, go to question 4 If NO, go to question 5</td>
</tr>
<tr>
<td>6. Does the mother made any antenatal care visits for the previous pregnancy?</td>
</tr>
<tr>
<td>7. L. Had the mother received at least 2 antenatal visits during the last pregnancy?</td>
</tr>
<tr>
<td>8. Are you currently using any method to avoid/postpone getting pregnant?</td>
</tr>
<tr>
<td>If YES, go to question 6 If NO, go to question 7</td>
</tr>
<tr>
<td>Child's name</td>
</tr>
<tr>
<td>-------------</td>
</tr>
<tr>
<td>Child's number</td>
</tr>
</tbody>
</table>

**6. What is the main method you or your husband are using to avoid/postpone pregnancy?**

*Prompt for each listed symptom and tick if YES*

- a. Tubal ligation
- b. Vasectomy
- c. Norplant
- d. Injections
- e. Pill
- f. IUD
- g. Barrier method/diaphragm
- h. Condom
- i. Foam/gel
- j. Exclusive breastfeeding
- k. Rhythm
- l. Abstinence
- m. Coitus interruptus
- n. Other (specify)

**M. Women using a modern method of birth control? Y or N**

**7. When should you take a child to a health worker or health facility?**

*Do not prompt. Tick all signs mentioned*

- a. Don't know
- b. Fast or difficult breathing
- c. Not playing
- d. Looks sick/getting sicker/very sick
- e. Fever
<table>
<thead>
<tr>
<th>Child’s name</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Child’s number</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7. When should you take a child to a health facility? (cont)

- **f. Convulsions**
- **g. Lethargic/drowsy**
- **h. Not eating or drinking/breastfeeding**
- **i. Vomiting**
- **i. Other (specify):**

N. Does the caretaker know at least 2 signs for seeking care? *Yes or No*

8. Ask to see the vessel that drinking water is usually **carried** in

Is water carried in a narrow-necked, covered, water container? *Yes or No*

9. Ask to see the vessel that drinking water is usually **stored** in

Is water stored in a narrow-necked, covered, water container? *Yes or No*

10. Do you have soap for hand-washing in the house? *Yes or No*

*If YES, can you see the soap? *Yes or No*

11. Is there a place for washing hands? *Yes or No*

Is the soap located at the place where hands are washed? *Yes or No*

M. Is soap available for where hands are washed? *Yes or No*

---

END OF THE HOUSEHOLD QUESTIONNAIRE

Ask the caretaker whether they have any questions. Ensure that they know how to correctly give ORS and oral medications and that they know correctly the signs for care-seeking with their sick child.
APPENDIX F

SUMMARIES FOR IN-DEPTH ANALYSIS OF EMPHASIS BEHAVIORS
Appendix F: One Page Summaries for In-depth Analysis of Emphasis Behaviors

Breastfeed exclusively for about 6 months

What are people doing now?
- Are mothers initiating breastfeeding within a couple hours after birth?
- Are children under 3 months given any supplemental teas, milks or other liquids?
- Are children under 4-6 months given any supplemental teas, milks, liquids or solids?
- Are children fed on demand, including night feeding?

What are the reasons for doing the behaviors?

What are the reasons for not doing the behaviors?
- What do mothers do if they perceive their milk is not enough for the baby?
- What do mothers do if they have to be separated from the infant for more than half a day?

Suggested Methods

Beans with Key Informants (grandmothers, TBAs, mothers of children under 6 months)
- The total pile of beans is all children under 6 months old
- How many beans are exclusively breastfed?
- Of the beans not exclusively breastfed, what are the main reasons for not exclusively breastfeeding?

Interviews with women exclusively breastfeeding and not exclusively breastfeeding child under 6 months (can be identified from the survey)

Interviews with health care providers, traditional healers

<table>
<thead>
<tr>
<th>Common Reasons why people do not do these behaviors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concerns of the mother</td>
</tr>
<tr>
<td>&quot;Child is always hungry&quot; -- Mother believes she does not have enough milk for the child</td>
</tr>
<tr>
<td>Women believe that the first milk is harmful.</td>
</tr>
<tr>
<td>&quot;I don't know what to do&quot; -- There is no family member or friend who can help the mother when she has a problem with breastfeeding</td>
</tr>
<tr>
<td>&quot;The weather is very hot&quot; -- Concern that the child needs additional fluids on hot days, breastmilk is not sufficient</td>
</tr>
<tr>
<td>Family members and friends want to help mother, look after child much of the day, mother does not get chance to breastfeed</td>
</tr>
<tr>
<td>If mother is sick, she should stop breastfeeding or sickness will be transmitted to her child</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Concerns of the father</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual relations not allowed if mother is breastfeeding, so father does not encourage mother to breastfeed</td>
</tr>
<tr>
<td>Mother spends too much time breastfeeding, neglects others duties such as agricultural work, care of other children</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health care providers and traditional healers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother advised not to breastfeed if child has diarrhea.</td>
</tr>
<tr>
<td>Health care providers do not know what to tell mother if she has trouble breastfeeding</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Environmental/Economic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women do not take their infant to the field, market, or workplace and hence cannot breastfeed</td>
</tr>
<tr>
<td>A mother may not sleep with her infant making night feeding difficult</td>
</tr>
</tbody>
</table>
From 6-24 months, provide appropriate complimentary feeding

What are people doing now?
- At what age are children given mushy, semi-solid foods? What are the main ingredients (oils, animal products, fruits, vegetables)?
- What foods are considered inappropriate for children 6-24 months?
- What are the variations in feeding within this age group?
- What are the seasonal variations in the types of food given?
- How often during the day are children fed (are these "meals" or "snacks"? From a shared pot or plate? By mothers, siblings, neighbors and other relatives?
- Is tea given with meals?

What are the reasons for doing the behaviors?

What are the reasons for not doing the behaviors?

Suggested Methods
- Seasonal calendar of foods, income, access to markets, mothers' work
- Food narrative or 24 hour recall with mothers of young children (amounts of raw ingredients and dilution, type and frequency of feedings)
- Village walk to observe gardens and how young children are cared for and fed
- Observe hygiene handling of food and feeding of infants

Reasons why some people in other cultures do not do these behaviors

Concerns of the mother
- Meat and other animal products are not appropriate for infants, should be reserved for men.
- "Children can't digest un-diluted foods"
- Mothers don't know how to cook to nutritious food combinations, to retain vitamins, etc.

Cultural norms
- Children may have to eat from a common pot with older children, with older children eating faster and more.
- Children may wander from house to house with neighbors feeding them inappropriate foods.
- Higher status people (men, boys) get the energy dense foods (meats, fats, sweets)

Environmental / Economic
- Availability and affordability of different foods by season
- Different sources of foods - kitchen gardens, markets, subsistence farming
Take infant for measles vaccination as soon as possible after completing 9 months

What are people doing now?
Do mothers know when children should get the measles vaccine?
Is measles a disease that mothers want to prevent?
Is the child taken for vaccinations when sick?

What are the reasons for doing the behaviors?
What are the reasons for not doing the behaviors?

Suggested Methods
Beans with Key Informants:
Total beans are all children under 2 years
How many beans are vaccinated and not vaccinated?
Of the non-vaccinated, what are the main reasons?
Of the vaccinated, what are the main reasons people go?

Interviews with mothers of children under 2 years who are not vaccinated
Previous vaccination experience (HW treatment, side effects)
Reasons for not getting child vaccinated

Reasons why some people in other cultures do not do these behaviors

Concerns of the parents
"Every child has to get measles" -- Children who don't get measles when they are young may get a worse case of measles later
"Measles is not a big problem here" -- Parents don't see the point of vaccination if there have not been recent epidemics
Fear of side effects or of injections

Health care system
Vaccinations only provided one day a week
Health facility is too far away
Health workers do not check if child has been immunized when he/she is brought to the clinic for another reason
Health workers do not recommend vaccination if child has any other illness
Health workers scold mother for not bringing card or bringing child late

Environmental / Economic
Vaccinations only provided 1 day a week
Health facility is too far
For pregnant women and women of childbearing age, seek tetanus toxoid (TT) vaccine at every opportunity.

What are people doing now?
- Are women aware of the need for TT?
- What are the beliefs about getting injections during pregnancy?
- How often do women go for antenatal services?

What are the reasons for doing the behaviors?

What are the reasons for not doing the behaviors?

**Suggested Methods**

Beans with key informants
- Total beans are all the mothers of children under 2 years old
- How many beans received 2 or more TT vaccinations?
- How many beans received 1 TT vaccine?
- Of those who received no TT vaccine, what are the main reasons why?

---

**Reasons why some people in other cultures do not do these behaviors**

*Concerns of the women*
- Concern that vaccine may be harmful to unborn child
- Fear that vaccine may be a form of birth control
- Unaware of importance and benefits of TT vaccination

*Health care providers and traditional midwives*
- When mother brings in sick child, health worker does not check to see if mother has been vaccinated.
- Health workers do not actively encourage women to come for prenatal consultations because they are too busy treating acute illnesses.
- Traditional midwives do not mention tetanus toxoid vaccination to mothers when they make prenatal visits.
Use latrines consistently

What are people doing now?
Where do men, women and young children defecate?
Are latrines available to all households (within 100 meters)?
Are the latrines kept clean (not full and no visible feces) and covered?

What are the reasons for doing the behaviors?

What are the reasons for not doing the behaviors?

Suggested Methods
Beans with key informants (men, elders)
Total beans is all households in the community
How many beans have a latrine within 100 meters?
For those with a latrine, how many of the latrines are clean and covered?
For those without a latrine, what are the main reasons why there is no latrine?

Reasons why some people in other cultures do not do these behaviors

Knowledge and skills
People do not know why it is important to use latrines.
People think that having everyone defecate in one place increases the spread of disease.
People do not know how to build latrines.
People do not know how to maintain latrines, stop using them because they become too dirty or have a bad smell.
Children's feces is not considered dirty.
Difficult for children to use the latrine.

Environmental
The yard of the house is very small, no place to put a latrine, or latrine has to be located close to the house.
The soil is hard or rocky, difficult to dig a hole deep enough for a latrine.
During the rainy season the latrine overflows.
Water is scarce and perception that using a latrine requires more water.

Economic
Lack of tools to build a latrine
Wash hands with soap at appropriate times

What are people doing now?
Is soap available in every household?
When are hands washed? (after defecation, before cooking, before feeding a child)
How are hands dried? On a clean cloth?

What are the reasons for doing the behaviors?
What are the reasons for not doing the behaviors?

Suggested Methods
Observations of food preparation and child feeding
Matrix scoring with beans: List all the times you wash your hands and then score with matrix below

<table>
<thead>
<tr>
<th>Times to wash hands</th>
<th>How much will washing hands at this time prevent illness?</th>
<th>How often do you wash your hands with just water?</th>
<th>How often do you wash your hands with soap?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before cooking</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>After you defecate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>After you clean your child’s defecation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Before feeding child</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others to be added by respondent</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Reasons why some people in other cultures do not do these behaviors

Knowledge and skills
People think that washing hands takes a lot of water, do not wash hands because water is scarce.
People think that feces of infants are "clean", do not wash hands after handling infant feces.
People wash hands after preparing food instead of before.
"If hands look clean, why wash them?"
Soap means you have to use more water.

Economic
Lack of money to purchase soap.
Lack of water.

Environmental / Economic
Soap is not available or expensive.
Water is scarce.
Continue feeding and increase fluids during and after illness

What are people doing now?
Are young children breastfed during illness?
Do mothers try to feed even small amounts to children during illness?
After illness, are children given increased amounts of food and energy-dense foods?

What are the reasons for doing the behaviors?

What are the reasons for not doing the behaviors?
Is there a recognition that children need extra feeding during convalescence?

Suggested Methods
Interviews with mothers of children who are currently sick.
Interviews with various types of health workers about the advice they give.
Interviews with key informants using previously generated list of illnesses:

<table>
<thead>
<tr>
<th>List of Illnesses</th>
<th>Good foods</th>
<th>Bad foods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illness 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Illness 2 etc.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Reasons why some people in other cultures do not do these behaviors

Concerns/knowledge of parents
"Increasing fluids will make diarrhea worse"
"The child got sick from drinking this dirty water, and if we give him/her more of it, he/she will get more sick"
"A sick person should not eat heavy/hot/fatty foods or should not drink milk"
"A sick person should only drink clear fluids"
"Child won’t eat, he vomits everything”
"After illness, the stomach is weak so light foods should be given.”
"Breastmilk caused this illness, so it must be stopped”.

Health care providers
Health workers recommend that sick child not be given heavy/hot/fatty foods or milk.
Health workers do not give any advice about feeding the child.

Social Support
Grandmothers may have very strong beliefs about what should and shouldn't be fed to sick children.
Mother’s lack of time and confidence in preparing and feeding special foods for child.
Child is perceived to have no appetite.
Health workers or traditional healers may advise with-holding food or breastmilk.
Mix and administer ORS or appropriate home-available fluids correctly

What are people doing now?
Which types of diarrhea is treated with ORS or home fluids?

What are the reasons for doing the behaviors?
What are the reasons for not doing the behaviors?

Suggested Methods
Observe mothers mixing the ORS (you provide the sachet).
Interviews with mothers who did and did not use ORS or home fluids during last diarrhea episode (identified from survey).
Interviews with key informants - ranking medicines for different types of diarrhea using samples of available medicines:

<table>
<thead>
<tr>
<th>Type of diarrhea (including dehydration, sunken fontanelle)</th>
<th>First choice of drug</th>
<th>Second choice of drug</th>
<th>Third choice of drug</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type 1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type 2, etc.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Common Reasons some people do not do these behaviors

Concerns/knowledge of parents
Do not know how to mix ORS
Do not know how to administer ORS
Do not know that home fluids can have same beneficial effects as ORS sachets
ORS does not stop the diarrhea, so it doesn't work very well
Do not have the appropriate containers.
Child will not drink it.
No time to keep feeding it to the child.
Belief that antibiotics and/or injections are better.

Health care providers
No ORT corner in the clinic
No instruction on use of ORT in the clinic
Prescription of antibiotics and other drugs for simple diarrhea

Economic and other barriers
Lack of time/money to administer ORS to child
Administer treatment medications according to instructions (amount and duration)

What are people doing now?
  Do people usually give their child a full course of antibiotics?
  Where do people usually purchase their medicines?
  What advice is given when they purchase the medicines?

What are the reasons for doing the behaviors?

What are the reasons for not doing the behaviors?

Suggested Methods
Interviews with drug sellers and pharmacists
Interviews with mothers of children who were recently sick

Interview mothers and take an inventory of medicines in the home and discuss their use, where obtained, what they do with “left-overs”, whether they “stock up” on certain drugs. Ask what drugs are important to keep in the house.

Show key informants a few common drugs and ask what they are for, how often and for how long they should be taken.

**Reasons why some people in other cultures do not do these behaviors**

**Concerns/knowledge of parents**
Do not want to use up all the drug, in order to have some left over for next illness episode (Especially if drug supply is unreliable).
Parents stop giving the medicine when the symptoms go away.
Parents get use medicines from previous illness episodes or get it from a neighbor.
Parents “stock up” on certain medicines during certain seasons or on market days.

**Drug sellers**
Drug sellers sell incomplete doses of drug.
Drug sellers sell expired medication.
Drug sellers do not provide information on how to take the drug.
Drug sellers sell unsafe drug combinations.

**Health care providers**
Drugs out of stock at the clinic.
Health workers do not provide information on how to take the drug or verify mothers’ comprehension of it.
Health workers do not provide information on drug side effects.

**Economic and other barriers**
Lack of money to purchase full course of treatment.
Some of the medications given free at clinic are given or sold to neighbors and relatives.
Seek appropriate care when infant or child is recognized as being sick
(i.e., looks unwell, is not eating or drinking, develops lethargy or change in
consciousness, vomits everything, develops a high fever, develops fast or difficult
breathing)

What are people doing now?
What signs or symptoms make a mother worried and seek care outside the home?
What decides when and where a child is taken for care?

What are the reasons for doing the behaviors?
What are the reasons for not doing the behaviors?

Suggested Methods
Interviews with mothers of children who have recently been sick or died
Type and order of health care providers that were visited
Who made the decisions to seek care? Who was consulted and who disagreed?
What signs, symptoms, or events "triggered" seeking care from a health care provider?
What was the “story” of the illness or death?

Seasonal calendar - types of illness, access to health facilities, time available or amount of work,
money availability, child deaths

Matrix scoring with beans of health care providers: List all the places you go for health care or
medicines. Then list important characteristics of them and score them with up to 10 beans in
each row. Then ask “If you could only have one of these providers, which would you choose and
why?”

<table>
<thead>
<tr>
<th>Place 1</th>
<th>Place 2</th>
<th>Place 3</th>
<th>Place 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expense</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Distance, etc.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Reasons why some people in other cultures do not do these behaviors

Concerns of Mothers
Mother does not think the symptoms are very serious.
The child will be made stronger by suffering this illness.
Mother cannot decide herself whether to take the child for treatment, she must consult others.

Concerns of other family members
Father and grandmother may blame the mother for the child’s illness.
There is no time or person to take the child for treatment.
For certain illnesses, traditional healers or drug vendors are preferred.

Environmental / Economic
Health providers are very far.
There is no money to buy medicines or pay fees.
APPENDIX G

SUMMARY OF COMMUNITY ACTION PLANS
Appendix G: Summary of Community Action Plans

Summary of community planning process
Woreda: Alaba  
Kebele: Ashoka

1. Community priorities

GENERAL:
♦ Water - no water available within the kebele during dry season
♦ No health services in the kebele, health center in Alabe is a 3 hour walk
♦ Roads are poor and impassable during the rainy season
♦ No school in the kebele
♦ Grinding mill

HEALTH-RELATED:
♦ Malaria
♦ Diarrhea
♦ Intestinal parasites
♦ Malnutrition
♦ Eye diseases

2. Emphasis behaviors selected

♦ Exclusive breastfeeding
♦ Complementary feeding
♦ Feeding/fluids during and after illness
♦ Water storage in narrow-necked and covered containers

3. Summary of actions to be taken as a result of the community meeting

a. Men will help women after birth so they have time to breastfeed.
b. Mothers to prepare and give children appropriate complementary foods.
c. Mothers will give small/frequent feedings during illness.
d. Water storage in jerry cans, instead of transferring water from jerry cans to clay pots
e. Formation of a health committee
f. Collection of 3 Birr per household within one week to start a revolving drug fund
g. Purchase of drugs for the health post (Zone/woreda health department)
h. Rehabilitation of the health post (BASICS)
i. CHA to start work again, need for further training
j. Outreach services at the health post: immunization, antenatal care, family planning (Zone/woreda health department)
4. **Problems encountered**

a. People wanting treatment of acute illnesses for themselves or their children.
b. Difficult to involve women actively in the participatory diagnosis.

5. **Suggested changes in the HH questionnaire**

Q4. Retain options b, e, f, i (fresh milk only), j and k
   No need to ask about fruit juice, bottles soft drinks, infant formula, tinned/powdered milk or vitamins ==> all are exceedingly rare in the kebele
Q6. Meat, fish and eggs are never eaten daily. The words "every day" are a problems, many foods are eaten at most every other day.
Q11 & Q13 Combine options C + D into one (government health center and hospital)
   People do not distinguish health centre and hospital
Q15 & Q16 Don't make sense for breastfed children ==> should be "eat or breastfeed"
Q19 Growth monitoring card is same a vaccination card
HH Q1, Q2 Maternal health card is usually kept in the health centre, mothers only get to keep the appointment card
HH Q6 No need for list of options
HH Q10 Do you use soap to wash your hands?
HH Add a questions "How long to you take to fetch water (during the dry season)?"

6. **Plan for follow-up of the community plan**

**Key people/contacts in the community:**

AA = Amharic and Alabigna, AO = Alabigna only

a. Hamdino (AO) - Chairman of the Peasants' Association
b. Kadir (AA) - Secretary of the Peasants' Association and translator for the survey, very helpful person
c. Sitamo (AO) - Member of the Committee of the Peasants' Association, very helpful person, representative of the Abite section of the Kebele
d. Mohammed Ribato (AA) - Reconfirmed by the community as the CHA during public meeting, will work in health post when it opens
e. Fatuma Lango - TTBA, is working but not getting any supervision, works only in her immediate neighborhood
f. Mulunah (AA) - Drug smuggler, lives in neighboring kebele, one of main sources of drugs in Ashoka, good friend of Hamdino and Kadir. Concern about his practice: 1) Gives injections, but not trained in how to give them, 2) Sells incomplete doses, 3) Gives unnecessary drugs for children like tetracycline capsules for babies, 4) Expensive: one injection costs 30-40 Birr, 5) Prescribes according to how much money people have, 6) Does not give proper instructions. Need to be circumspect in disciplining him because he is well connected.
g. Hajji Jamal (AA) - Older man, excellent interpreter, good understanding of health and prevention, has ability to convince the community.

h. Badru Hajji Jamal (younger man) and Wakena Kadir - newly elected members of the health committee.

Key contacts in the Ministry of Health

a. Abu Awol - Alaba Woreda Health Office Head
b. Leulseged Asfaw - Zonal Health Department

List of actions to be taken by the community

♦ Collection of 3 Birr from each household within 1 week to establish a revolving drug fund.
♦ A health committee will be formed that meet within a week and will administer the revolving drug fund.
♦ Mohammed Ribato will start working again as a CHA once the health post has been repaired.
♦ Men will help women after birth with fetching of water and buying from the market so that they are able to exclusively breastfeed for 6 months.
♦ Mothers will prepare and give complementary foods to their young children. A complementary food that was demonstrated at the public meeting is a combination of: maize powder, water, salt, 1 egg, oil or butter and cabbage, all of which are available in the community.
♦ Mothers will continue feeding during illness with breastmilk, food-based home-made ORT and small amounts of the regular food given frequently.

List of actions to be taken by the health department

♦ Facilitate procurement of drugs from Pharmid in Awassa using money collected from the community (zone).
♦ Provide certain drugs such as Vitamin A and ORS which are in zonal stores free of charge. Assess other potential sources of free drugs such as the Catholic Missions (zone).
♦ Supervise revolving drug fund (woreda).
♦ Participate in community-based training. Schedule and content will be prepared in the woreda office.
♦ Provide outreach (vaccination, antenatal/postnatal care and family planning) at the kebele health post (woreda).

List of actions to be taken by BASICS/ESHE

♦ Contribute materials for repair of the health post (cement, door and windows, sand) and labor cost.
♦ Arrange refresher courses for Mohammed Ribato (CHA) and Fatuma Lango (TTBA), consider training additional TTBAs and CHAs. Additional CHAs might help with health education, vaccination days and community mobilization. Mohammed Ribato would
concentrate on treatment and health education in the health post. Fatuma Lango works in Abite section of the Kebele, other TTBAs could cover the other three sections: Gelanto, Toku and Gidano.

♦ Possibly use Ashoka as a site for community-based TOT training.
♦ Initial support for establishing the revolving drug fund.
♦ Furniture and equipment for the health post.

**Topics to be covered in future community-based training**

♦ Exclusive breastfeeding, appropriate complementary feeding, feeding during illness, water storage in narrow-necked containers: All four were discussed during the community meeting, but require reinforcement.
♦ Importance of going to health post for vaccination and ante/postnatal care.
♦ Importance of taking treatment medications according to instructions, both for health personnel and community members. This should happen once drug supply has been established in the community.
♦ Family planning: This is totally unknown in the community. We should start with discussion of impact of overpopulation on the land, and benefits of spacing children.
♦ Washing hands with soap: This was demonstrated at the public meeting, but requires reinforcement.

**Future public meetings**

♦ Another public meeting should be held once the health post is functioning. The services available at the health post should be explained, and some of the key behaviors reinforced.
Summary of community planning process
  Woreda: Bonke
  Kabele: Dambele Lado

1. Community priorities
   - Malaria
   - Water quality
   - Diarrhea/typhoid
   - Respiratory diseases
   - Pregnancy-related problems
   - Malnutrition
   - Measles

2. Emphasis behaviors selected
   - Exclusive breastfeeding
   - Immunization seeking
   - Antenatal care seeking
   - Quality of drug administration
   - Handwashing with soap

3. Actions to be taken as a result of the community meeting
   a. Health education on exclusive breastfeeding, handwashing with soap, immunization and antenatal care seeking (*Disease areas addressed: diarrhea, respiratory problems, malnutrition, measles and pregnancy related problems*)
      Using schools, churches, agricultural extension workers, CHAs, health workers in government and mission facilities
   b. Improving essential service delivery to the community (*Disease areas addressed: malaria, diarrhea, respiratory infections, measles and other vaccine preventable diseases*)
      i) Re-training/training CHAs
      ii) Assist with the construction of a small community health post
      iii) Train health workers at government and mission health facilities to improve immunization practices at fixed sites and during monthly outreach clinics
      iv) Add antenatal screening for pregnant women to immunization services currently provided by outreach clinics from local health facilities

4. Problems encountered
   Nil

5. Suggested changes in the HH questionnaire
   Q4a. Change the first option “vitamins” to something that is may be used by mothers
Q14-16. Consider adding another option “Less” to the choices. The options would then include “More”, “Same”, “Less”, “Much Less”

Q8. Source of water and time taken to collect water could be added

Q10. Consider adding, “What is the importance of washing hands with soap”, and “do you use soap for handwashing”.

6. **Plan for follow-up of the community plan**

**Key people/contacts in the community**
AG= Amharic and Gemugna, G=Gemucyna

a. Gumide Gosaye (AG): Chairman of the Kabele Council
b. Melese Menza (AG): Community member in “core” community committee who was also a good guide to HH
c. Bezuneh Utela (AG): Community member in “core” community committee
d. Damenech Dendol (G): Community member in “core” community committee
e. Meseha Dilnesaw (AG): Community member in “Core” community committee
f. Desta Assefa (AG): Inactive CHA very interested in working again
g. Maga Selfa (AG): Inactive CHA
h. Yohanes Bokane (AG): Inactive CHA
i. Mathewos Mekese (AG): Community member who was a good guide to HH

**Key contacts in the MOH**

a. Thomas Toyna: Bonke Woreda Health Office
b. Kassahun Belete: N.Omo Health Department
c. Tadesse Mezo: Health Assistant, Mission Health Station

**Key Contacts in the Agriculture Department**

a. Samuel Kampa: Extension worker
b. Kebede Ayele: Veterinarian worker

**List of actions to be taken by the community**

♦ Selection/re-selection of community health workers
♦ Collection of materials and provision of labor for the construction of local community health post
♦ Develop a community health fund for providing support to CHAs and administer this fund with the kebele council and community coordinating committee
♦ Provide farming support for CHAs when required to allow CHAs to attend training or work in the community health post
♦ Oversight of CHA performance in the community
♦ Encourage caretakers and other community members to use CHAs and outreach sites for immunization and antenatal visits
Encourage and help coordinate health education activities with school teachers, churches, CHAs and agricultural extension workers
Contribute to the assessment of options for improving water sources in the community

**List of actions to be taken by the health department**

- Organize and facilitate the training of local HWs and CHAs
- Assist with the selection of CHAs and other groups in the community who will be used to transmit health education messages
- Provide technical assistance for the construction of community health post
- Assist with the equipping of CHAs with essential equipment and drugs
- Participate in the establishment of antenatal screening with immunization outreach in the community
- Provide technical assistance in assessment of water needs and local spring protection projects
- Provide oversight and supervision of project activities with BASICS/ESHE staff
- Assist with the monitoring and evaluation of project activities
- Participate in the design of approaches to provide community support to CHAs

**List of actions to be taken by BASICS/ESHE**

- Organize and coordinate training and supply necessary training materials
- Provide technical assistance for the selection of CHAs and the development of systems for the community to provide support to CHAs in the long term
- Provide technical assistance and materials for training community groups to deliver health education messages
- Provide essential industrial materials for the construction of a small community health post and for some water source protection activities
- Assist with the equipping of CHAs with essential equipment
- Develop mechanisms for providing essential drugs to CHAs (may include a drug fund, drugs may be contributed by government and mission facilities)
- Coordinate activities with community group, CHAs, WHWs, AHWs, NGOs and other sectoral offices as required
- Monitor and evaluate project activities

**Future public meetings**

- A meeting is scheduled for the 3rd week of February, 1997 to follow up on the next steps based on the above plan
7. Summary of qualitative investigations

<table>
<thead>
<tr>
<th>Reasons for doing</th>
<th>Reasons for not doing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Breastfeeding</strong></td>
<td><strong>Breastfeeding</strong></td>
</tr>
<tr>
<td>Accepted cultural norm</td>
<td>Difficult when going to fields or to the market</td>
</tr>
<tr>
<td>A way to settle a crying child</td>
<td>Breast-milk is not enough to sustain a child because mothers do not get enough good food; therefore it should be supplemented</td>
</tr>
<tr>
<td>Helps the growth of child</td>
<td>Breastmilk is not sufficient</td>
</tr>
<tr>
<td></td>
<td>When a child cries, it means that breastmilk is not enough and that additional fluids or food is needed</td>
</tr>
<tr>
<td><strong>Immunization</strong></td>
<td><strong>Immunization</strong></td>
</tr>
<tr>
<td>Useful for preventing illnesses including diarrhea</td>
<td>Lack of awareness about importance</td>
</tr>
<tr>
<td></td>
<td>No clear understanding of diseases prevented</td>
</tr>
<tr>
<td></td>
<td>Healthy children should not go outside since they would be exposed to the “evil eye” which can make them sick</td>
</tr>
<tr>
<td></td>
<td>Injection abscesses are likely to form following injections</td>
</tr>
<tr>
<td></td>
<td>Lack of awareness about immunization days</td>
</tr>
<tr>
<td><strong>Antenatal visits</strong></td>
<td><strong>Antenatal visits</strong></td>
</tr>
<tr>
<td>When pregnant women feel that they are sick</td>
<td>Lack of awareness</td>
</tr>
<tr>
<td>To check the position of the fetus</td>
<td>Long distance to reach health facilities</td>
</tr>
<tr>
<td></td>
<td>Neighbors can assist with deliveries, don’t need others</td>
</tr>
<tr>
<td><strong>Handwashing with soap</strong></td>
<td><strong>Handwashing with soap</strong></td>
</tr>
<tr>
<td>Not done</td>
<td>Lack of awareness of the importance of handwashing</td>
</tr>
<tr>
<td></td>
<td>Soap used for other things (washing clothes and hair)</td>
</tr>
<tr>
<td><strong>Administer treatment appropriately</strong></td>
<td>Stop when the child gets better</td>
</tr>
<tr>
<td>To treat the child properly</td>
<td>To save medicine and keep for future use</td>
</tr>
<tr>
<td></td>
<td>Mothers forget the correct prescription</td>
</tr>
<tr>
<td></td>
<td>Drugs not labeled</td>
</tr>
<tr>
<td></td>
<td>Can’t afford the full course since it is too expensive</td>
</tr>
</tbody>
</table>
Summary of community planning process  
*Woreda: Dale*  
*Wicho community*

1. **Community priorities**

- Population pressure - land
- Water (safety contamination)
- Agriculture - seeds - fertilizer
- Diseases - diarrhoea, parasite diseases, malnutrition, malaria (men)
- lack of health facilities = drug smugglers, high drug prices (RDV)

2. **Emphasis behaviors selected**

- Exclusive B/F
- ANC
- Administer drugs according to instructions
- Modern methods of contraception
- Water transport/storage - (handwashing)

3. **Main elements of action plan as a result of the community meeting**

a. Develop H/E materials/models  
b. Training reorientation for health care providers (RDV, TBAs, CHAs, HWS, CDN etc.)  
c. Rehabilitation of health post  
d. Regular supervision  
e. Establish CBD and supply with modern FP methods  
f. Improving the status of safe water supply:  
   i. Do feasibility study of water spring, wells, hand pumps) build demo VIP at school and H. post  
   ii. Construct or rehabilitate according to priority and as the resources are available  
   iii. Establish a water sanitation committee for maintenance (ownership)

4. **Problems encountered**

a. Expectation for capital/curative activities  
b. FP quest. sensitive (need privacy) also a high demand for methods not available

5. **Queries, comments or recommendations on the HH survey questionnaire**

a. Child’s section

Q # 4 & 6   More urban oriented and vitamins and mineral supplies, ORS as food supplements; preliminary investigation on what is commonly given in rural communities would help in designing questions for the future.
Q # 7 Somewhat confusing, especially going back and crossing out process if it can be simplified.
Q # 9 Milk and tea? Home fluids?
Q # 13 Taking out the line so that the interviewer would not be tempted to write over.
Codes “H” and “T” What to do if foods can not be not applicable like for breastfed infants
Q # 18 & code - Considering measles vaccination from age 9 months and above - may be more sensitive to catch all that have benefited from the service.
Q # 20 & 21 NGO clinics using different (non standard) clinical cards (Can we consider it as available?)

b. Caretaker’s section

* On the caretakers section, the first question should be if a lady was ever pregnant or not?
* Mother is fairly confident that she has the card but it was locked? How to categorize it?
Q # 7 If diseases are mentioned under others?
Overlapping symptoms
Q # Availability of soap and actual behavior?

5. Plan for follow-up of the community plan

Key people/contacts in a focus community

a. Ato Yirgalem: P/A Chairman
b. Ato Yitera Kamiso: P/A Deputy
c. Ato Hailu Kebede: Teacher
d. Ato Beyene Shora: CHA
e. W/o Kebete Belela: TTBA
f. W/o Alemitu Irbamo: TTBA
g. Ato Karissa Kake: PA member
h. W/o Tirunesh Lera
i. Ato Urago Umballo
j. Ato Abebe Asana

Key contacts at health offices

Sidama Zonal Committee
Paulos Markos
Ashenafi Ergata
Begashaw Dabena

Woreda H. Office
Ato Kekebo Debeko
Ato Mamo Diramo
W/o Workenesh Gonsamo
Actions to be taken by the community

♦ Selection of candidates for TTBA and CHA training
♦ Collaboration in terms of labor, locally available materials after specific project activities are identified such as rehabilitation of the health post, spring protection, well protection and rehabilitation of pumps
♦ Active participation in health education and training activities
♦ Assigning a responsible body for water-sanitation activities

List of actions to be taken by health department

♦ Supervision – monthly
♦ Trainings to HW, TTBA, CHAs, others
♦ Coordinating and monitoring project activities
♦ Technical support (sanitation, other program issues)
♦ Assistance in mobilizing additional resources to supplement project activities.

List of activities to be taken by BASICS/ESHE

♦ Arrange for feasibility study (experts, technicians)
♦ Soliciting and developing training/HE modules and materials
♦ Contribute materials for the identified community activities (HP, springs, wells, spares for hand pumps)
♦ Training for additional TBA and CHA and reorientation of the existing ones
♦ Training of RDV and traditional healers
♦ Continuing to use Wicho as a training site for community health activities
♦ Support with equipments, supplies and essential drugs in order to begin a revolving fund system
♦ Regular monitoring and supervision on the progress

Topics to be covered in future HE (community-based training)

* priority (focus) health behaviors

Future meeting

♦ In the next 1 or 2 weeks:
  1. For assessing the existing hand pumps, springs and wells and estimating the cost for future intervention
  2. Discussions regarding possible construction of a H. post
  3. For further negotiation on the community’s concrete contributions
Summary of community action plans
*Shurmo Dubancho-Konteb Woreda*
*Hadiya Zone*

1. **Community priorities**
   - Pneumonia (because it kills)
   - *sorkopa* (tonsillitis, fever)
   - skin infections
   - scabies
   - diarrhea
   - water supply

2. **Emphasis behaviors selected**
   - Appropriate complimentary feeding, 6-24 months
   - Measles vaccination at 9 months
   - ANC and TT during pregnancy
   - Transport and store drinking water in narrow-necked containers

3. **Strategies decided upon as a result of the community meeting**
   - Safe water supply
   - Promote production of narrow-necked *harala* (clay pots) by potters
   - Train TBAs and CHAs
   - Promote integration of health services
     - Identification of pregnant women
     - Daily vaccination service
     - Check vaccination status during sick child visits
   - Increase community participation through sub-committees in each katana
     - Formation of nutrition clubs
     - Identification of pregnant women
     - Identification of children to be vaccinated
     - Involvement of school children to disseminate messages
   - Promote gardening with development agent
   - Health education
     - Use of narrow-necked containers
     - Importance of ANC and TT
     - Complimentary feeding with *ereta* (local weaning food)
     - Health worker counseling on side effects of immunization and vaccine preventable diseases
4. **Problems encountered**

   a. Our pace and the community pace was different. The public meetings were not very successful which may be because public meetings are not a recognized forum for discussion at the kabele level. In the future, meetings should be held in each katana (there were 10 katanas in this kabele) to orient and brief people.

   b. The community team expected to be paid for working with us. This may be due to the fact that community-based distributors of contraceptives were recently recruited in the area and are being paid for their work.

   c. There is a sense that both the community and health staff expect large capital investments.

5. **Suggested modifications to the household survey**

   Q4: Several of the items on this prompted list were unknown in the community, especially infant formula and vitamins. Vitamins and minerals should be the last item on the list because it was confusing to many people.

   Q6: Many of the foods on this list were not commonly eaten in general. By asking if they were eaten every day, most of the responses were negative for all foods. Most people said they give those foods when available.

   Q14-16: It was difficult to know how to code this question because many children were not receiving any complimentary foods to begin with and there was no change in food consumption during or after illness. If we code these questions are “the same”, it implies that adequate food is given to the children.

   Q17 and 19: The immunization and growth monitoring cards are the same so there is no need for both questions.

   Q6 (Mothers): Many think that exclusive breastfeeding is protecting them from getting pregnant and we might want to prompt this method.

   Q10 (Household): Some women were insulted by being asked if they had soap saying “do you think we don’t have such things?”

   Overall - The questions in the survey should be numbered sequentially throughout; do not begin the mothers section with a new number 1.

6. **Plan for follow-up**

   **Key People**

   a. Ato Mekuria - PA Chairman
   b. Ato Tesfaye - CHA
   c. Ato Lamboro Haidoro - community member
   d. Wiro Bogalech Shibeshi - TBA
   e. Ato Biru Sharage - community member
   f. Wiro Tagesech Weilamo - Development Agent, working on gardens
   g. Ato Shiferew Salo - School teacher, excellent translator and facilitator
   h. Ato Dessalegn Hankore - Head of clinic
I. Ato Tirfe Mesfin - Konteb Woreda
j. Dr. Tekleab Kedamo - Hadiya Zone

Actions and Next Steps

- Orient people in each katana and identify two people for health sub-committees
- Orient health staff in zone and woreda
- Strengthen kebele health committee
- Counseling of health staff on integration
- Identify and/or develop health education materials for the selected behaviors
- Identify and select TBAs and CHAs for training according to criteria set by the health committee
- Train TBAs and CHAs at the zone
- Identify and evaluate water springs to be protected
- Brief representatives from the Ministries of Water and Energy, Agriculture, and Education on the plans which have been developed to enlist their support and potential collaboration
- Conduct focus groups on the feasibility and acceptability of using narrow-necked haralla (clay pots for water)
- Form nutrition groups to promote ereta
APPENDIX H

TEAM EVALUATIONS
### Appendix H: Team Evaluations

#### Evaluation of the Community Assessment and Training

<table>
<thead>
<tr>
<th>Method</th>
<th>Could you do this method on your own without help?</th>
<th>Do you expect to use this method in your work during the coming months?</th>
<th>Could you teach other people how to use this method?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3=Yes, with no help 2=Yes, with a little help 1=No, need more training</td>
<td>3=Yes, several times 2=Yes, rarely 1=No, never</td>
<td>3=Yes, with no help 2=Yes, with a little help 1=No, need more training and practice</td>
</tr>
<tr>
<td></td>
<td>N=13</td>
<td>N=12</td>
<td>N=13</td>
</tr>
<tr>
<td>Social mapping</td>
<td>0 1 12</td>
<td>0 6 6</td>
<td>0 3 10</td>
</tr>
<tr>
<td>Matrix ranking</td>
<td>1 4 8</td>
<td>1 5 5</td>
<td>2 6 5</td>
</tr>
<tr>
<td>Semi-structured interviews</td>
<td>0 4 9</td>
<td>1 2 9</td>
<td>0 6 7</td>
</tr>
<tr>
<td>Free-listing</td>
<td>1 0 12</td>
<td>0 2 10</td>
<td>0 2 11</td>
</tr>
<tr>
<td>Holding a community meeting</td>
<td>1 5 7</td>
<td>0 6 6</td>
<td>1 5 7</td>
</tr>
<tr>
<td>Conducting a survey (asking questions)</td>
<td>0 3 10</td>
<td>1 3 8</td>
<td>0 6 7</td>
</tr>
<tr>
<td>Random sampling</td>
<td>2 4 7</td>
<td>2 6 4</td>
<td>2 4 7</td>
</tr>
<tr>
<td>Manual tabulation to calculate indicators</td>
<td>1 9 3</td>
<td>0 8 4</td>
<td>2 8 3</td>
</tr>
<tr>
<td>Choosing priority behaviors</td>
<td>1 6 6</td>
<td>0 8 5</td>
<td>0 6 7</td>
</tr>
<tr>
<td>Making a checklist to ask the reasons for the behavior</td>
<td>1 3 9</td>
<td>0 4 8</td>
<td>0 6 7</td>
</tr>
<tr>
<td>Identifying strategies to promote behavior change</td>
<td>1 6 6</td>
<td>0 3 9</td>
<td>0 5 8</td>
</tr>
<tr>
<td>Developing an action plan with the community</td>
<td>1 5 7</td>
<td>0 6 6</td>
<td>0 6 7</td>
</tr>
</tbody>
</table>
Comments
- I have learned much more during the workshop especially in the field work from the community and from other members of the team. So from this experience I can do a lot in the community by creating good contact with them.

- The time given for the field work and for the total process was not sufficient. I gained good experience. It was really a very good workshop.

- I gained more experience. I learned more from the community.

- The community needs should always be studied for a successful implementation of planned activities. Points to be gathered from this kind of activity are of high value.

- I will have interest to work in the community according to their problems.

- Through the support of BASICS, I will try to teach the community the good behaviors.

- I can say that this workshop has contributed to my knowledge of how to work with the community. I got many good ideas about semi-structured questionnaires due to this workshop.

- I will not push a community toward any decision. I have understood that the community’s knowledge is far greater than we had expected.

- The workshop has given me my first opportunity to deal with the community. I would like to work towards giving the community more and more responsibility.