



Demand Creation Strategy for MNCH-CBNC Final Evaluation Results

23 November 2017

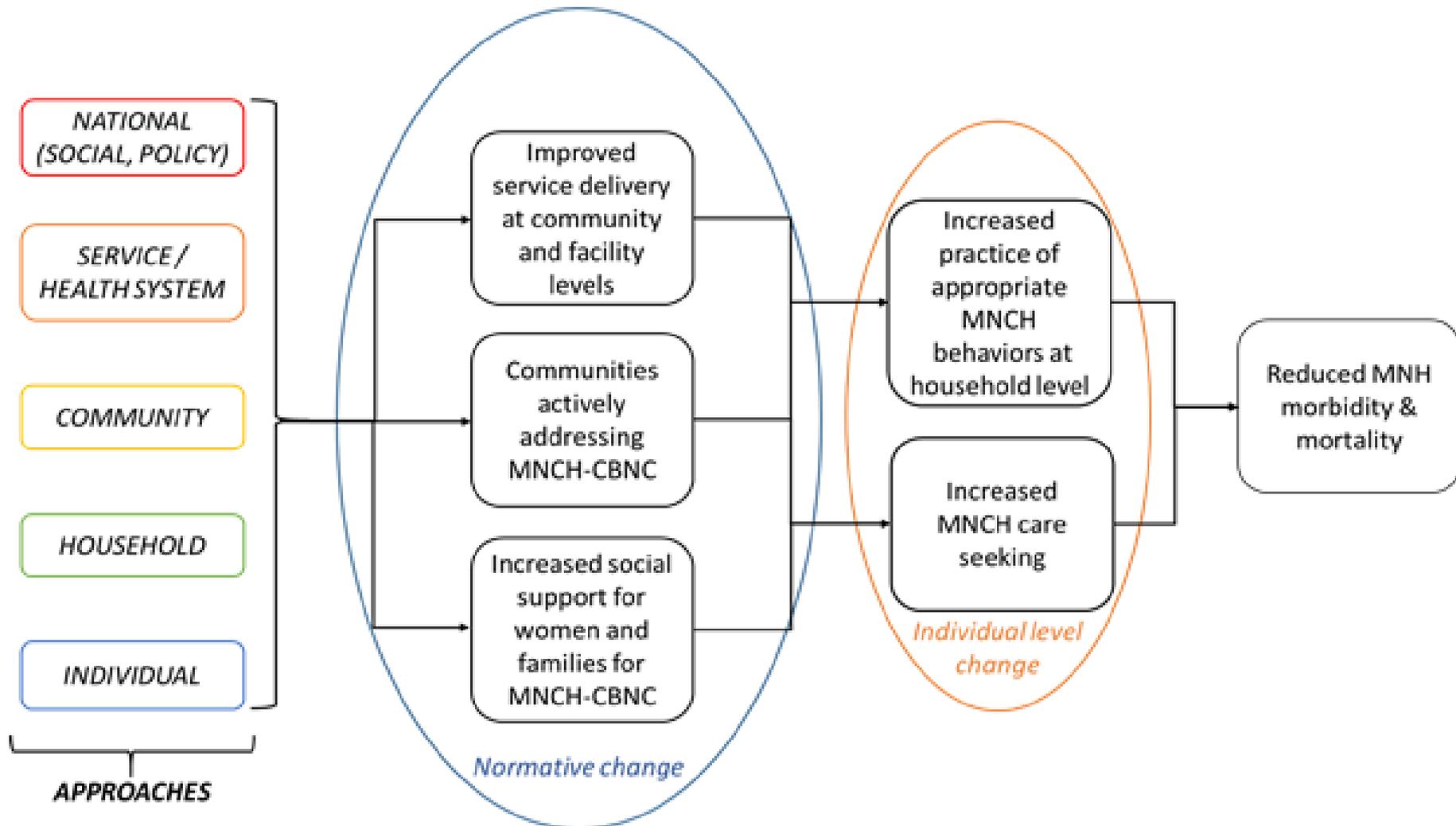
Dr. Yared Amare, Dr. William Story

Outline

- Conceptual framework
- Evaluation questions
- Expanded questions & propositions
- Methodology
- Main findings
- Recommendations



Conceptual Framework



Evaluation Questions

1) To what extent did the package of demand creation activities contribute to a change in the **enabling environment** at household, community, and health facility/system levels (i.e., normative change)?

2) To what extent did the demand creation activities contribute to a change in **MNCH-related care seeking and household behaviors** (i.e., individual-level change)?

Evaluation Question #1 (Expanded)

- Are there differences in the enabling environment between kebeles with high **implementation strength** versus low implementation strength? If so, what are those differences?
- What **SBC** approaches/activities were perceived to be the most useful for changing the enabling environment?
- How has **community capacity** been strengthened to address MNCH?
- How is **DC institutionalized** within health systems at sub-zonal levels? How might it be sustained or scaled-up?

Proposition (1.A)

A more enabling household environment is indicated by:

- Families dialog and support for MNCH/FP
- Supportive male engagement
- Belief that newborns can survive if small and/or sick

Proposition (I.B)

A more enabling community environment is indicated by:

- MNCH/FP is a male issue
- Early ANC & institutional deliveries valued
- Communities are engaged in MNCH
- Pregnancy is discussed early
- All newborns are valued

Proposition (I.C)

A more enabling environment at the health facility is indicated by:

- Humanized care at health facility
- DC is a health systems responsibility
- Health system is responsive to community needs

Evaluation Question #2 (Expanded)

- Are there changes in the **numbers of clients** seen for selected MNCH services over time?
- Are there **differences in care seeking and household behaviors** between kebeles with high implementation strength versus low implementation strength? If so, what are those differences?

Proposition (2.A)

Kebeles with **high implementation strength** would have more women and families who:

- Practiced appropriate MNCH household behaviors
- Had early ANC enrollment
- Delivered in facilities

Proposition (2.B)

Kebeles with **high implementation strength** would have more women and families who:

- Had greater knowledge of MNCH home practices
- Values the importance of early ANC and facility delivery
- Had health services available

Proposition (2.C)

Kebeles with **high implementation strength** would have more women and families who:

- Knew about newborn danger signs
- Sought care for newborn danger signs

Implementation Strength Criteria

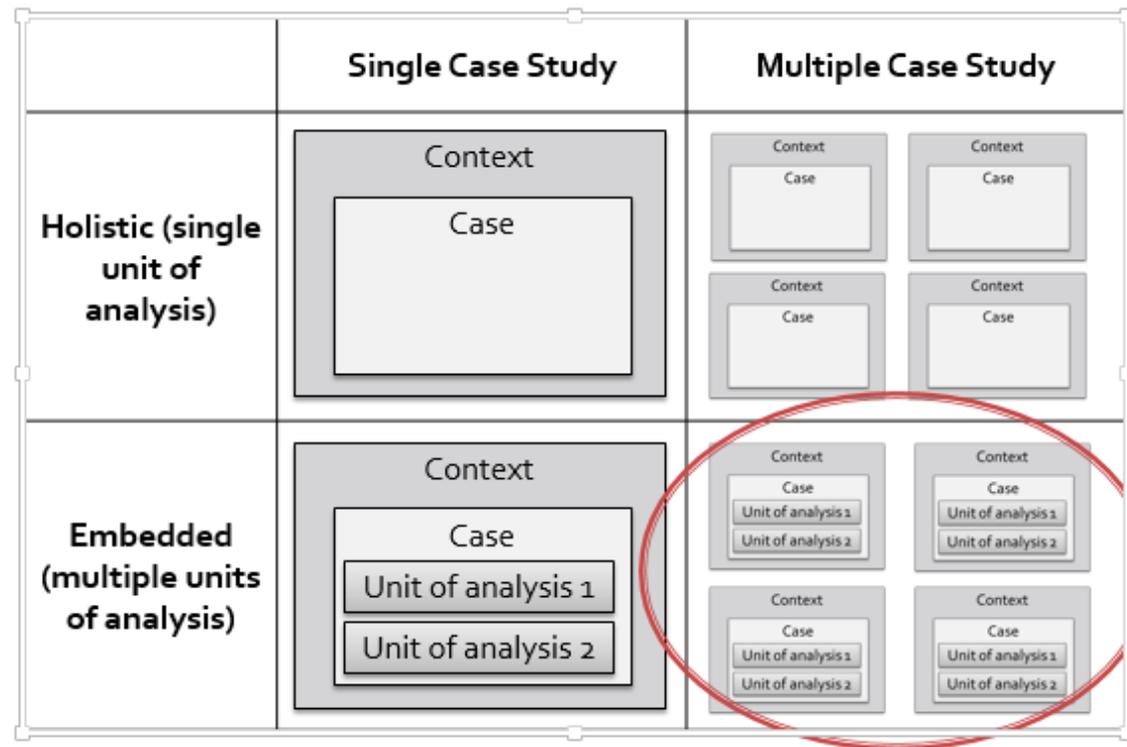
KCP Characteristic (put "1" instead of "X") if this is true for the KCP

- Has no religious leaders engaged
- Has no TBAs engaged
- Has no affected populations engaged
- KCP re-structured/reformed by government
- Meetings without quorum
- Does not have updated meeting minutes recorded in the last two months
- No actions identified in meeting
- Not meeting regularly as per their schedule [excluding special seasons]
- Do not receive regular support from the health center on demand creation implementation
- No meetings/activities held in community
- PWC not conducted regularly as per the schedule
- Community action plan not complete
- Has not applied participatory tools
- Has not raised human, financial or material resources

Methodology: Case Study Design

Multiple cases – “replication logic” provides support for theoretical propositions by:

- Comparing similar results
- Contrasting results for predictable reasons
 - Theoretical framework must clearly identify conditions when particular phenomenon is likely to be found, not found
 - Number of case replications depends upon desired certainty



Data Collection

- **In-depth interviews**
 - Women who have given birth in the last 3 months
- **Group interviews**
 - Woreda officials
 - Save staff
 - PRT members
 - HEWs
- **Focus Group Discussions**
 - Husbands
 - Mothers-in-law
 - KCP members
 - HDAs
- **Illness Narratives**
 - Mothers and families
- **Secondary Data**
 - Extracted from health post & health center registers

Data Analysis

Qualitative

- Analyze cases
- Develop codebook & input live updates
- Independently code in NVivo
- Complete coding of each transcript
- Develop a case report using the outline

Quantitative

- Used Stata 14/IC for the analysis
- Conducted mean and time trend analyses
- Study limitation – data quality issues

Linking Data to Propositions

- Two general strategies:
 - **Relying on theoretical propositions** – helps focus attention on certain data
 - **Developing a cross-case report** – analysis of individual case reports comparing high and low IS kebeles and organized based on theoretical propositions

Findings – Q1. Enabling Environment

- Husbands more **knowledgeable** about MNCH issues and mothers-in-law were **less fatalistic** about newborn survival in high IS kebeles
- Across all kebeles, strategy contributed to people's **willingness and ability** to take a sick newborn to a HF
- Across all kebeles, a number of respondents **no longer use traditional treatments** or customs in the same way
- Across all kebeles, recent positive changes in **men's involvement** in MNCH/FP

Findings - Q1. Enabling Environment (con't)

- In low IS kebeles, respondents were more likely to state **disadvantages** to early discussion of pregnancy
- In high IS kebeles, **support for early ANC** has increased in recent years due to the work of HEWs, HDA leaders, and one-to-five groups
- Across all kebeles, **one-to-five groups are more active** and the **capacity of the SKCP has improved** regarding planning, implementation, and evaluation of MNCH activities.

Findings – QI. Enabling Environment (con't)

- All kebeles mentioned **three forms of communication** between communities and health centers:
 - Health center staff visit community meetings & receive feedback;
 - HEWs submit monthly reports to health center staff, including complaints; and,
 - Community communicates issues via SKCP, which in turn communicates to health center

Findings: Q1 - Useful SBCC Approaches

- In high IS kebeles, **strengthening of the KCP** was mentioned as one of the most important components of the Strategy, including the woreda health officials.
- SKCP was most effective and efficient when the **HEW worked alongside the SKCP** to plan MNCH activities and delegate tasks.
- By engaging **religious and spiritual leaders** in the MNCH-CBNC Demand Creation Strategy, two kebeles noted a significant change in a practice called *hamachisa*.

Findings – Q1. Useful SBCC Approaches (con't)

- Although focused on addressing MNCH issues, all kebeles said Community Action Cycle (CAC) was **helpful process for other sectors**.
- **Primary barriers** to CAC - staff turnover (especially at KCP level), commitment, and ownership from PRT and KCP leadership to invest time in utilizing approach.
- High IS kebele respondents felt CAC would be **sustained**; however, low IS kebeles did not mention sustainability.

Findings – Q1. Community Capacity Strengthening

- **Skills acquired** through the SKCP were capacity to mobilize and educate the community, problem identification, planning, and evaluation.
- In the high IS kebeles, the SKCP received **supportive supervision** from the woreda health officials as well as the Save the Children staff; low IS kebeles, little support provided.

Findings – Q1. Institutionalization

- **Continuation of the SKCP** mentioned by all kebeles as key to the sustainability of the Strategy.
- Recent efforts to **improve the monitoring of health services**, especially in Oromia (via frequent data review meetings at each level), may support a more effective response to community needs.

Findings – Q2. Knowledge & Practice of MNCH Behaviors

- All mothers, fathers and mothers-in-law in all kebeles agreed that it is beneficial for pregnant women to have **ANC visits**.
- Most mothers said that ANC should start between the **third and fourth month** and most women started ANC during the preferred month.
- All mothers, fathers and mothers-in-law in all kebeles believed that a **health facility was the best place** to give birth.

Findings – Q2. Knowledge & Practice of MNCH Behaviors (con't)

- All mothers and mothers-in-law from all of the kebeles agreed newborns should **breastfeed immediately** after birth; all mothers reported the initiation of breastfeeding within 30 minutes of delivery.
 - Low IS kebeles' mothers had **more difficulty describing the reasons** why she should breastfeed immediately.
- All mothers and most mothers-in-law agreed that they should **give the newborn the colostrum**; only two mothers did not give their newborn colostrum.
 - Low IS kebeles' mothers were **not as informed on the reasons** to give colostrum as the mothers in the high IS kebeles.

Findings – Q2. Knowledge & Practice of MNCH Behaviors

- All 4 mothers in the high IS kebele reported **receiving education about newborn illness** from health workers or HEWs.
- 3 out of 4 mothers in the high IS kebele **took their child to the health facility** due to recognition of symptoms that they heard about from health workers.
 - In the low IS kebele, only one mother went directly to the health facility.
- Respondents indicated that women's utilization of antenatal care, delivery services (especially in contrast to their preference for home delivery), and care seeking for sick newborns had **significantly increased** very recently.

Recommendations

- Prioritize efforts to intentionally **strengthen the KCP across all kebeles** by inviting active participation of key community groups and individuals, including those most marginalized or interested in MNCH.
- Ensure **supportive supervision from the PRT** within the PHCU and woreda health officials.

Recommendations (con't)

- Engage mothers and key family decision-makers, especially men, in RMNCH initiatives to influence social norms.
- Strengthen the capacity of the HEW and Women Development Army platforms and work with them when planning for health service provision and implementing demand-creation strategies.

Recommendations (con't)

- Integrate **indicators for demand-creation activities** into supervision checklists and routine reporting systems.
- **Advocate for commitment** from zonal and woreda levels (including a budget line) for demand-creation activities as well as for integration with the health management information system to keep the government accountable for sustaining demand-creation activities.

Recommendations (con't)

- Plan for a **longer timeline frames** (at least three years) to ensure successful implementation of demand-creation activities.
- **Continue investing in quality of care and human resources** for health at the facility level, including cultural adaptations. Consider extending the number of HEWs to more than two per health post.

THANK YOU



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