Save the Children

Demand Creation Strategy for MNCH-CBNC
Final Evaluation Results

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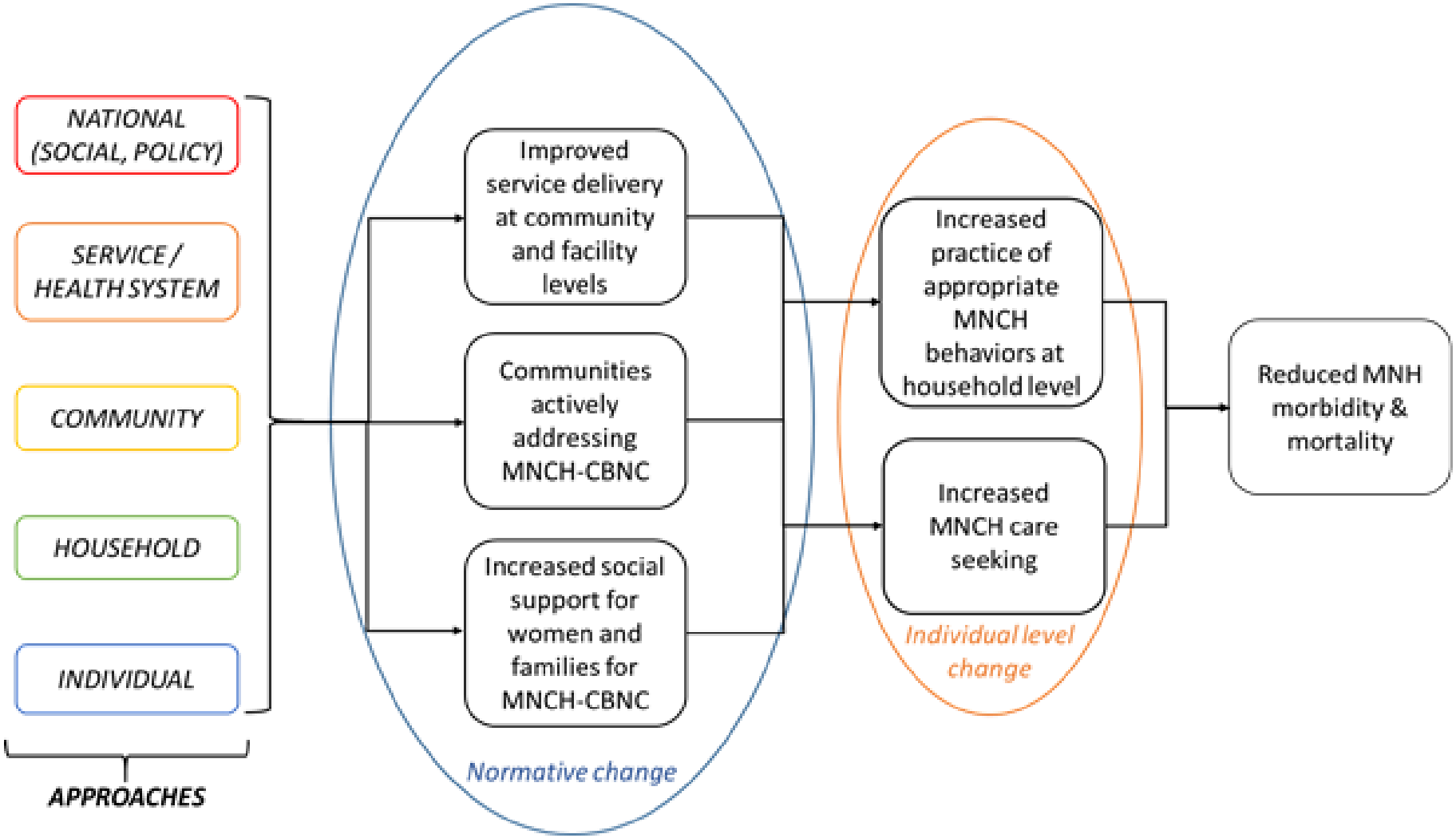
Outline

- 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 SBCC 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 (1.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 (1.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

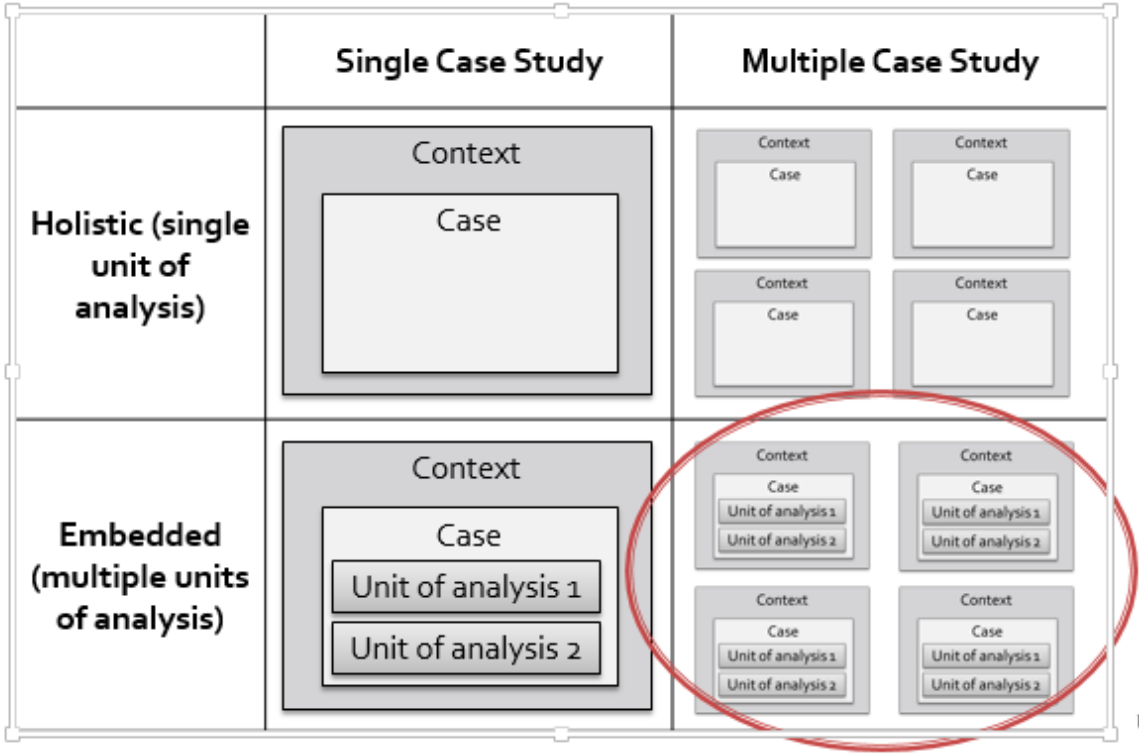
KCP Characteristic (put "1" instead of "X") if this is true for the KCP

- 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 – Q1. 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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