

## 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.<sup>8</sup> 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,

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<sup>8</sup> 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*<sup>9</sup> and the *Essential Services for Health in Ethiopia Project*<sup>10</sup> (or *ESHE*). ESHE and two other partners—Pathfinder and World Learning<sup>11</sup>—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.

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<sup>9</sup> 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.

<sup>10</sup> 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.

<sup>11</sup> 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.

## CHAPTER 9

# FOCUSING ON THE CHALLENGES OF YOUTH



**A**ED has taken a special interest in expanding the Champion approach to youth. Building on the early Beacon Schools experience, AED has designed programs for different ages—both in and out of school—in Madagascar, Ethiopia, and Jordan. These initiatives have all focused on adolescent health, but in the much larger context of empowering youth to make informed decisions about their lives, gain skills and confidence in dealing with peers, and help others.

### A CONTINUUM OF SUPPORT

In Ethiopia, where the highest prevalence of HIV/AIDS is among youth between the ages of 15 and 24, young people are in desperate need of information, skills, and the self-confidence to make difficult personal choices. AED designed a stream of activities to provide a continuum of support throughout the pre- and adolescent years. Three curriculum-based programs include:

- **For grades 5 and 6: Life's Skills Curriculum<sup>12</sup>** to help young people define their own values, navigate the opinions and influence of their peers, and make personal decisions.

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<sup>12</sup> The curriculum was produced by AED and Save the Children under USAID's BESO Project (Basic Education System Overhaul).

- **For grades 7 and 8: Sports for Life Program**, with additional emphasis on relationships, romance and sex, and prevention of HIV/AIDS and other STIs. The program is facilitated by physical education teachers and coaches (during PE, recess, or after school).
- **For ages 15 to 20: Youth Action Kit**, with additional emphasis on relationships and managing emotions, reproductive anatomy and health, sex and its consequences, gender-based violence, and prevention of HIV/AIDS.

The *Youth Action Kit*, developed for the oldest group, was created in response to a push by the government to form anti-AIDS clubs in each school throughout Ethiopia.<sup>13</sup> Many clubs exist in name but are non-functional. The Kit also aimed to reach out-of-school youth who are served by some 10,000 clubs sponsored by the Ethiopian Orthodox Church, the Ethiopian Youth Network, and other organizations.

The basic curriculum of the Kit is highly participatory, youth-led, and designed to meet the needs of young folks with different personalities and learning styles. It is also designed to be fun. Activities center on three objectives:

- develop individual skills,
- strengthen group ties, and
- engage parents and communities

An accompanying book of around 20 skits lays out common scenarios (e.g., guy pressures girl to have sex; group pressures guy to prove he is a “man”). The skits have proven especially popular. Guided role plays encourage youth to tap into personal experiences and

<sup>13</sup> The Kit was created in collaboration with Pathfinder International, the Ethiopian Youth Network, SAVE, various on-the-ground groups, and the active participation of Ethiopian youth.

## STICKING TO THE INDICATORS

The Champion Community Initiative, in all its various iterations, is a behavior change program. The test of any behavior change program is whether it does in fact lead to positive improvements in designated indicators.

Both the Madagascar and Ethiopia youth programs described here were designed to address individual as well as community indicators. These are:

### INDIVIDUAL INDICATORS

- Delayed sexual debut
- Secondary abstinence
- Partner reduction and mutual fidelity
- Increased use of ARH/SRH services and VCT
- Increased correct and consistent use of condoms by sexually active youth

### COMMUNITY INDICATORS

- Stigma reduction and active acceptance and participation of PLWA
- Care and Support of PLWA
- Active youth leadership in community HIV/AIDS activities
- Increased involvement from parents and other adults

For the most part, these indicators were not put forth as the “simple doable actions” of AED’s youth programs. The real challenge was to design activities and goals that would address the key determinants of target behaviors in order to promote these desired changes.

Qualitative research can help reveal important determinants. Even more helpful to these programs, however, was the process of working with young people and families to come up with role plays and skits that “strike a nerve.” Through extended brainstorming and pretests with young people, the programs have tried to zero in on how young people can confront what to them are the most difficult challenges of HIV/AIDS.

In the end (or rather in a few months) a quantitative evaluation will measure whether these determinants, and these activities, do have a strong link to the desired indicators.

anxieties, as well as the creativity and high energy and humor of their age group. Role plays also push participants to reflect on how to negotiate typical situations successfully.

Another key element of the Kit is the illustrated Youth Passport. Each adolescent receives a Passport as his or her own personal resource about reproductive health and as a guide for assessing his or her own risk for HIV/AIDS, thinking about setting boundaries and resisting pressures, and a place to record personal thoughts.

### THE GREAT JOURNEY

The curriculum was constructed along a well-defined framework: that of a Great Journey. Its fundamental objective is not just for youth to “learn” or “grow” or “help others,” but to reach a clearly defined destination—and to reach that destination as a group. It aims not only to create confidence among individuals, but to create collective self-efficacy and a sense that group norms can be changed.

The framework of the *Great Journey* is a variation on the Champion Community approach, with a few distinct features.

The goals of the Great Journey fall into five categories:

- Skill-building: Each member completes 15 skill-building activities.
- Peer education: Fifty percent of club members guide friends through the Youth Passport.
- Outreach: The group carries out three neighborhood activities
- Resource identification: Each member visits an AIDS counseling center or an orphanage.
- Celebration: The group selects and organizes a community-wide activity (festival).



Each of the objectives allows a degree of individual or group choice. For example, ten ideas are presented for ways a group can help support people affected by HIV/AIDS (the “outreach activity”). The Kit also includes a list of imaginative activities that could be included in the club's final celebration. And of course it includes forms for self-monitoring.

The Great Journey goals do not include specific health- or education-related “doable actions.” The underlying behavioral goals of the Journey are prevention of HIV/AIDS, and support for those who are already infected. A quantitative evaluation will assess changes in these key indicators among a cohort of youth after they have participated in the program for around ten months. However, the curriculum itself focuses on a list of behaviors that are linked to and support these indicators. These are the same age-specific behaviors that are the focus of role plays, for example. (*See box on previous page.*)

In order to orient parents and communities to the program, a town meeting is held whenever a club is about to begin the Great Journey. In addition, AED is helping to create 45-second radio spots featuring brief interviews with parents and community leaders. The broadcasts serve to “brand” the program positively and create a draw for new clubs.

In 2004 the Youth Action Kit and the Great Journey were launched in youth clubs in four urban areas. In 2005 the program expanded into rural areas with the support of the Ethiopian Orthodox church. To date it has reached 515 youth groups, 900 schools, and around 42,000 youth. The goal is reach to youth nationwide.

## MADAGASCAR

In Madagascar, AED built on this model to create a youth program especially suited to the scouting movement. The idea of working towards well-defined goals and earning “badges,” and a system of “ranks” to indicate levels of achievement, is almost as old as scouting itself. Friendly competition between troops and celebrations of group achievement are also part of the long and popular tradition. AED created the *Ankoay Scout Program*<sup>14</sup> to fit into this framework.

More than half of Madagascar's population is under the age of 20. And the highest prevalence of HIV/AIDS in Madagascar is among 15-19 year olds. Because the epidemic has already spread to the general population, however, few communication activities are targeted at specific groups. AED has been working with the National Anti-AIDS Committee<sup>15</sup> to reach this critical population.

The scouting structure provided an opportunity to design a program with large-scale implementation in mind from the start. The movement is very popular in Madagascar and reaches throughout the country. Troops for both boys and girls are sponsored primarily by the Anglican, Lutheran, and Catholic churches.

The Ankoay program is a minimum package in terms of complexity, training, and cost, and was designed for rapid start-up. To build early consensus, an Ankoay Stakeholders' Meeting (with regional scouting directors and other partners), as well as meetings with scouts themselves, introduced the objectives as well as sample exercises. This also helped generate concrete ideas early in the process.

As in Ethiopia, the task of mapping out “doable actions” and messages central to the program was highly participatory. Brainstorming and many rounds of testing with youth helped zero in on the “every day behaviors” that directly and indirectly support a youth in protecting him or herself and others from HIV/AIDS and other STIs. These became the primary focus of activities and skits. But the program focuses beyond the individual.

Ankoay goals fall into three categories. Broadly stated, a successful troop must:

- Actively engage in developing basic life skills
- Carry out a peer education program
- Reach out to educate and serve the community

Troops can take different paths to achieve these goals. In that sense the structure of Ankoay is more flexible than that of the Great Journey. Four different merit badges focus on different activities, with each badge also allowing for some personal choice. (For example, one of the merit badges is called “Actor, Story Teller,” and provides guidance and goals for more outgoing scouts to develop and perform skits for others.)

The Ankoay program has been launched in three urban areas. By October 2006 it will be rolled out to between 225 and 360 scout troops, serving at least 10,000 young people. The program is also being modified for expansion into secondary schools and sports teams.

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<sup>14</sup> *Ankoay* means “eagle” in Malagasy. The eagle is revered as a strong and wise bird. The Ankoay Program is not related to the Eagle Scout program familiar in the U.S. and elsewhere.

<sup>15</sup> This work is being carried out as part of AED's role in Madagascar under USAID's Health Communication Partnership.

## CHAPTER 10

# JORDAN—HEALTH TRANSITION AND HEALTH COMPETENCE

Jordan is another country with a very young population. Out of a total population of around five million people, three million Jordanians are under the age of 25. Unlike Madagascar and Ethiopia, however, Jordan is a country undergoing an epidemiological transition. Chronic conditions such as diabetes, obesity, and cardiovascular diseases are beginning to replace infectious diseases as the leading causes of morbidity and mortality. These conditions are associated with unhealthy lifestyles—in particular, smoking, lack of exercise, and poor nutritional habits.

Many unhealthy behaviors take hold at a very young age. In 2003, around 43 percent of youth between 13 and 15 had tried smoking.<sup>16</sup> The Global School Health Survey for 2000 found that 13.5 percent of school-aged children were at risk for developing obesity. That year, around 90 percent of 12 year-olds and 92 percent of 15 year-olds suffered from dental caries. The prevalence of micronutrient deficiencies (vitamin A, iron, and iodine) are all high among youth.

*USAID's Health Communication Partnership (HCP)* has been working in Jordan with both the Ministry of Health and the Ministry of Education to design a participatory school-based program for youth in early secondary school (grades 7-10).

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<sup>16</sup> Global Youth Tobacco Survey, 2003.



***The Ministry of Health asked HCP to focus on four basic health areas: exercise, nutrition, hygiene, and anti-smoking. The project combined these under the umbrella theme, “Our Health, Our Responsibility.” It structured goals, content, and activities around the concept of the “health competent school.”***

The effort overlaps with several high priority programs in Jordan. Among these are the King Abdullah program for youth (modeled on the President's Challenge Physical Activity and Fitness Awards Program), an ongoing revision of the overall school health curriculum, and a national initiative to shift educational approaches in general away from passive memorization to critical thinking and problem-solving.

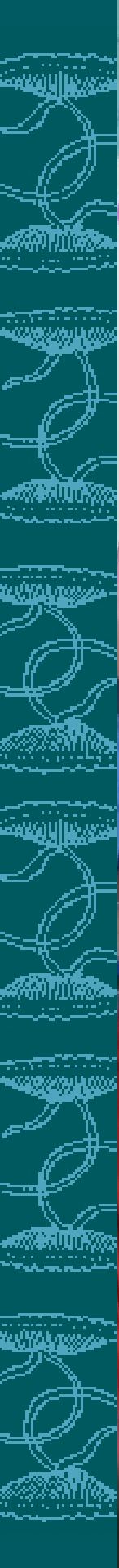
The Ministry of Health asked HCP to focus on four basic health areas: exercise, nutrition, hygiene, and anti-smoking. The project combined these under the umbrella theme, “Our Health, Our Responsibility.” It structured goals, content, and activities around the concept of the *Health Competent School*. A school that achieves this status has met specific criteria indicating that its students can make informed choices about their health, that students reach out to influence peers and family members, and that the school itself has developed a partnership with the community (parents and local leaders) to promote a healthy climate.

A major design workshop brought together a mix of representatives from the Ministry of Education, the Ministry of Health, school administrators, teachers, and parents. This group proposed an initial mix of “doable”

behaviors targeting the four health areas. These included ten student behaviors as well as eight supportive family behaviors. (See box on next page.) A menu of activities for each health area, as well as a list of school-community goals, were also proposed to support these behaviors. Supplemental materials are being created for the suggested activities. These are both curriculum based (for specific classes such as vocational education, science, and physical education) and extra-curricular.

Each participating school is expected to establish a steering committee (a small number of teachers, the school principal, community representatives, and students) to decide on yearly goals and pick the school-community activity. Examples of the school-community goals include:

- Introduction of healthy food and elimination of junk food in the school canteen
- Elimination of smoking on the school premises
- A yearly health festival including contests, theater, posters, youth-led advocacy, etc.
- Establishing a sports or physical activity program in the community run on a volunteer basis by parents



## BEHAVIORS FOR “TRANSITION”

The Ministry of Health asked that HCP focus its school health program on four areas: exercise, nutrition, hygiene, and anti-smoking. The first task, as for all Champion programs, was to identify the small number of “doable actions” that would be central to all program activities. These are:

### TEN HEALTHY ACTIONS

- Say No to smoking
- Help a friend to Say No to smoking too
- Earn the King Abdullah Fitness Award
- Exercise vigorously 30 minutes a day
- Have a traditional breakfast of cheese, egg, olives, thyme, olive oil and bread
- Eat at least 2 serving of fruits and 2 serving of vegetables every day
- Decrease the consumption of soda and sweets
- Brush your teeth at least twice a day
- Wash your hair at least twice a week
- Use soap to wash your hands before eating and after using the toilet

In addition the program devised “Eight Family Actions” to support the student in making these changes.

Involving family members is just the first point of outreach. Other activities in the program also involve parents and members of the broader community in facilitating healthy behaviors by youth. Although lack of exercise, smoking, and other personal lifestyle choices lie at the root of many chronic diseases, social and cultural norms make choices more or less difficult for young people to make. “Our Health, Our Responsibility” therefore applies equally to the individual and the community.



The process encourages choice and innovation by individual schools.

A draft *Activity Book* explains the package of goals, the process for selecting activities in each health area, and the various steps for carrying out the program. The program also includes a *Scenario Book* for role plays, and a *Monitoring Manual*. Feedback during the current pilot stage will help refine the whole process further.

The Health Competent School Initiative has been launched in a small number of pilot schools representing a mix of public, private, and military institutions in both urban and rural areas. The program will be rolled out district by district. The Ministry of Education is especially pleased that teachers are being introduced to more participatory approaches to learning. Ultimately, not only the behaviors of students, but the behaviors of teachers, may be changed in positive ways.

## CHAPTER 11

# MOVING FORWARD



**A**s the Champion Community Initiative has evolved over the last ten years, a number of basic principles and a few inherent challenges have emerged.

- The process of setting goals is critical. Objectives must strike a “happy medium” in terms of number, difficulty, time to completion, local choice, and other factors.
- Negotiation of goals is paramount. And consensus may be even harder for collaborating partner organizations to reach than for communities themselves.
- The enthusiasm of local populations is fundamental. Celebrating collective achievements and even challenges is more important than “winning” per se. The objective is to build a sense collective efficacy so that energy is harnessed over time.
- Mass media—to announce competitions and highlight specific goals as well reward the “winners”—contributes greatly to the scale of program impact.

***Each of the various iterations of the Champion Community approach has aimed to balance public priorities—in health, education, or the environment—with the immediate concerns of local communities.***

- Phasing of the approach, so that local energy is sustained and refocused over time, is being tried in different ways. (A purely linear process—where goals are reached and activities “end”—is not a successful development model.)
- Various ways of monitoring and advising the whole process are also being worked out. District teams, local NGOs, and other partners have taken different roles according to available resources and intended program scale.

Each of the various iterations of the *Champion Community* approach has aimed to balance public priorities—in health, education, or the environment—with the immediate concerns of local communities. Each of the programs has aimed to combine the urgency of major development indicators with the energy of grass roots enthusiasm. And each of the approaches has aimed to achieve short- to medium-term gains for large populations. These elements are all essential to development efforts in the context of decentralization. 11





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