

CHAPTER 5

THE ROLE OF CHILDREN

One of the principles of Champion Communities is to involve as many sectors of society as possible. This includes children.

The potential role of children in development programs of all kinds is often overlooked. Children are more receptive than adults to new ideas. Skills or behaviors learned while young are likely to “stick” in adulthood. Children are eager to be involved in adult issues and can be passionate about them. They are natural communicators. They can act as the conscience of a community.

In Madagascar, UNICEF came to the *BASICS Project* around 1996 for help developing a school-based health curriculum for primary schools. An AED curriculum specialist worked with both the Ministry of Health and the Ministry of Education to create a pilot program that would inform, engage, and entertain children.

BEYOND THE CLASSROOM, BEYOND SCHOOL

The program focused on nutrition, immunization, diarrheal disease, and hygiene. It incorporated a child-to-community approach, and a school-to-community approach. The curriculum specialist worked with teachers and also families to create and test various learning activities for the classroom including games and other kinds of active learning, as well as assignments that would require them to talk to their parents, influence their peers, and carry out “real projects” with adults in their community.

Many lessons took children out into their neighborhoods to do a mini-survey. For example, they might be asked to find out how many under-one-year olds among their family's friends were immunized. Or they might be asked to observe practices in their



own homes. (Do the chickens walk freely in the kitchen?) Students were also asked to think about why a certain desirable behavior might be difficult. (Do parents not have enough time to do it? Do they not have enough information?) And then they were asked to think about some possible solutions to the problems they discovered.

In this way, children actually became informed advocates for many of the same “doable actions” central to the Champion Community Initiative. They learned how to carry out some of the actions themselves, and also how to help their communities achieve change. Groups of four to five children might work together to take responsibility for making sure at least one infant they knew received all of his or her vaccinations. Several classrooms might work together to clean up a public area.

BECOMING A BEACON SCHOOL

The program was integrated with the Champion Community Initiative. The curriculum laid out a pathway whereby schools could themselves become champions—or *Beacon Schools*. Criteria cut across the different health areas and included some of the same goals as the Champion Community Initiative. These combined both quantifiable targets and educational or community activities. Goals included:

- Eighty percent of infant siblings of students complete their vaccinations by one year of age
- Children know how to use and maintain a latrine
- Eighty percent of students wash hands before eating and after using the toilet/latrine
- The school and parents’ association work together on a clean-up activity (e.g., the school or another public area)

- The school makes safe drinking water available for students
- The parents’ association carries out at least one demonstration every two months on how to prepare nutritious food
- The parents’ association carries out awareness-raising at least twice a year on how to prevent and treat diarrhea

Targets for the Beacon Schools were refined during field testing. For example, it turned out that handwashing was an unreasonable goal in some schools because water wasn't available. So the first feasible target was to make safe drinking water available. Achieving all the targets meant that not only students but parents and administrators had fulfilled certain responsibilities.

The curriculum included instructions on how a school could monitor its own progress. A special poster was also created to help schools track and share this progress. Schools were encouraged to celebrate their accomplishments at several points during the year. And at the end of the year, administrative districts held impressive festivals to honor winners of the Beacon School banners. A spirit of friendly competition infused the program.

Beacon Schools was piloted in 39 primary schools in two districts. A newsletter publicized accomplishments of the schools and communities. The program was gradually expanded to 219 primary schools and 50 middle schools. Thirty-two schools received official Beacon School banners before activities in Madagascar were interrupted by political turmoil in 2001. However, the school program was later resumed and expanded to secondary schools with additional lessons on reproductive health. Both the *LINKAGES Project* and CARE helped with this expansion.

CHAPTER 6

CONTRIBUTION TO HEALTH IMPACT IN MADAGASCAR

The Champion Community and Beacon School Initiatives were integral to a major community health mobilization strategy in Madagascar. But a focus on families and communities was only one of several “pillars” designed to improve the health of children. Other pillars included advocacy at the policy level and support for changes in the delivery and quality of health services. Furthermore, several projects and multiple partners and grass roots organizations contributed to these changes. So it is not possible to link any one contribution directly to the improvements in health status that took place in Madagascar between about 1999 and 2004. But it is clear that impressive changes did occur in several major indicators.

EARLY RESULTS UNDER BASICS

Results associated with *BASICS*' early work in its pilot areas of Antananarivo and Fianarantsoa were striking. The project conducted baseline and follow-up surveys at both the household and facility levels to test the effectiveness of pilot strategies.

Results of the household surveys reflected the impact of the intensive community mobilization strategies:



TABLE 1

CHANGES IN KEY INDICATORS DURING BASICS PROJECT, HOUSEHOLD SURVEYS

INDICATOR	1996	1998
• Children 12-23 months fully immunized	57%	78%
• Women whose infants were protected against neonatal tetanus at last birth	53%	72%
• Women who began breastfeeding immediately after delivery	21%	69%
• Infants under 6 months of age who were exclusively breastfed	48%	72%
• Children 12-23 months receiving at least five meals per day	10%	42%
• Mothers who knew two or more danger signs for seeking care when their child was ill	40%	70%
• Women receiving 90 or more iron/folic acid tablets during pregnancy	6%	43%
• Women receiving vitamin A supplements within the first eight weeks after delivery	10%	37%
• Households with iodized salt available on the day of the survey	29%	81%
• Children 6-59 months who received a vitamin A capsule the last six months.*	--	29%

* Distribution of vitamin A capsules began after the baseline study. BASICS supported communities in achieving their initial nearly 30 percent coverage of that new intervention.

Source: (2004) *Improving Family Health Using an Integrated, Community-based Approach*. Published by the BASICS II project for USAID.

According to DHS data, the proportion of fully immunized children between 12–23 months of age was actually declining nationally in the five year period before BASICS began. In 1997, national immunization coverage was only 36 percent. These data contrast strikingly with improvements in the program areas of the two target districts. The percentage of immunized children in these areas rose to 78 percent by 1998. (At the start of the program, immunization rates in the two target districts were already higher—at 57 percent—than the national rate. Nevertheless, the increase of 21 percent in these areas between 1996 and 1998 was impressive.)

During this program phase before *LINKAGES* arrived, many nutrition practices improved. But nutrition also proved one of the most challenging areas. For example, between baseline and follow-up surveys, children who

received additional meals after illnesses increased minimally, from 18 percent to 19 percent.

CHAMPION COMMUNITY PERIOD— JEREO AND LINKAGES

The period during which *Jereo Salama Isika* and *LINKAGES* collaborated in Madagascar saw an expansion of the basic target area to 20 districts—or around 4.2 million people. This was the also the period during which the Champion Community Initiative was rolled out systematically (although not in all communities). Indicators during this time improved in three major areas: child survival, nutrition, and family planning.

Immunization. Once again, sharp improvements occurred in immunization rates, as measured against a program baseline in 2000 and in rapid assessments conducted in 2001 and 2002.

TABLE 2

**IMMUNIZATION COVERAGE IN CHILDREN
12–23 MONTHS IN PROGRAM AREAS**

Coverage Indicator	Program areas at baseline '00	Program areas in '01 (RAPS)	Program areas in '02 (RAPS)
BCG	92	96	97
DPT3	84	94	93
Measles	79	88	88
Fully immunized	78	87	88

Source: Agnès Guyon, et al. (2005). *Assessing a Behavior Change Strategy for the Essential Nutrition Actions, Immunization, and Family Planning—Antananarivo and Fianarantsoa Provinces, Madagascar*. Washington, DC: Academy for Educational Development, LINKAGES Project.

Local improvements were also associated with the Beacon School program. According to district reports between October 1998 and September 2001 in Antananarivo North, where the program worked with both primary and secondary schools, immunization rates increased 12 percent. Similar reports in Ambalavao District, where the program was also active, showed immunization rates increased 15.7 percent.⁶

Infant and Child Nutrition. Research by the LINKAGES project during this time period document large improvements in nutrition-related practices, particularly related to breastfeeding.

Figure 1 shows that initiation of breastfeeding within the first hour of birth rose dramatically from the baseline of 34 percent and remained at a high of

73 to 78 percent throughout the program period. Figure 2 shows improvements in exclusive breastfeeding rates. Rates for infants at three different ages showed gains of at least 20 percent throughout the program.

FIG. 1

**INITIATION OF BREASTFEEDING
WITHIN THE FIRST HOUR OF DELIVERY**

(infants 0–5 months)

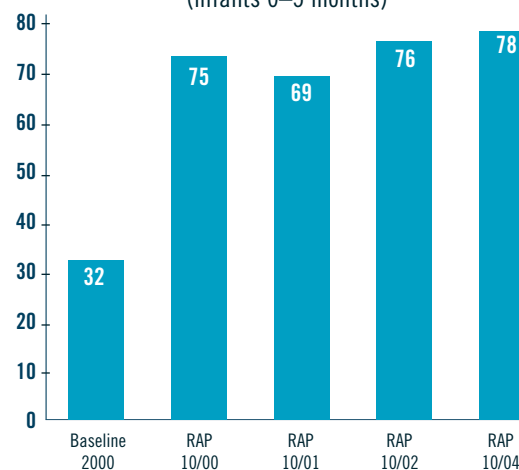
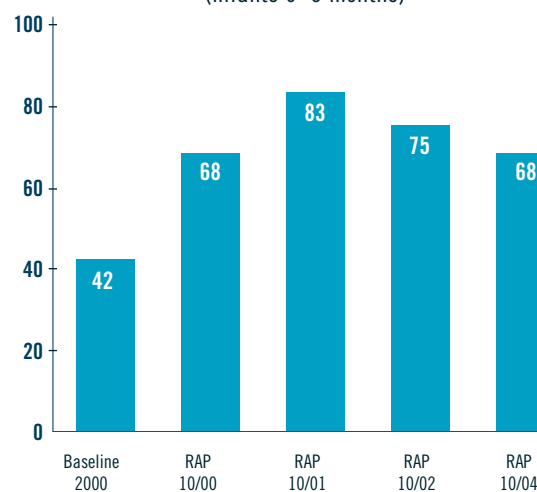


FIG. 2

EXCLUSIVE BREASTFEEDING

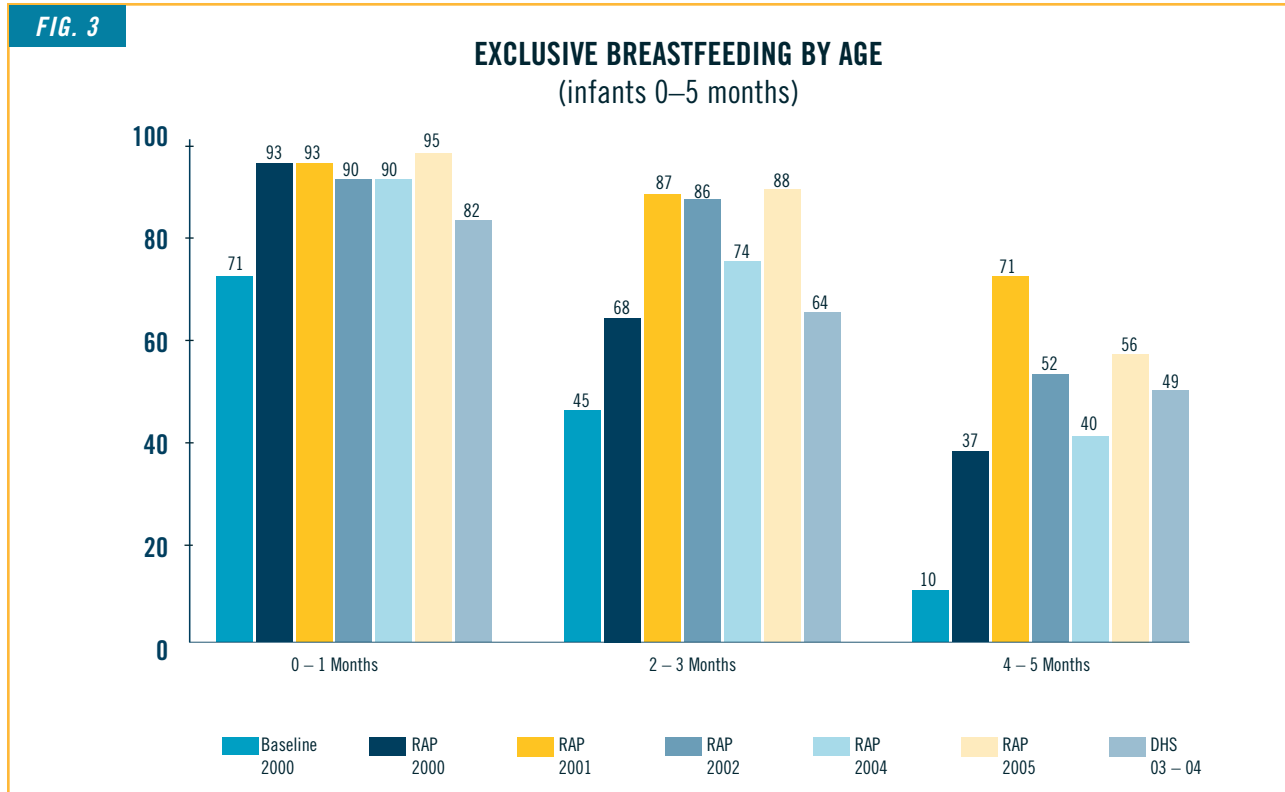
(infants 0–5 months)



Source: Agnès Guyon, et al. (2004). *Assessing a Behavior Change Strategy for the Essential Nutrition Actions, Immunization, and Family Planning—Antananarivo and Fianarantsoa Provinces, Madagascar*. Washington, DC: Academy for Educational Development, LINKAGES Project.

⁶ *Final Report, Jereo Salama Isika, 1999-2003*. Republic of Madagascar, Ministry of Health, and JSI. Boston: John Snow Inc.

FIG. 3



Reproductive Health and Family Planning. Family planning indicators also showed improvements. Between 1997 and 2000,⁷ the contraceptive prevalence rate in Fianarantsoa rose from 5 to 7 percent, whereas in program areas of the province they reached 15 percent. In Antananarivo, contraceptive prevalence during this period rose from 16 to 17 percent. In program areas of the province they reached a high of 23 percent.

⁷ *Improving Family Health Using an Integrated, Community-based Approach.* (2004). Published by the BASICS II project for USAID

CHAPTER 7

EXPANSION IN MADAGASCAR



Experience in Madagascar made the potential of Champion Communities clear to USAID (who funded the early evolution of the strategy) and to many partner organizations.

FOCUS ON POVERTY REDUCTION

When *Jereo Salama Isika* ended in 2003, USAID's next large project in Madagascar, called *SantéNet*, adopted the approach as the framework for its entire five-year program. Under *SantéNet*, communities are led through a process of negotiating goals in four different sectors: environmental and rural development, health, economic growth, and democracy and government. Each community signs a contract indicating its commitment to the selected objectives. After a 12- to 18- month implementation cycle, a community earns a star for achieving objectives in any given sector. The goal is to become a "four-star" champion community.

The project has established a ten-step process for the *Kôminina Mendrika* approach, as it is called. A local committee leads the process. Members receive both on-site and off-site training in how to conduct a participatory assessment, how to negotiate goals, and how to monitor progress. Three kits support their efforts in the community: a *Marketing Kit* with print materials to help motivate community-based agents; a *Mass Media Communication Kit* with songs, sketches, and promotional spots for local radio; and an *Interpersonal Communication Kit*.

SantéNet is working in four of Madagascar's six provinces. Between 2004 and 2008, the project aims to involve 4.5 million people in Champion Community activities (more than a quarter of the country's total population). In the first 18-month round of activities, 1.2 million people were involved.

FOCUS ON THE ENVIRONMENT

Other organizations in Madagascar are also building directly on the potential for the Champion Community Initiative to create synergies between different development sectors. John Snow, Inc. obtained funding from the David and Lucille Packard Foundation to work in areas of high environmental sensitivity in the country. Their aim is to improve basic health indicators while also protecting livelihoods that are dependent on the increasingly endangered ecosystems.

This work emerged from the unique collaboration among Jereo, *LINKAGES*, and the *Environmental Health Project (EHP)*. In the mid 1990s *EHP* helped establish a local nongovernmental organization, Voahary Salama (“Healthy Nature”)—an association of 20 conservation, health, and rural development partners from five biodiverse regions of Madagascar. The partners have a common vision of “a healthy population living in a healthy environment, based on a rational management of natural resources.”

NGO partners play a special role in this iteration of Champion Communities, providing training, technical support, and in some cases resources for new activities. In each community a partner NGO also helps to supervise and monitor progress towards specific objectives. (*See box.*) The NGO generally works with an intermediary group, such as the local resource management council, whose members are active within the community.

COMBINING HEALTH AND ENVIRONMENTAL GOALS

The Madagascar Green Healthy Communities Project targets the delicate balance between viable livelihoods, food security, and protection of natural resources.

Objectives for the *Champion Communities* cut across these different areas. They include:

- 80 percent of children under one are fully vaccinated
- parents of 65 percent of children under three years have a Family Health Record
- 500 or more trees are planted in 9 months
- management systems for farming practices are improved
- 10 percent of cultivated surfaces rely on improved agriculture techniques

Communities need technical support to achieve these goals. NGOs provide training in the System of Improved Rice-culture (SRA), System of Intensive Rice-culture (SRI), and reforestation. The project is also helping to engage households in new income-generating activities.

At the same time, the project has trained nearly 200 Community Service Agents (CSAs) to provide family planning services. In the first 14 months of implementation, 40,000 trees were planted and 12,300 contraceptive products were distributed.

One of the goals of this model is to develop a sustainable way of managing the overall champion process, and engage partners who can also leverage additional funds.

Sixty communities are now participating in the program. JSI is also adapting this health-environmental model of the Champion Community Initiative in Tanzania.

CHAPTER 8

INTEGRATING HEALTH AND EDUCATION GOALS

In Ethiopia, USAID has supported organizations in two different sectors—health and education—to work together and launch a Champion Community Initiative that will more effectively link their very different objectives and resources.

The synergy between health and education outcomes is clear. An educated mother is more apt to have safe and well-spaced pregnancies and healthy children. Adequately-nourished, healthy children are better able to thrive and to stay in school. But the strong connection between health and education indicators is rarely reflected in the level of cooperation between governmental ministries or even between the different arms of a donor organization.

In Ethiopia, the challenge of creating such a positive synergy is staggering. Nearly half of all children under five are malnourished. For every 1000 children born, 170 do not survive to their fifth birthdays.⁸ Only around 40 percent of the population complete primary school; for women, the rate is just 30 percent.

One of USAID's goals in Ethiopia is to promote social resilience in communities so that they are better able to mobilize resources and reduce their vulnerability to cycles of famine,

⁸ World Development Indicators database, August 2005. (The World Bank. Data are for 2003.)



disease, and poverty. This goal is supported by new structures in Ethiopia at the district level that combine education and health in one office. USAID’s hope was that a new *Kokeb Kebeles*, (or *Star Community Initiative*) would stimulate even more crucial collaboration at the grass roots.

MULTIPLE PARTNERS, MULTIPLE ROLES

AED’s responsibility in the new initiative has been to design the program framework, develop materials and monitoring systems, conduct training, and coordinate support by the several partners. These roles emerged out of AED’s participation in two major USAID programs in Ethiopia: *The Health Communication Partnership*⁹ and the *Essential Services for Health in Ethiopia Project*¹⁰ (or *ESHE*). ESHE and two other partners—Pathfinder and World Learning¹¹—are tasked with implementing the program on the ground.

Planning for the Kokeb Kebeles Initiative began in 2003 in the Southern National Nationalities and People’s Region (SNNPR). Regional stakeholders from different sectors participated in the design meetings. Intense

discussions also took place among the different USAID partners. AED documented agreed-on roles and processes in a Partners’ Manual and a 12-step *Activities Guide* for the communities (or Kebeles).

District-level orientations were conducted over two days. The first day brought together district (Woreda) officials connected with health, education, water, and

FOLLOW THE STEPS – AND THEN?

One of the principles of the Champion Community approach is to establish goals that can be met within a reasonable time frame.

As the approach has undergone different iterations, program designers have attempted to systematize the process of defining and reaching goals, and at the same time put increasing control in the hands of communities themselves. This encourages local ownership of the process and is also necessary to achieve scale.

The Kokeb Kebeles Initiative was built around a 12-step process laid out succinctly in a simple *Activities Guide*. The document provides a road map for the Kebele Action Committee to use in guiding its community through the program. Each step is accompanied by a basic checklist, examples, and tools (such as a sample monthly activity monitoring chart). Communities track their own progress. The Action Committee “reports” directly to a district task force.

Step 7 is designed to shift communities into a more independent mode. Groups are challenged to “select an open goal” and repeat the whole process (assessing the problem, selecting activities, monitoring progress, and so forth). The process of learning and practicing goal setting, self-assessment, collective planning and action, is therefore an explicit part of the program.

One of the ongoing challenges of all Champion models has been to design for round 2, and round 3. In a short time communities have “succeeded” and celebrated. And then what? One of the primary challenges is to assure “the end” is a beginning, and sustaining effort and enthusiasm is somehow part of the system.

⁹ The Health Communication Partnership (HCP, 2000-2007) is a global program funded by USAID and managed by the Johns Hopkins University, Center for Communication Programs. Partners include the Academy for Educational Development, the International HIV-AIDS Alliance, Save the Children, Tulane University, and the University of North Carolina. AED manages the HCP program in Ethiopia.

¹⁰ Essential Services for Health in Ethiopia Activities (ESHE, 2003–2008) is funded by USAID and managed by John Snow, Inc. Subcontractors include the Academy for Educational Development, Abt Associates, American Manufacturers Export Group, and Initiatives, Inc.

¹¹ Pathfinder International manages the USAID bilateral reproductive health and family planning project in Ethiopia. World Learning manages USAID’s Basic Education Systems Overhaul Program in Ethiopia.



women's affairs to build mutual understanding and consensus on roles. The second day brought in leaders from several Kebeles to discuss goals, gauge interest, and solicit feedback.

The Kebele representatives then returned to their villages to explain the program to elders and, with their support, conduct community orientations. In each community, one of the goals of this orientation was to select members to serve on a Kebele Action Committee. The small team—half of whom had to be women—would take responsibility for leading the whole process.

Members of several Action Committees took part in a short, joint training program to introduce the steps outlined in the Activity Guide. The teams learned how to help their communities collect information about local problems and document their “baselines.” They discussed how to work with their

communities to agree on goals, plan activities, and monitor progress.

In early meetings, Kebele members also reviewed and negotiated the goals of the overall program. Predictably, there was lively interest in possible construction activities. Some communities wanted to build schools or health posts. But for the limited number of required goals, they eventually agreed collective action should focus on smaller projects such as building latrines.

Initial goals for the Kokeb Kebeles Initiative were:

- Increase number of children under one year who are immunized
- Increase awareness of family planning services
- Increase enrollment of girls in school
- Construct pit latrines at schools and homes
- Increase HIV/AIDS awareness in the community.

The teams learned how to help their communities collect information about local problems and document their “baselines.” They discussed how to work with their communities to agree on goals, plan activities, and monitor progress.

Communities were also asked to select two goals from a list of nine options that had emerged as popular during program pretesting. These ranged from “ensure water is available in schools” to “increase number of households using insecticide treated mosquito nets,” to “construct health post.”

As in other Champion Community models, self-monitoring is crucial in the Kokeb Kebeles Initiative. When designing the Activity Guide, AED consulted with school directors on the easiest way to calculate enrollment and female dropout rates. Some behaviors that could not be easily measured were translated into activity goals. For example, instead of tracking numbers of modern family planning users, each community aimed to achieve a specific number of education sessions on family planning. As the program is scaled up, the lists of activities that satisfy the two goals to “increase awareness” (of family planning and HIV/AIDS) will be refined through community suggestions and practical experience.

Once communities achieve their initial goals, they are invited to select their own goal with no external guidance or restrictions—not even a list from which to choose ideas. The requirement is that communities go through the same systematic process: reach consensus on the goal, plan activities, and monitor progress.

Twenty Kebeles in SNNPR participated in the pilot program. The pilot is being followed by expansion into additional districts in SNNPR. The initiative will then be launched in the Ahmara region, followed by the Ormia region.

NEGOTIATING DIFFERENCES

One of the biggest challenges of the initiative has been resolving philosophical and operational differences among the different collaborating organizations. The typical USAID bilateral project is funded for a short period (three to five years) and includes measurable targets. It must aim at reaching a large number of communities within this short time in order to achieve impact. On the other hand, many nongovernmental organizations believe in the importance of establishing a long-term presence in communities, gaining trust over time, and facilitating comprehensive community self-assessments and planning. They are frequently not comfortable with short-term goals and a relatively “hands-off” monitoring approach.

USAID resolved this philosophical difference to some degree by assigning different implementing partners to different communities and allowing varying degrees of support. Results will be monitored and will provide insight into the best model, or the range of possible range of models, for reaching scale effectively.