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Maternal and Child Survival Program

Community-Based Care in Ethiopia

Implementing a Demand Creation Strategy for Improved Maternal, Newborn, and Child Health Outcomes

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Maternal and Child Survival Program (MCSP) Community-Based Newborn Care (CBNC)/Newborns in Ethiopia Gaining Attention (NEGA) Project

Process Documentation Report: Demand Creation Process Documentation

MCSP is a global United States Agency for International Development (USAID) initiative to introduce and support high-impact health interventions in 25 priority countries to help prevent child and maternal deaths. MCSP supports programming in maternal, newborn, and child health, immunization, family planning and reproductive health, nutrition, health systems strengthening, water/sanitation/hygiene, malaria, prevention of mother-to-child transmission of HIV, and pediatric HIV care and treatment. MCSP will tackle these issues through approaches that also focus on household and community mobilization, gender integration, and digital health, among others.

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Abbreviations

ANC	antenatal care
CAC	Community Action Cycle
CBNC	community-based newborn care
FHG	Family Health Guide
FMOH	Federal Ministry of Health
HDA	Health Development Army
HEP	Health Extension Program
HEW	health extension worker
HW	health worker
IR	intermediate result
KCP	Kebele Command Post
LK	learning kebele
MCSP	Maternal and Child Survival Program
MNCH	maternal, newborn, and child health
NEGA	Newborns in Ethiopia Gaining Attention
NLK	non-learning kebele
PDQ	Partnership Defined Quality
PHCU	primary health care unit
PNC	postnatal care
PRCMM	Performance Review and Clinical Mentoring Meeting
PRT	Performance Review Team
PSBI	possible serious bacterial infection
PTFU	post-training follow-up
PWC	pregnant women conference
SBCC	social and behavior change communication
SNNPR	Southern Nations Nationalities and Peoples' Region
SSG	Supportive Supervision Guide
TBA	traditional birth attendant
TOT	training of trainers
USAID	United States Agency for International Development

Acknowledgments

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I. Introduction

In 2014, the Federal Ministry of Health (FMOH), the Maternal and Child Survival Program – Newborns in Ethiopia Gaining Attention (MCSP-NEGA) project, and country partners developed a *Demand Creation Strategy for MNCH-CBNC (draft, 2015)* that focused on approaches to address the persistent low demand for community-based newborn care(CBNC). The design process included a review of global and local demand creation experiences for MNCH-CBNC, consultation workshops and cross-learning visits, as well as a design workshop attended by the FMOH and its partners. The resulting strategy supported a *systems-strengthening* approach that built the capacity of zonal, *woreda*, Primary Health Care Unit (PHCU) and *kebele* levels to improve MNCH-CBNC.

The following is a synthesis of the MNCH-CBNC Demand Creation process undertaken by MCSP-NEGA to support the effective implementation of the national FMOH CBNC Program. It is hoped that the key results and lessons learned will provide helpful design and implementation guidance for future program implementation.

Background of MCSP-NEGA

MCSP-NEGA's goal from October 2014 to January 2018 was to contribute to reductions in newborn morbidity and mortality[1] in Ethiopia through capacity building for the provision of high-impact services at the community and the PHCU levels. The project included the following three intermediate results (IRs):

IR 1: Improved community maternal and newborn health (MNH) practices and care-seeking behaviors.

- IR 1.1 Enhanced capacity of the Health Extension Program (HEP) to promote MNH
- IR1.2. Improved implementation of evidence-based and culturally sensitive social and behavior change communication (SBCC) interventions, including increased community engagement

IR 2: Increased provision of high-impact, quality newborn care services in the community.

- IR 2.1. Increased availability of newborn care services at the community level
- IR 2.2: Improved quality of newborn care services at community and health facilities
- IR 2.3: Strengthened linkages with existing MNH activities/interventions to ensure synergies and efficient use of resources

IR 3: Strengthened supportive systems for provision of newborn health care.

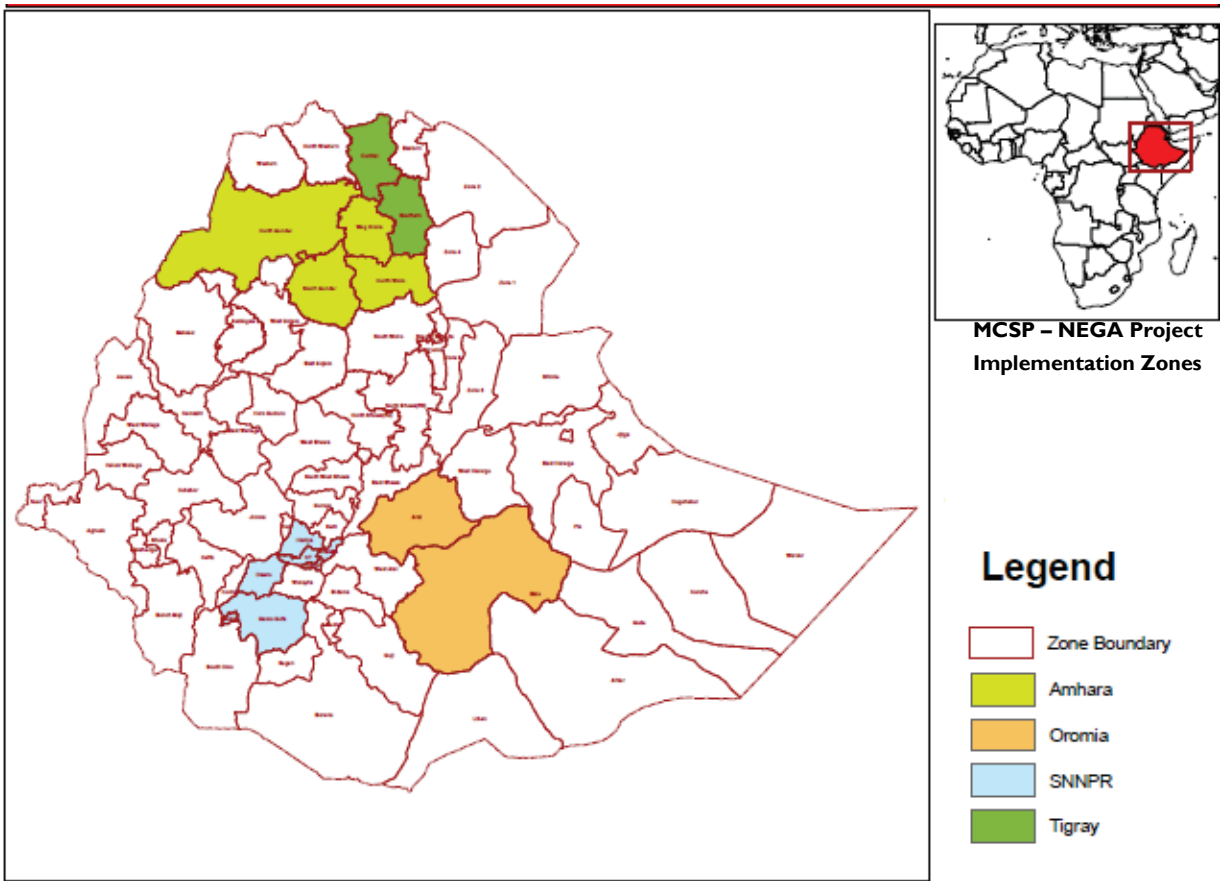
- IR 3.1: Enhanced woreda capacity to coordinate, monitor, and evaluate community newborn care interventions
- IR 3.2: Enhanced program learning through operations research
- IR 3.3: Strengthened linkages with partners and other interventions to ensure uninterrupted supply of essential supplies for newborn care

[1] National goal to reduce NMR to 11 per 1,000 live births by 2020, National Newborn and Child Survival Strategy 2015/16-2019-20, FMOH, June 2015.

MCSP CBNC Project Implementation Areas

MCSP-NEGA implemented in 135 woredas (equivalent to a district) across four regions: Tigray (two zones), Amhara (four zones), Oromia (two zones), and Southern Nations Nationalities and Peoples' Region (SNNPR) (four zones and two special woredas[2]) (see Figure 1 below). A total of 3,762 kebeles, 3,605 health posts, and 730 health centers were covered under the project.

Figure 1. Geographic distribution of MCSP CBNC/NEGA implementation zones in four major regions of Ethiopia



Total of 12 zones and 135 woredas.

[2] "Special woredas" are woredas composed of population from one ethnic group, but not large enough to form a zone. They are typically bigger than other woredas and report directly to the Regional Administration.

II. Demand Creation Strategy

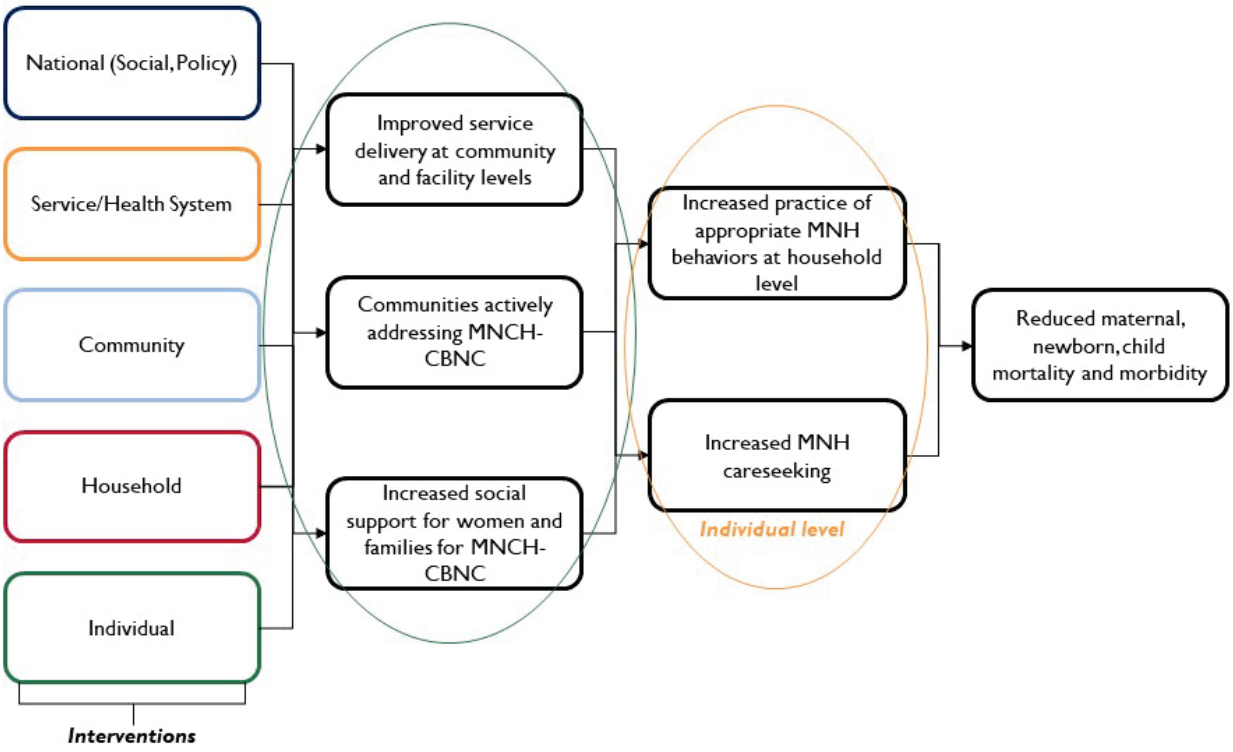
Empowering communities to actively participate in demand creation strategies that support the effective use of MNCH services, and promote key family and community care practices, is among the objectives of the 2016–2020 *National Strategy for Newborn and Child Survival in Ethiopia*. This approach includes meaningful community participation and ownership in planning, implementing, monitoring and evaluating community-based interventions. As such, the *MNCH-CBNC Demand Creation Strategy* employs an empowering community mobilization process to improve demand for health services.

The *Demand Creation Strategy for MNCH-CBNC* addresses the barriers to families for appropriate care-seeking and improved newborn care practice. The strategy focuses on increasing the uptake of appropriate MNCH-CBNC services. The objectives are:

- Improve MNCH-CBNC-related household practices and norms;
- Increase timely care-seeking for maternal and newborn illnesses; and
- Create enabling social norms that support appropriate MNCH-CBNC behaviors.

A conceptual framework (Figure 2) illustrates how the *MNCH-CBNC Demand Creation Strategy* set out to improve social norms and individual practices to reduce newborn mortality and morbidity. Through the implementation of interventions at multiple levels of the framework, the strategy created an enabled environment by improving service delivery, active community engagement, and increased social support for women and their families. As a result, individuals made positive changes in MNCH-CBNC household behaviors and increased timely MNCH-CBNC care-seeking.

Figure 2. Conceptual framework for MNCH-CBNC demand creation strategy



The guidance provided by the *MNCH-CBNC Demand Creation Strategy* encouraged the implementation of a combination of community empowerment strategies. These include:

- Strengthening kebele command posts
- Supporting pregnant women's conferences (PWCs)
- Encouraging teamwork for demand creation and service delivery
- Actively engaging men and other decision-makers in families
- Using multiple communication channels
- Using community-based data for decision-making
- Creating an enabling environment at community and facility levels
- Promoting a non-delivery role for traditional birth attendants (TBAs)
- Offering family-friendly health services and matching demand with quality services
- Building and linking community social networks

The section that follows describes in detail the application of these strategies.

III. Implementation Process

MCSP-NEGA implemented the *MNCH-CBNC Demand Creation Strategy* through a catalytic process that worked to strengthen existing health systems. As such, the project strived to integrate demand creation strategies with existing FMOH institutions, the training process and supportive supervision systems at national, zonal, woreda, PHCU and community levels. In order to improve opportunities for sustainability and institutionalization, it was intentionally designed not to be implemented as a vertical, stand-alone effort. Implementation centered on the government HEP, made up of health extension workers (HEWs), the Women's Development Army, zonal and woreda health offices, health centers, and existing community groups and stakeholders.

Laying the Foundation

Based on the gaps identified during implementing the Community Based Interventions for Newborns in Ethiopia (COMBINE) research trial and the integrated Community Case Management (iCCM) program, in 2013 Save the Children through the Saving Newborn Lives (SNL) project partnered with the FMOH and other newborn partners to develop a demand creation strategy that can be implemented at scale. The design process included desk review of local and global experiences on demand creation for MNCH-CBNC, consultative workshops, cross-learning visits and a demand creation design workshop for key FMOH and partner organizations. The strategy was on its final stages when the MCSP NEGA project was awarded. This provided an opportunity for the project to systematically integrate the demand creation training as part of the overall CBNC training for health workers and HEWs.

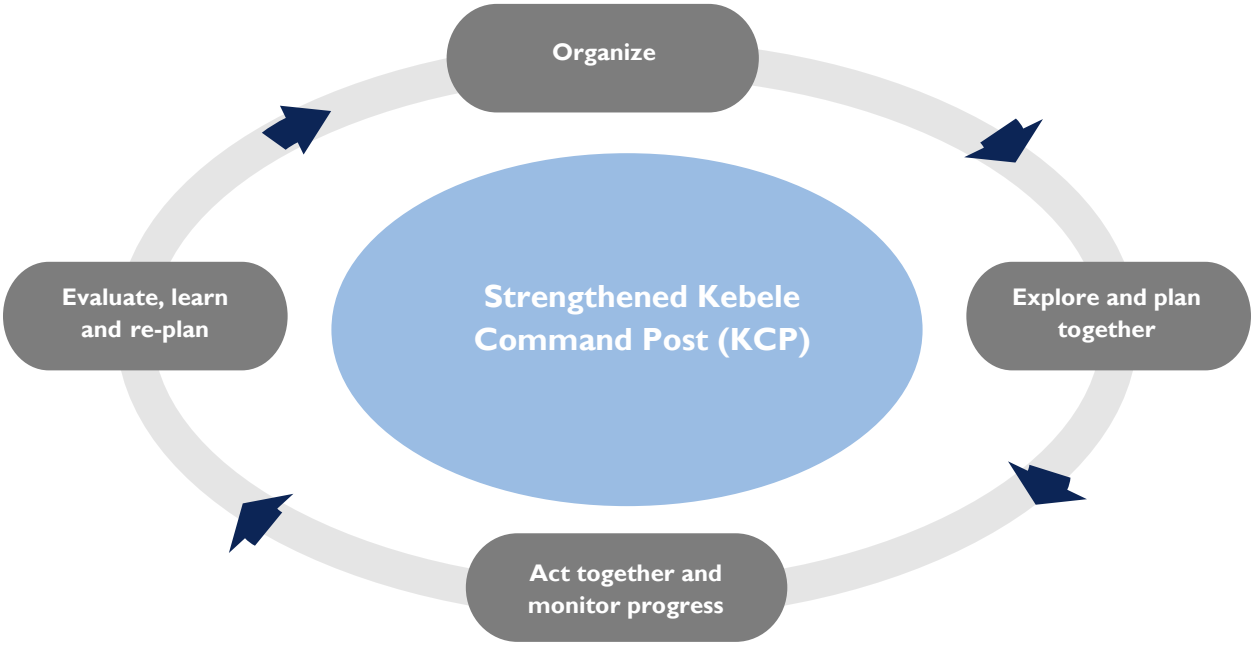
From the start, the project sought to foster ownership and a common vision around the importance of demand creation by investing significant time and effort into the orientation and capacity-strengthening of key health management structures at the federal, regional, zonal, woreda, and PHCU levels, as well as woreda cabinets[3] and faith-based groups. The orientation to woreda cabinet members was considered strategic as it (i) clearly laid out the roles of the different sectors and political and administrative structures to advance community empowerment strategies; and (ii) fostered support to the health sector.

An *MNCH-CBNC Demand Creation Training Package* was developed to support the capacity of health care providers and managers to implement the community-empowering, demand-creation approaches. The *Training Package* was essential not only in building skills, but in creating a foundation of understanding of the value demand creation and community engagement brings to improving health service utilization, the quality of services, and improving family MNCH-CBNC illness recognition and prompt care-seeking.

Central to the *Training Package* was the *Community Action Cycle* (CAC)[4] model of community empowerment, which enabled communities to identify barriers, prioritize MNCH-CBNC issues, develop an action plan, act collectively, and celebrate successes. Specifically, the community empowerment process entailed four stages, with associated steps (Figure 3). This process was used by community groups to better organize themselves for MNCH-CBNC; explore and plan around key MNCH-CBNC issues, and act together to improve their MNCH-CBNC priorities. Central to the sound application of the CAC was building ownership, skills, and capacity at multiple levels of the health system to support its sound application and monitoring of results at the community level, including the roll-out of the MNCH-CBNC Demand Creation Training Package.

[3] This is the executive branch of government at the woreda level. Led by the woreda administrator, it is a multi-sectoral body composed of leaders of the key development sectors (health, education, agriculture, women's and youth affairs, etc.) and political representatives.
[4] Stages of the Community Strengthening and Mobilisation Process; Adapted from Community Action Cycle, Save the Children & Health Communication Partnership. 2003. *How to Mobilize Communities for Health and Social Change Field Guide*.

Figure 3. Stages of community strengthening and mobilization for MNCH-CBNC



The *Training Package* was applied at multiple health system levels and was tested and adapted during the life of the project. It consisted of the following four parts:

- Demand Creation Orientation Guide for HEWs
- Zonal, Woreda and PHCU MNCH-CBNC Demand Creation Workshop Guide (3-day workshop)
- PHCU Supportive Supervision Guide (SSGs) for MNCH-CBNC Demand Creation
- Community Partners MNCH-CBNC Demand Creation Guide

Key to the MCSP-NEGA demand creation implementation process was building skills and capacity in a phased approach at multiple levels of the health system. Having a team of experienced and well-trained project staff to strengthen capacity and mentor health management structure at the zonal; woreda, and PHCU levels was essential. At the start of the project, 64 MCSP-NEGA project staff, including SBCC officers, project officers, zonal coordinators, and regional managers, all with prior training of CBNC and integrated management of neonatal and childhood illnesses, were trained on the *MNCH-CBNC Demand Creation Strategy*, including the CAC. Staff were based at regional, zonal, and woreda levels and served as a pool of master trainers for the demand creation strategy.

The following section describes the important processes undertaken at multiple levels to effectively integrate and implement demand creation through a systems' strengthening approach.

Federal Level

Effectively integrating demand creation capacity-strengthening into existing and ongoing national training opportunities proved a more effective strategy than creating a stand-alone demand creation training. At the national level, the *MNCH-CBNC Demand Creation Strategy* was integrated into the existing FMOH *CBNC Training for HEWs*. Specifically, the *MNCH-CBNC Demand Creation Orientation Guide for HEWs* was developed by MCSP-NEGA and integrated into the CBNC training package for HEWs, and added as a half-day training onto the standard 4-day training.

The half-day training supported participants' understanding of demand creation and provided essential job aids to support implementation. Integrating demand creation into the CBNC training provided an opportunity for HEWs to analyze the interconnectedness between provision of services and the barriers and enablers for families and communities to demand these services. While the half-day training was not sufficient to develop the full demand creation skill base of HEWs, the project integrated further skills development through HEW mentoring during post-training follow-up (PTFU), performance reviews, clinical mentoring meeting (PRCMM), and regular supportive supervision.

Table 1. Number of HEWs and HWs trained on demand creation by project year

Number of HEWs and HWs trained on demand creation	Year 1	Year 2	Year 3	Total
# of HWs attended training of trainers (TOT) on CBNC, with demand creation integrated	474	-	-	474
# of HWs trained on demand creation, integrated with CBNC training	874	324	-	1,198
# of HEWs trained on demand creation, integrated with CBNC training	5,373	1,502	123	6,998
# of HWs attended training on demand creation	-	959		959

Zonal and Woreda Level

At the zonal and woreda levels, emphasis was placed on creating ownership over the MNCH-CBNC demand-creation process, while encouraging a balance of service delivery and demand-creation interventions in health systems planning and budgeting process. As such, MCSP-NEGA implementation focused on training a significantly large cadre of zonal- and woreda-level health care providers and managers who would support each other to advance the demand creation agenda. MCSP-NEGA developed an *MNCH-CBNC Demand Creation Workshop for Zonal and Woreda Offices and PHCUs,* and conducted the 3-day training workshop for 981 health care providers and managers based at zonal and woreda health offices and PHCUs[5] to strengthen knowledge and skills on planning, budgeting, implementing, and monitoring demand creation interventions within the health system.

To ensure the quality of the trainings, MCSP-NEGA maintained a facilitator-participant ratio of (1:6), conducted daily evaluations, administered pre- and post-tests, and provided relevant demand creation reference materials such as the *MNCH-CBNC Demand Creation Strategy*, and *Demand Creation SSGs*. For quality purposes, daily review sessions by trainers identified trainees in need of follow-up support. Important to the training process was applying what was learned. As such, woreda and PHCU participants jointly drafted woreda-specific MNCH-CBNC demand creation implementation plans that included details on supportive supervision, timelines, and budgets for rolling out demand creation interventions within the PHCUs and communities in the woreda.

Moreover, all woreda cabinet members in MCSP-NEGA implementation areas were oriented on the *MNCH-CBNC Demand Creation Strategy*. This approach helped leverage multi-sectoral interest and support for reducing maternal and newborn mortality.

[5] One health worker was selected per each PHCU, except for PHCUs supervising more than eight health posts. For these, two health workers were trained.

PHCU Level

MSCP-NEGA recognized the limited time that health care providers have for off-site training; therefore, as part of the implementation design, capacity-building on demand creation strategies was woven into existing health systems and functions of the PHCU Performance Review Teams (PRTs) through ongoing mentoring and coaching. Because of the limited number of health center staff who were represented on the PRT, and in an effort to address high turnover and the subsequent loss of capacity, the PRT was expanded to include a broader representation of health center staff, especially those directly supervising health posts. Following on-the-job training, HWs assigned to supervise health posts/kebeles took responsibility for facilitating the demand creation process at the community level, and for presenting progress during monthly PHCU PRT meetings. MCSP-NEGA effectively expanded 95% of the PRTs in its implementation areas, leading to greater health system capacity for demand creation interventions.

Box 1. Organization of the Supportive Supervision Guides

Demand Guide #1: Orientation and Planning for Effective MNCH-CBNC Demand Creation
Demand Guide #2: Organize the Community for Action – Part1
Demand Guide #3: Organize the Community for Action – Part 2
Demand Guide #4: Explore and Plan Together – Part 1
Demand Guide #5: Explore and Plan Together – Part 2
Demand Guide #6: Act Together and Monitor Success

A series of 6 SSGs (Box 1) and associated helpful tools, which aligned with the CAC, were developed by MCSP-NEGA as on-the-job training guides to assist the expanded PRTs in the step-by-step implementation of MNCH-CBNC demand creation strategies with their community partners. The tools assisted the expanded PRTs to apply their learning and skills at the community level, specifically to building community capacity to organize, explore, plan, and act together for improved MNCH-CBNC.

Table 2. SSG structure aligned with Community Action Cycle stages

Stage	Steps	SSG #	Community Meeting #
1: Organize the Kebele Command Post (KCP)	1. Orient the KCP	SSG # 1 SSG # 2	Meeting #1
	2. Identify interested community groups and individuals		
	3. Invite community groups and individuals		
	4. Organize and strengthen the KCP	SSG # 3	Meeting #2
2: Explore local MNCH issues, prioritize, and develop a community action plan	1. Explore MNCH-CBNC issues with the community	SSG # 4	Meeting #3
	2. Analyze what was learned and set priorities		
	3. Develop an MNCH-CBNC community action plan	SSG # 5	Meeting #4 Meeting #5 Meeting #6
3. Develop an MNCH- CBNC community action plan	1. Define roles in carrying out the action plan	SSG # 6	Meeting #7 Meeting #8 Meeting #9
	2. Strengthen the community's capacity to carry out its MNCH-CBNC action plan		
	3. Monitor community progress		
4. Evaluate, Learn, and Re-run			Meeting #10

Each SSG required approximately 3 to 4 hours of interaction and used practical tools and techniques, including discussions, simulations, exercises, and question and answers. After each session, PHCU staff cascaded the relevant sessions to their respective KCPs.

By the end of the project, 695 (95%) PHCU PRTs were oriented on the first SSG, with these PHCUs forming *expanded* PRTs, reaching a total of 6,074 HWs. Subsequent SSG orientations were dependent on the PRTs cascading what they had learned to the KCPs. Progress on the cascade of SSGs was not uniform across project target areas for various reasons, including HWs' motivation; competing priorities related to campaigns, disease outbreaks and drought response; as well as civil unrest in parts of Oromia and Amara. In total, 94% of the PRTs progressed to the second SSG (covering a total of 5,974 HWs and 80% of the PRTs progressed to the third SSG. Overall, about a quarter of the *expanded* PRTs (171; 23%) completed all six SSGs, resulting in an available cadre of health care workers in all the regions with the knowledge and skills to implement community empowerment demand-creation strategies in their areas (Table 2).

Adaptations were made to the cascade of training to increase efficiency and effectiveness. Furthermore, the second and third SSGs were merged to save time, given that no community-level activity was expected following these initial PHCU orientation sessions.

Community Level

At the community level, MCSP-NEGA focused on building capacity and linking existing community groups and networks for improved MNCH-CBNC. A deep understanding of community leadership structures (formal and traditional), decision-makers, and gender and power relations proved essential in the effective implementation of the project's community-level efforts.

Central to the *MNCH-CBNC Demand Creation Strategy* was strengthening the role and capacity of the community-level KCPs[6] to apply the CAC. During the development of the MNCH-CBNC *Demand Creation Strategy* (2013), the importance of working with community groups whose function was embedded into existing social and administration systems was discussed, given that it enables sustained support and oversight. MCSP-NEGA's decision to work with KCPs was based on their existing role as a government multi-sectoral development platform, the decision-making role they play in their catchment areas, and their potential to mobilize human, financial, and material resources.

Since KCPs were not uniformly represented by individuals with a stake in maternal or newborn health, the *MNCH-CBNC Demand Creation Strategy* applied the *Organize Stage* of *the CAC* to invite those most affected and interested in MNCH-CBNC to become members of a strengthened KCP. The strengthened KCPs shared a mobilizing goal of **"Reducing maternal and newborn deaths and ensuring the survival of the coming generation!"** Additional members included health development army leaders, TBAs in a non-delivery role, respected elders, interested and affected individuals, and representatives from faith-based organizations and other community groups as relevant, increasing the KCP membership from an average of seven members to an average of 20 members. Key to the effective functioning of the strengthened KCPs was ensuring a gender balance and that voices of women were equitably represented. A 50%–60% ratio of women to men was achieved through the formation of the strengthened KCP, allowing women's voices to be heard and their priorities integrated into community action. The mandate of the additional members of the strengthened KCP was focused on creating demand for MNCH-CBNC. The original mandate and structure of the existing KCP remained intact.

[6] The KCP membership mirrors the high level cabinet /administrative structure. The default KCP membership is: Kebele Manager, a political appointee, a school director (representing the education sector), an HEW (representing the health sector), an agriculture development agent (representing the agriculture sector), a representative from the women's association, a representative from the youth association.

The *Community Partners Guide for Demand Creation* provided user-friendly tools for strengthened KCPs to apply at each stage and step of the CAC. Tools included guidance on how to select new members and develop norms for a functioning group; participatory tools such as the Problem Tree to explore issues affecting mothers and newborns in the community; a guide on how to prioritize community issues; how to make a community MNCH-CBNC action plan, and ways to mobilize human, material, and financial resources to implement activities in their action plans. Assuring these tools reached community partners, and that communities felt confident in their use, was important for building community skills and the ability to act collectively.

Community Engagement in Quality Services

Poor quality of care emerged as an important barrier to access and utilization of MNCH-CBNC services by mothers and families. Therefore, in addition to the clinical service quality efforts undertaken in 13 health centers with a high volume of deliveries supported by MCSP-NEGA, the project recognized the importance of engaging the users of health services in a process to create more user-friendly services. As such, the project piloted a Partnership Defined Quality (PDQ)[7] approach in six of the project's health centers' Quality Improvement Teams (QITs) to foster community engagement in the quality improvement process.

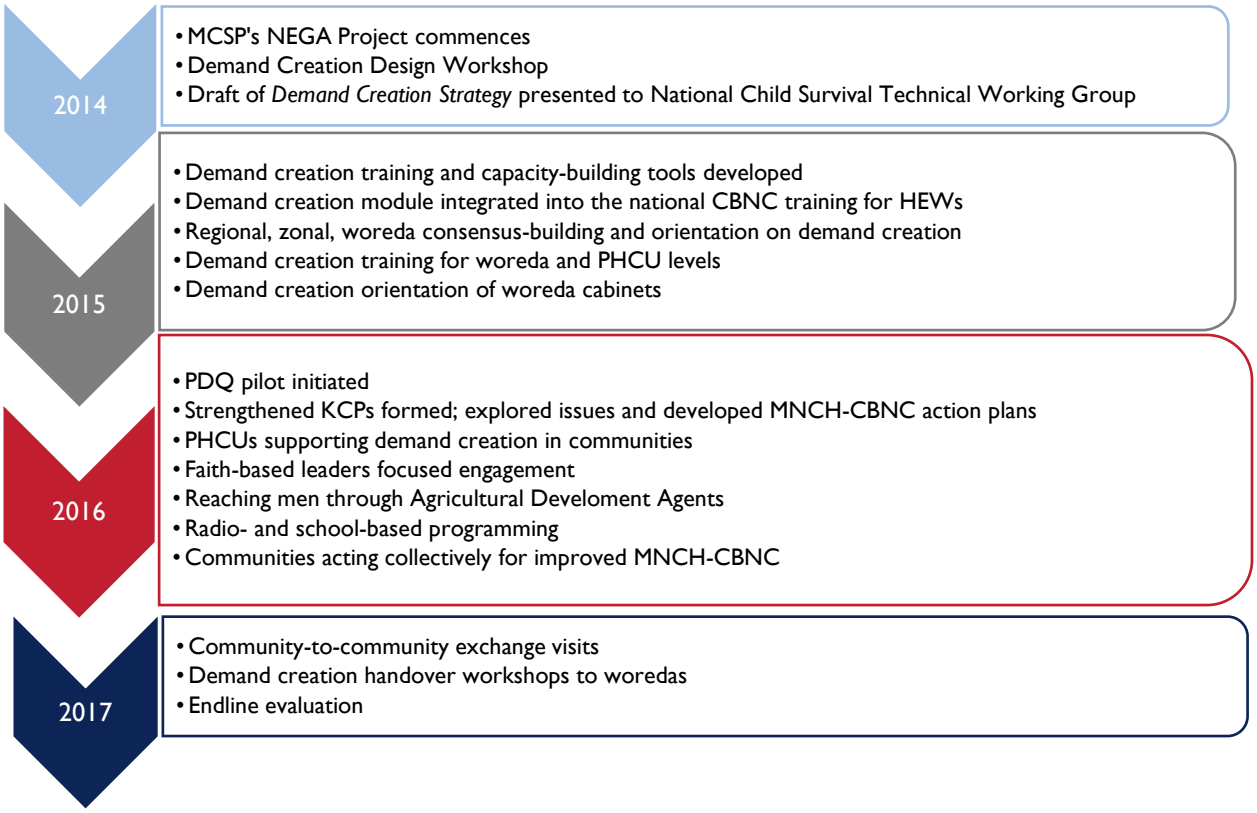
The PDQ approach brought together health service providers and the users/clients to define, explore, and improve the quality of health service delivery based on their respective perspectives. The approach was undertaken in four phases, namely Building Support; Exploring Quality; Bridging the Gap; and Working in Partnership and reinforces the social accountability role communities play in monitoring the quality of health services being provided to their constituents and fosters their participation in improvement efforts.

The approach started with building support among health centers and soliciting their interest in participating in the PDQ process. Once support was secured, the expanded PRTs began exploring how their communities and providers defined and perceived MNCH-CBNC quality. The Exploring Quality phase involved a series of small group discussions held first with small community groups of women, men, and mothers with newborns. A similar process was undertaken with health care providers. The Bridging the Gap sessions were conducted by bringing together community representatives and health care providers to further discuss critical quality issues identified by the two groups, and highlighted issues they had in common. At the end of this session, community representatives were identified to join the PRTs for the Work in Partnership phase on prioritized quality problems. This phase included the development of a shared vision for quality, and joint action plans to guide the collaborative work of communities and HWs to address key quality gaps in their respective health centers. For example, in the Waka health center where PDQ was piloted, a post-program follow-up indicated that PRTs, along with their respective community representatives, are implementing their quality improvement action plans, continue to meet regularly, and are jointly monitoring quality of MNCH-CBNC services. Of the 17 members of the QIT, eight are now from the community. Achievements include improvements in maternity waiting rooms with community contributions of funds for food, utensils, and coffee; improvements in early identification of pregnant women (Annex C attached separately); and increases in the number of institutional deliveries. PDQ and quality improvement achievements were also shared with four woredas in the associated Dawro zone, with health facilities initiating replication of the process.

The PDQ approach improved trust, mutual understanding, accountability, and quality to drive better service utilization. It also encouraged and supported communities and health care providers to actively participate together toward improving health quality through ongoing dialogue, planning, collective action, and monitoring of outcomes—leading to increased demand for and access to health services.

[7] Partnership Defined Quality—A Tool Book for Community Health Provider Collaboration for Quality Improvement, Save the Children, 1996.

Figure 4. Timeline of demand creation activities



IV. Learning and Monitoring Process

Monitoring and Planning tools

The project developed demand creation planning and monitoring tools that are important for tracking the strength of implementation and progress. In particular, the demand creation planning tools provided to woreda and PHCUs during MCSP-NEGA training workshops proved essential in their ownership and development of comprehensive action plans, and monitoring demand creation activities in their catchment areas. The following Demand Creation Tools may be found in the *MNCH-CBNC Demand Creation Training Package:*

- Health Center Demand Creation Planning Tool
- Woreda Demand Creation Planning Tool
- Demand Creation Form I: Monthly Monitoring Tool used by health centers to monitor the demand creation (CAC) process at the kebele level
- Demand Creation Form II: Monthly Monitoring Tool used by health centers to monitor community-level SBCC activities undertaken by health posts and strengthened KCPs
- PHCU Demand Creation Notebook (along with guidelines for standard minutes) used to keep minutes of the regular expanded PRTs and strengthened KCP meetings, including meeting agenda, number of participants, major discussion points, key action points, and persons responsible.

These tools were developed for use by the expanded PRTs. Although consensus was reached with the PRTs on the importance of these tools to adequately track progress, there were implementation shortfalls and serious challenges faced in their effective application. This resulted in lack of adequate and credible data for timely and tailored action. Sample select tools are included in the annexes (specifically Annexes A and B) and attached separately.

In addition, changes in community capacity were measured at both baseline and endline evaluations, specifically to document changes as a result of the projects community empowering demand creation approaches. Women were asked about their perceptions of their own capacity and that of their community around MNCH related issues. Measures of community capacity were organized under themes, including:

- Community ability to find solutions to MNCH problems
- Leadership and participation in groups to address MNCH
- Confidence, skills and abilities, and commitment to MNCH problem solving
- Willingness to help neighbors with an MNCH problem
- Male participation in improving MNCH outcomes
- Community planning to address MNCH issues
- Emergency transport systems in place
- Community norms and action encouraging early pregnancy disclosure; ANC; exclusive breastfeeding; participation in pregnancy women's conferences, and deliveries at health centers

Women rated their level of agreement on a Likert Scale[8]. Responses were pooled to reflect agreement and disagreement with statements organized into six capacity domains: self-efficacy, collective efficacy, social cohesiveness, collective action, participation and effective leadership. Statistically significant improvement was observed at end-line in women's perception around self-efficacy (70% baseline vs 77% end-line; $p<.001$), collective action (72% baseline vs 75% end-line; $p<0.04$), effective leadership (55% baseline vs 67% end-line; $p<0.001$) and participation (63% baseline vs 71% end-line; $p<.001$). A two-percentage point reduction is observed in collective efficacy as well as in social cohesion (79% baseline vs 77% end-line).

8 Underwood et al. Community capacity as means to improved health practices and end in itself; Evidence from a multi-stage study. International Quarterly of Community Health Education, Vol. 33(2) 105-127, 2012-2013

Adaptive Management

Midway through implementation, the project realized it was not able to cascade the *Demand Creation Strategy* from the strengthened PRTs to the KCP level as efficiently as it originally anticipated. This was due to a number of factors including: transportation challenges of health centers, limiting supportive supervision visits; insecurity caused by political unrest; other competing priorities of HWs including response to disease outbreaks, health campaigns, and nutrition emergencies related to drought; and failure of some HWs to fully take responsibility for demand creation activities. Considering the slow progress of strengthened PRTs cascading the demand creation activities to KCPs, MCSP-NEGA decided to modify the implementation modality halfway through the project life. The revised strategy categorized implementation into learning and non-learning kebeles. The following outlines the criteria for learning and non-learning kebeles. .

Learning Kebeles:

- At least two kebeles from each woreda were selected (370 kebeles total) based on strong PHCU leadership; conviction of the leadership that implementing the *Demand Creation Strategy* would improve service utilization and their relationship with communities; willingness and commitment of PRTs to cascade the strategy as originally designed; and geographic accessibility of the kebeles to facilitate frequent monitoring by project staff. Implementation followed the original MNCH-CBNC *Demand Creation Strategy* and tools.
- Project staff provided close mentoring to the expanded PRTs on how to facilitate the CAC, and built capacity of strengthened KCPs.
- Expanded PRTs and strengthened KCPs organized community-to-community exchange visits, which served as learning sites for neighboring communities.

Non-Learning Kebeles:

- MCSP-NEGA adjusted and simplified the demand creation implementation approach by reducing the number of tools, meetings, and processes.
- Demand creation efforts were implemented by kebele managers and HEWs without substantial support of the supervising expanded PRT. The role of the PRTs was limited to orienting the KCPs on the simplified demand creation guide; and to follow up its execution as part of their routine supervision.
- Minimal support was provided from project staff.
- Strengthened KCPs reduced the number of community meetings from 10 to five for implementation of the CAC, along with simplifying and reducing the number of tools used.

Community-to-Community Learning Visits

Community-to-community learning visits to learning kebeles, which were aimed at transferring MNCH-CBNC demand creation-related lessons to neighboring kebeles and health centers, constituted an important experience-sharing and cross-learning initiative. Participants included woreda cabinet members consisting of administrators, political bureau heads, zonal health bureau representatives, kebele leaders, HEWs, and health center heads. The learning forums were organized at the woreda level where health centers and kebeles learned from experiences of learning kebeles and developed implementation plans for their areas. The process enabled scale-up of elements of the MNCH-CBNC *Demand Creation Strategy*.

Table 3. Participants of community- to- community learning exchange visits on MNCH-CBNC demand creation-related experiences in the 4 project regions (cumulative as of July 2017)

Regions	Planned Events	Completed Events	Participant Numbers			
			Kebeles / Health Posts	Health Centers	Woredas	Individuals
SNNPR	27	23	147	97	22	3,082
Oromia	30	22	171	77	22	852
Amhara	34	33	147	159	42	1,506
Tigray	14	15	171	87	14	916
Total	**105**	**93 (87%)**	**636**	**420**	**100**	**6,356**

The *Guide for Community-to-Community Exchange* for experience-sharing was developed, which highlighted the criteria for selecting those strengthened KCPs that would host learning visits. Selection was based on completing one round of the CAC, reaching the "act together" stage, and demonstrating evidence of changes observed in community and household MNCH-CBNC-related practices.

The half-day exchange programs included presentations and discussions supported by field visit observations. The hosting strengthened KCP made presentations on how they mobilized and empowered their community for collective MNCH-CBNC actions, and the results achieved. HEWs and strengthened KCP chairpersons also discussed positive changes observed as a result of the demand creation work they initiated, including early signs in service utilization uptake. Observations included review of strengthened KCP meeting minute books and by-laws (the organizing stage of the CAC); MNCH-CBNC community action plans; community MNCH-CBNC Health Bulletin Boards; CBNC monitoring charts; PWCs' registration books; cereals and grains collected from communities for distribution to pregnant women while at maternity waiting areas of health centers; and photos of roads cleared to provide better access to ambulances. In addition, community members—including strengthened KCP members, beneficiary women, faith-based leaders, agriculture development agents and TBAs in their non-delivery role—presented and described what they were able to accomplish once organized around a common MNCH-CBNC goal. School clubs also participated, presenting songs and poems demonstrating their learning on MNCH-CBNC.

To evaluate the experience-sharing visits, MCSP-NEGA collected participants' feedback using a structured questionnaire. Overall, participants indicated they learned from the successes as well as challenges the strengthened KCPs faced and were able to draft plans to scale up selected promising practices for their respective kebeles. The presence of woreda administrators, political representatives, woreda and zonal health office heads at the experience-sharing visit was instrumental in supporting the development of scale-up plans. These leaders have indicated their commitment to follow up on the implementation of the drafted kebele-levels plans.

Community Use of Data for Decision-Making

The use of health data by communities enabled a greater understanding of their collective health progress, and motivated ongoing commitment for communities to work collectively. Community health bulletin boards were used by the strengthened KCPs to track pregnant women, antenatal care (ANC) coverage, facility deliveries, maternal deaths, newborn deaths, newborn postnatal follow-up, and child vaccination coverage. Easy-to-use drawings pointed to each health issue and guided analysis of progress on a monthly basis, enabling communities to celebrate successes or adjust health strategies. Bulletin boards were made from chalk boards similar to those used in schools. Their portability allowed health progress to be shared at community meetings.

SBCC Strategy

Building on the MNCH-CBNC demand creation efforts, MCSP-NEGA designed a complementary SBCC strategy to identify and address additional audience groups that influence MNCH-CBNC norms, behaviors, and practices. The strategy focused on the social and political environment, service delivery, community, and individuals, and identified priority audience groups under each category, profiled each audience group and put forth a selection of communication approaches. The sections below summarize strategies to engage additional audience groups identified as having key roles in MNCH-CBNC, but that may not be reached as effectively through the strengthened KCPs.

School Engagement

The SBCC strategy identified targeting the school community as an important opportunity to: (i) leverage teachers and students as key agents of change for MNCH-CBNC; and (ii) introduce positive MNCH-CBNC behaviors and practices in the minds of students as potential future parents.

HEWs undertook the primary role of orienting the school community on key MNCH-CBNC information using relevant extracts from the *Family Health Guide* (FHG), posters and brochures (See Annex D, attached separately). School directors also played a role as members of the strengthened KCP and worked to mobilize teachers and school clubs on promoting positive MNCH-CBNC practice in families, and how to be local champions for maternal and newborn care at home and in their communities.

Engagement of Agriculture Development Agents

The cultural norm of men and spouses acting as household decision-makers on the use of household funds was identified as a barrier to enabling women and newborns access to MNCH-CBNC services. Therefore, opportunities to actively engage fathers were a key MCSP-NEGA demand creation principle. Among the main strategies to reach men, MCSP-NEGA adapted the FHG for use by agricultural development agents who integrated this information into their regular engagement with men. HEWs carried out the primary role of training agents on the key MNCH-CBNC principles for use with their respective constituencies.

Engagement of Faith-Based Leaders

Religion is highly intertwined with Ethiopian tradition, norms, and culture, and has a strong influence on everyday lives, including health care choices. Accordingly, MCSP-NEGA systematically engaged faith-based leaders in target woredas and communities to help address some of the barriers to seeking services and improving MNCH-CBNC outcomes through two approaches:

- Facilitating the engagement of faith-based leaders in the MNCH-CBNC demand creation activities, specifically strengthening the leaders' membership and function within KCPs through the CAC process;

  And

- Capacity-building of selected woreda-level faith-based leaders from each project woreda on key MNCH-CBNC actions to: (i) support other faith-based leaders engaged in the KCPs; and (ii) cascade learning to other woreda-level faith-based leaders for a broader reach.

MCSP-NEGA provided a 1-day training workshop for 505 faith-based leaders from the project's target woredas. The training workshops conducted at the zonal level were aimed at equipping participants with the knowledge and skills required to promote appropriate MNCH-CBNC behaviors among their constituencies. Discussions and presentations during the workshop were built on images, anecdotes, and quotations from the Bible and the Quran to stimulate interest, harmonize common goals, and generate ideas for action. Workshop participants were provided with copies of the FHG and simple reference materials in the local language. Key strategies were also discussed on how to integrate MNCH-CBNC health promotion and action into their current religious practices.

At the end of the workshops, participants were encouraged to develop their own plan of action for working with their constituents. They were asked to document their MNCH-CBNC-related activities to the extent possible in order to share at a review meeting the following year.

About 15 months after the initial orientation workshop, MCSP-NEGA, in collaboration with the respective zonal and woreda health offices, organized zonal-level experience-sharing workshops for faith-based leaders. These workshops provided an opportunity to hear and learn from what other faith-based leaders had achieved over the past year, address bottlenecks and challenges they may have faced, and discuss strategies for sustaining their work going forward. The workshops revealed that the majority of the trained faith-based leaders (over 90%) had promoted MNCH-CBNC behaviors among their respective communities during religious gatherings. Zonal and woreda health office representatives in the workshops noted that the faith-based leaders' work and teachings in MNCH-CBNC have gained significant acceptance from the community, their peers, health facilities, and offices. They confirmed that the faith-based leaders have consistently used the FHGs in their teachings. Over 80% of the faith-based leaders demonstrated a "very good"[9] level of knowledge of appropriate MNCH behaviors during a knowledge assessment session conducted using the MNCH knowledge assessment brochure developed by MCSP-NEGA.

The faith-based leaders indicated that, now that they have experienced what they can do in MNCH-CBNC and the small changes they can bring about, they want to continue to contribute their share to prevent unnecessary deaths of women and children. A total of 449 (83% of the faith-based leaders who participated in the initial training) participated in the review meetings.

Health Extension Workers and Health Development Army Coordination

In an effort to improve coordination among HEWs and HDAs, and to standardize MNCH-CBNC information shared with families by HEWs and HDAs, MCSP-NEGA revised the national *HEW-HDA Meeting Guide*. The structured meeting guide facilitated improved understanding by HDAs of the key messages in the FMOH's FHG. Specifically, it was used during regular fortnightly meetings by HEWs to build the capacity of HDAs on their key health promotion and family follow-up tasks, and improved coordination at the community level. By the end of the project, 1,743 health posts reported using the updated *HEW-HDA Meeting Guide* during their regular HDA meetings.

Strengthening Pregnant Women's Conferences

PWCs were among the key strategies implemented by the FMOH to improve uptake of key pregnancy- and delivery-related services. The monthly kebele-level meetings of pregnant women were facilitated by trained midwives and/or HEWs. MCSP-NEGA revised the national *PWC Facilitation Guideline* based on the need to: (i) create a more participatory environment during community meetings for women to feel comfortable and have the opportunity to ask questions, versus a top-down lecture on health; (ii) broaden the focus from primarily the promotion of facility delivery to also include key messages related to ANC, birth preparedness, postnatal care (PNC) for the mother and baby, and newborn danger signs. The contents in the revised version were aligned with the national, user-friendly *Integrated Refresher Training* manual developed jointly by FMOH and partners. MCSP-NEGA provided training to midwives and HWs who facilitated the PWCs at the kebele level so that newborn-related issues were properly integrated into discussions. By the end of the project, 1,484 HWs and midwives were using the revised guidelines. *C*opies were also provided to the health centers and health posts.

[9] Correct response to 80% or more of the questions in the MNCH knowledge assessment brochure is considered "very good," 60%–80% considered "good," and below 60% "poor."

Access to the Family Health Guide

The FHG is a national health communication publication with key messages related to MNCH-CBNC developed for low-literate communities by the FMOH and MNCH partners in 2011. It is a harmonized MNCH messaging tool for use by HEWs, HDAs, and households across the nation. It has since been revised with additional key messages and a full color version has been in use since 2015.

Over the project period, MCSP-NEGA consistently promoted and supported the use of the FHG as the main MNCH-CBNC communication tool at the community level. As such, MCSP-NEGA has printed and distributed over 65,000 FHGs in color in Amharic, Oromifa, and Tigrigna to communities in all the 135 project target woredas. MCSP-NEGA used extracts of the FHG to develop posters and brochures targeting specific audience groups (Annex D). These extracts in different languages include:

- Posters on newborn and maternal danger signs for display in kebele administration offices (targeting strengthened KCPs and other visiting community members), health posts, health centers, schools, and other public places.
- Posters targeting students and the heads of male households designed to promote family discussion on MNCH-CBNC.

Use of Strategic Communication

MCSP-NEGA was strategic in the use of media and a variety of communication channels to highlight the important issue of newborn health and survival to create a more enabled environment for positive change. Radio listening groups and culturally appropriate local radio programs, such as radio dramas, were developed with a focus on the newborn. An example being the integration of newborn issues in the development and broadcast of public service announcements in multiple languages spoken in project target areas during the weeks leading to and after World Prematurity Day (the month of November, which is used by the FMOH as the National Newborn Month).

Other key mass communication strategies used by MCSP-NEGA include:

- Use of audio mounted project vehicles to transmit pre-recorded key MNCH-CBNC messages to the broader community in market places and other large gatherings using different local languages. This was linked to project staff supervision visits to health centers or health posts. While technical staff do the supervision and mentoring at the health facility, project vehicle drivers who were provided with orientation and the pre-recorded message go to a pre-identified market place or other large gathering to transmit the key messages.
- Use of educational DVDs on MNCH-CBNC educational DVDs in Amharic and Affan Oromo languages[10] to be played in patient waiting areas of health centers. The DVDs promoted healthy newborn care behaviors and practices around ANC, facility delivery, PNC, and care for small babies including kangaroo mother care.

[10] The DVDs were developed by the Saving Newborn Lives project with technical contribution form MCSP-NEGA team members. MCSP-NEGA received 1,100 DVDs that were distributed to all 730 health centers and 135 woreda health offices.

V. Changes Observed in Learning and Non-Learning Kebeles

There is a clear difference observed between learning and non-learning kebeles. Learning kebeles performed better in reaching and completing advanced stages of the CAC. For example, communities developing MNCH-CBNC community action plans in learning versus non-learning kebeles were 61% and 14%, respectively (Table 4). There is also differences among regions within the learning kebeles, Tigray and SNNPR performing well, with 71% and 65% of learning kebeles having developed written MNCH action plans, respectively. The achievements of learning over non-learning kebeles is attributed to the direct support they received from the MCSP-NEGA project officers, the expanded PRT support, and their initial selection criteria based on their strong community leadership skills and commitment. Furthermore, while both learning and non- learning kebeles had similar KCP structures and functions prior to receiving direct support from MCSP- NEGA, there was a better ownership and commitment from KCPs in engaging in MNCH action among learning kebeles as compared to non-learning kebeles. This was primarily related to the strong leadership and commitment to implementing the Demand Creation strategy among the supervising health center leadership and PRTs, demonstrating yet again that leadership matters.

Table 4. CAC completion rates by Learning and Non-Learning Kebeles

Kebeles	Regions	Target	Oriented on MNCH demand creation	Formed KCP	Developed mobilizing goal	Developed written MNCH Action plans
Learning kebeles	SNNPR	150	141 (94%)	136 (91%)	131 (87%)	97 (65%)
	Oromia	110	100 (91%)	100 (91%)	98 (89%)	65 (59%)
	Amhara	68	67 (99%)	67 (99%)	66 (97%)	33 (49%)
	Tigray	42	42 (100%)	42 (100%)	40 (95%)	30 (71%)
Sub - Total		370	350 (95%)	345 (93%)	335 (91%)	225 (61%)
Non-learning kebeles	SNNPR	111	83 (75%)	47 (42%)	32 (29%)	16 (14%)
	Oromia	762	499 (65%)	339 (44%)	319 (42%)	218 (29%)
	Amhara	1270	869 (68%)	285 (22%)	211 (17%)	19 (1%)
	Tigray	245	183 (75%)	185 (76%)	160 (65%)	83 (34%)
Subtotal		2,388	1,634 (68%)	856 (36%)	722 (30%)	336 (14%)
TOTAL		**2,758**	**1,984 (72%)**	**1,201 (44%)**	**1,057 (38%)**	**561 (20%)**

Key activities in the KCP/community MNCH action plans developed by the learning kebeles included local-level SBCC interventions, resource mobilization, and engagement of key stakeholders, including religious leaders and schools. Overall, 40% of the learning kebeles have mobilized local resources for MNCH. Almost all learning kebeles have engaged schools, TBAs, religious leaders, and other community stakeholders in MNCH-CBNC health promotion activities (Table 4).

Changes in Service Utilization

Service utilization data were collected in August 2017 from a sample of 31 learning kebeles and 37 neighboring non-learning kebeles to see the changes following project interventions. Data were collected for four key indicators:

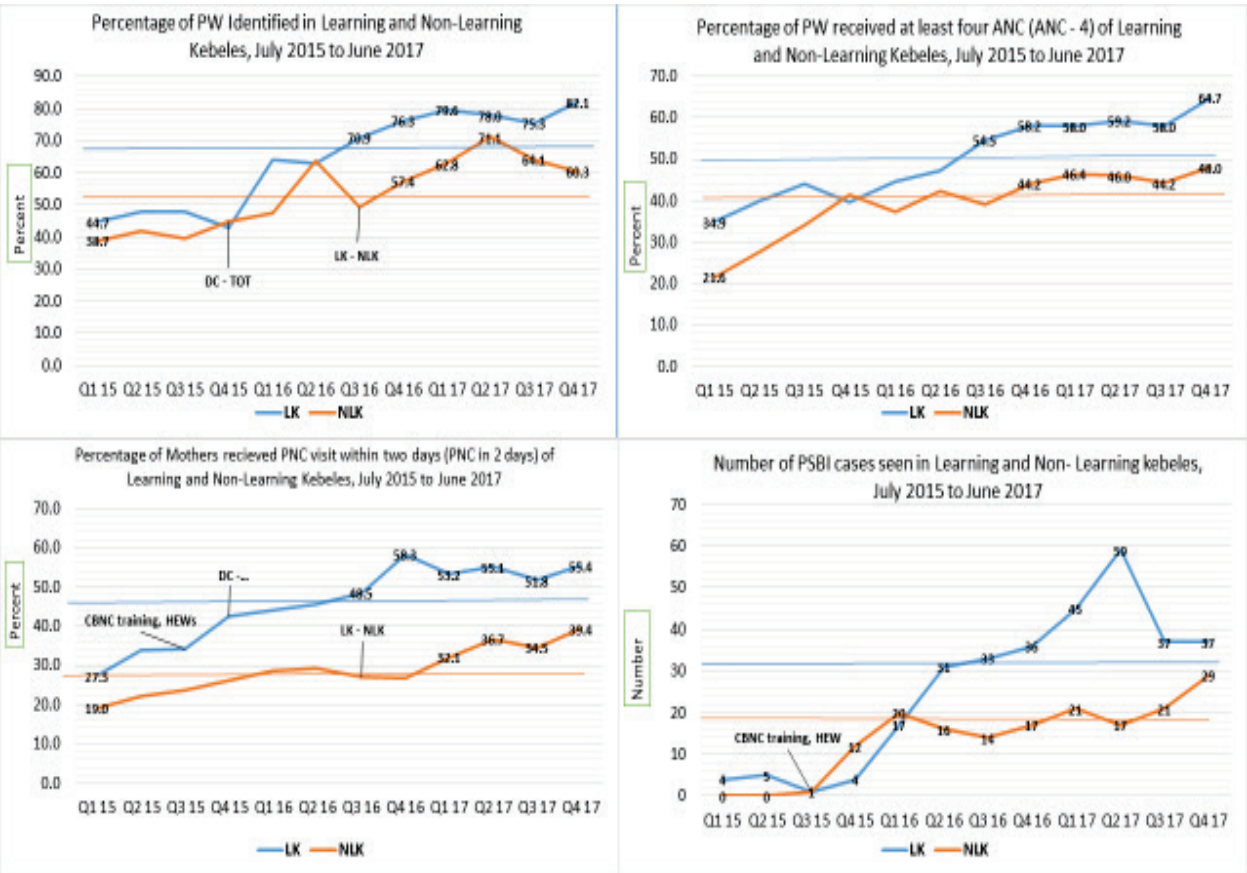
- Proportion of pregnant women identified
- Proportion of pregnant women who received at least four ANC

- Proportion of delivered women who received PNC within 2 days
- Number of newborns with possible serious bacterial infection (PSBI) seen at health posts

The data for each indicator were analyzed for both learning and non-learning kebeles and organized by quarter to observe trends. To determine whether the changes in trends is significant or not, the data for each quarter of the year and indicator are presented in a time series chart (run chart), and interpreted based on probability-based rules (shift and trend) defined for this purpose[11] (Figure 5). The fulfilment of the rules (shift and trend) indicates that the changes are not random, but a result of the intervention.

- Differences in changes observed between learning and non- learning kebeles (Figure 5):
  - Improvements over time were observed in both learning and non-learning kebeles in all four indicators. However, a significant improvement was observed only in the learning kebeles, as demonstrated by the shift, starting from the third quarter of 2016 in the first three indicators (pregnant women identified, received at least four ANC, received PNC visit within 2 days), and a trend, starting from the third quarter of 2016 in the number of PSBI cases seen. The third quarter of 2016 corresponds with the initiation of intensified community empowerment support to the learning kebeles.

Figure 5. Changes in selected service use indicators by learning and non-learning kebeles



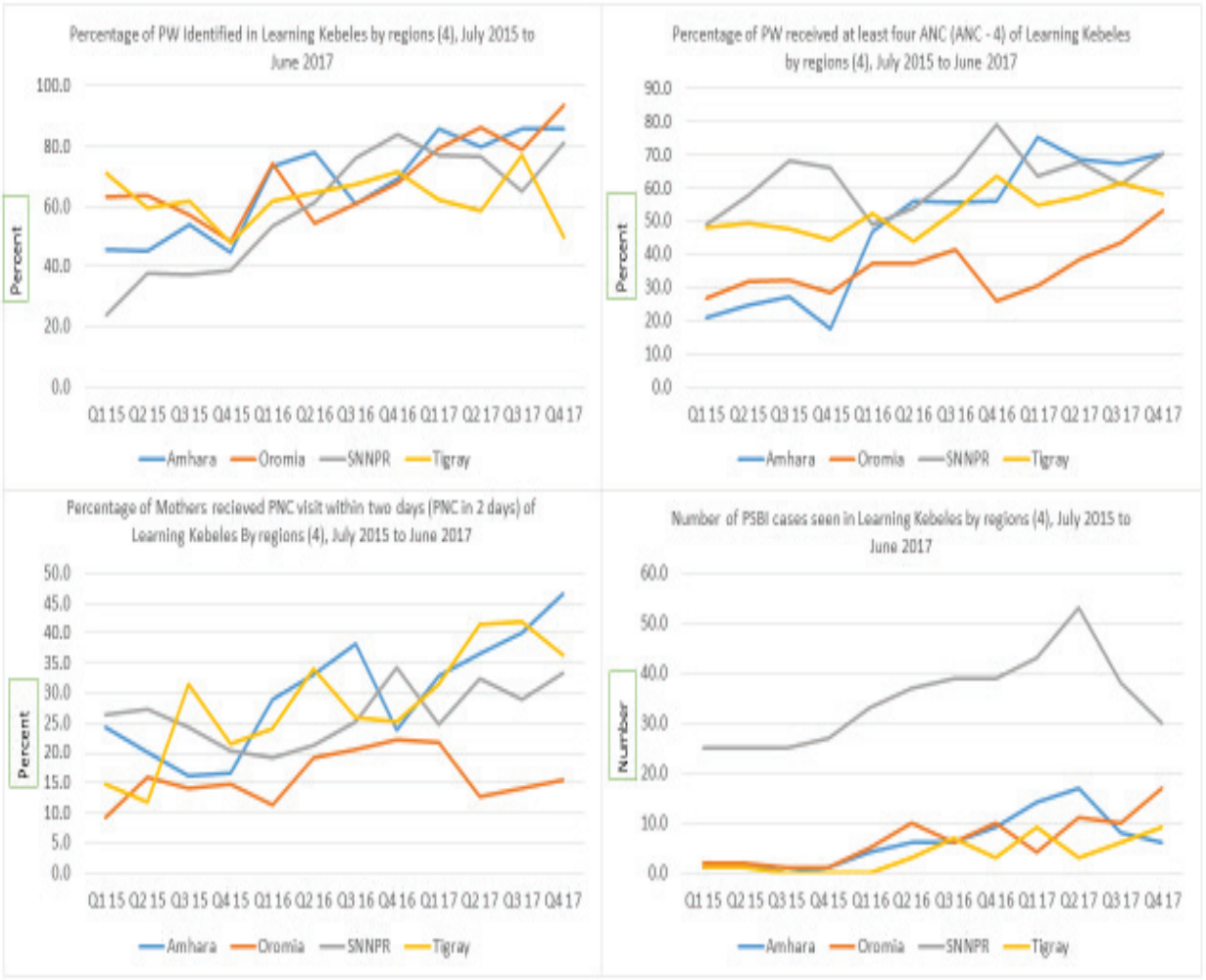
*LK: learning kebele; NLK: non-learning kebele

[11] Shift is when six or more consecutive data points fall either all above or all below the median; and trend is when five or more data points are all going up or all going down.

Differences in changes observed between regions in the learning kebeles (Figure 6):

- Increment in the percentage of pregnant women identified was observed in all regions except Tigray. A significant improvement, shift, was observed only in SNNPR, but not yet in other regions.
- Increment in the percentage of pregnant women who received at least four ANC was observed in all regions. The change in Amhara region, from 20.7% to 70.5%, was higher than other regions, but a significant improvement, shift, was observed only in Tigray.
- Increment in the percentage of delivered mothers who received a PNC visit within 2 days was observed in all regions. The change in Amhara and Tigray regions was higher than the other two regions but significant improvement have not yet been observed.
- Increment in the total number of PSBI cases was observed in all regions. As depicted, the number of PSBI cases seen in SNNPR is much higher than the other regions, which is due to the fact that the number of facilities included was higher in SNNPR.

Figure 6. Changes in selected service use indicators within learning kebeles, by region



Changes in Community Capacity

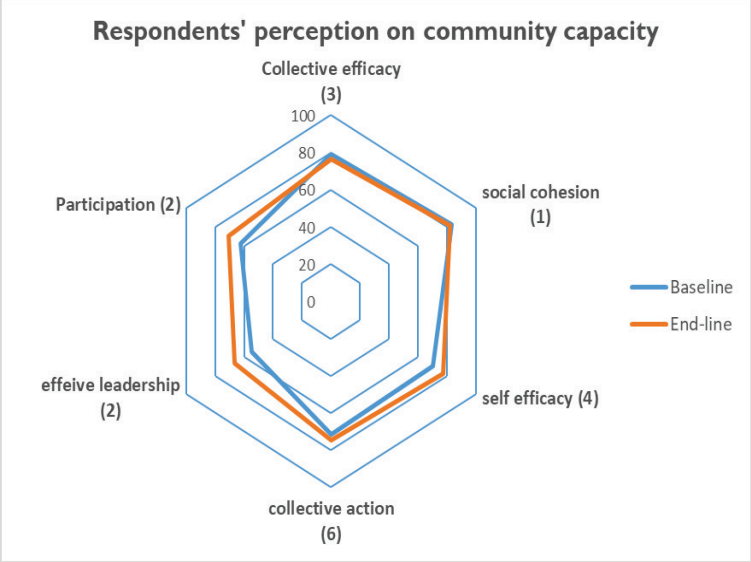
Measures of changes in community capacity to address MNCH-CBNC were organized into six capacity domains: self-efficacy, collective efficacy, social cohesiveness, collective action, participation and effective leadership. From the baseline to end line evaluation, significant improvements were observed in the community capacity domains of self-efficacy, collective action, effective leadership and participation (Figure7). The proportion of women who agreed with statements related to self-efficacy (perceptions on self-capacity, knowledge, skills and confidence to contribute to solving MNCH problems that may arise in the community) also increased from 70% at baseline to 77% at end-line ($p<0.001$).

The measure of participation also demonstrated increases with significantly more women at end-line (71%) compared with baseline (63%) agreed that men participate in activities to improving MNCH, and that they belong to one or more community group that addresses MNCH in their communities ($p<0.001$). Sixty-seven percent of the women at end-line considered themselves leaders in improving MNCH in their community compared with 55% at baseline ($p<0.001$). Figure 7 summarizes findings of the community capacity domains.

To assess collective action undertaken by the communities, women were also asked about what their community is doing on MNCH, including availability of emergency transport systems for pregnant or laboring women; encouraging women to disclose pregnancies early, seek ANC, deliver at health facilities or practice exclusive breast feeding. Seventy-five percent of women agree with statements on collective action at end-line compared to 72% at baseline, a three percentage point increase.

A two percentage point reduction was observed in collective efficacy (statements about commitment to the same goal, solving MNCH problems by working together, confidence in ability to solve MNCH problems jointly) at end-line compared to baseline (77% end-line vs 79% baseline). A slight reduction is also seen in social cohesion (statements related to neighbors supporting each other for MNCH problems) from 83% at baseline to 82% at end-line.

Figure 7. Community capacity measures organized under six capacity domains



VI. Sustainability of Demand Creation Activities

The *Demand Creation Strategy* and its rollout was designed with sustainability in mind. As such, the related trainings, post-training follow-up, periodic performance reviews, and ongoing supervisions were systematically integrated with the CBNC service delivery processes. A large pool of trainers was created at zonal, woreda and health center levels that can serve as a critical mass to provide ongoing support to the kebele-level demand creation work. Moreover, the responsibility to implement and support the community empowerment activities has been integrated with existing platforms, mandates, and accountability mechanisms—the PHCU and KCP platforms, and working relationships.

In the final 4 months of the project, zonal and woreda sustainability workshops were held to review MNCH-CBNC efforts, reinforce FMOH ownership, and plan for continuity. These 1-day workshops were designed to bring key stakeholders at the zonal and woreda levels (for each zone and woreda) to: (i) take stock of CBNC implementation status, including community empowerment activities; (ii) identify good practices, lessons, and challenges; (iii) identify unfinished activities; and (iv) outline/develop a plan as to how to take forward the project activities within the project life and beyond. Given that the demand creation activities are relatively new and were not yet institutionalized, the sustainability workshops also served as a platform to advocate for continued integration of demand creation activities into ongoing budgets and the planning process. Specifically, the woreda hand-over workshops supported the inclusion of selected demand creation activities in the woreda-based annual plans.

In addition, MCSP-NEGA successfully integrated elements of the *Demand Creation Strategy* and good implementation practices in the national integrated community case management/CBNC quality improvement and transition plan developed by the FMOH and partners as part of transitioning the CBNC implementation support from partners to the government. Implementation of the transition plan has already started.

VII. Challenges

MCSP-NEGA identified the following challenges to the demand creation implementation process, which relate not only to demand creation efforts, but overall health systems' ability to function effectively. Lessons learned and recommendation are included in the subsequent section.

- Health care providers are most often trained in health education approaches that favor didactic teaching methods and generally have limited skills in community empowerment strategies that most importantly require valuing community participation in health and time, practice, and a commitment to mastering new skills.
- The high turnover of health center staff who were trained on the demand creation approaches undermined the rollout of on-the-job training for those additional health center staff requiring skills.
- In some cases, lack of motivation of health workers in the health center resulted in a reluctance to cascade demand creation strategies to the community level. Numerous generalized health systems operational limitations were mentioned including: dissatisfaction with remuneration; lack of transportation to the health posts, which may require health workers to walk long distances for hours; lack and or intermittent supplies of drugs and stationery materials; poor supportive supervision and recognition; and limited carrier development opportunities.
- Frequent health campaigns, such as immunization, deworming, trachoma, etc., affected the quality and timely implementation of demand creation activities leading to loss of momentum from expanded PRT members.
- Many health care providers did not consider demand creation and associated community empowerment tasks as their responsibility, which had a negative impact on the institutionalization of the *Demand Creation Strategy* within the health system.
- Measurement of progress and outcomes has been a key challenge of the demand creation activity over the project period. While indicators and data collection tools were introduced and attempts were made to establish an information flow system, the short project period did not allow for monitoring systems to be tested and adjusted, as required. Community capacity indicators focused on measuring process as well as outcomes, given that indicators were included in the baseline; however, limited evaluation budgets and resources hindered analysis.
- Community empowerment approaches require sufficient project time for institutionalization to bring about the desired normative change in behavior and practices. Most of the approaches use iterative processes to address deep-rooted perceptions and practices, and tended to show incremental, qualitative changes. There was a general lack of understanding for these processes and expectations by partners of significant changes within the short project period.

VIII. Lessons Learned

MCSP-NEGA identified specific lessons learned to inform future MNCH-CBNC demand creation implementation efforts:

- Although demand creation strategies based on community empowerment approaches can be effectively integrated into existing training modules, mentoring, and supervision mechanisms for implementation at scale, actual implementation requires operational effectiveness of health workers at multiple levels. Hence, it is critical that leaders at the regional, zonal, woreda, and PHCU levels own the process and monitor implementation.
- The greater outcomes achieved by learning (over non-learning) kebeles were a result of the intensity of support provided by the PRTs who had received mentoring support from project staff; as well as the strong leadership capacity and motivation of the health center leaders. The greater the degree of support kebeles received, the better their performance. Community empowerment approaches require a commitment to a facilitation process over time.
- The kebele command post was an ideal platform to bring together multi-sectoral stakeholders and groups such as education, agriculture, and faith-based organizations to work collectively on improving maternal and newborn health outcomes. Once the CAC reached the kebele level, the community was able to own the approach and act collectively, while demonstrating high levels of motivation and commitment. None of the implementing kebeles expressed difficulty or a lack of time to implement demand creation strategies.
- One size does not fit all. It is important to be flexible and responsive to contextual changes based on monitoring data. A case in point was the adaptation of the strategy to fit the contextual challenges faced due to civil unrest that limited movement to kebeles halfway through the project.
- When properly implemented, a demand creation strategy based on a community empowerment approach has the potential to reduce the work burden of HEWs through task-sharing. In kebeles where the strengthened KCPs were functioning well, many HEWs labeled them as "our additional eyes and legs," indicating the strengthened KCPs' active engagement in community mobilization.
- By harnessing the efforts of the strengthened KCP members residing in an area, the MNCH-CBNC *Demand Creation Strategy* has the potential to reduce inequities within a kebele, for example, improving access to information through outreach to the furthest households that might not be reached by HEWs/HDAs.
- Engaging faith-based leaders for MNCH-CBNC action is an important strategy that has the potential for wide reach and high impact on the social and normative changes required to address the underlying barriers to demand for services and family practice. Faith-based leaders were willing to lend their influence to improve MNCH-CBNC outcomes. Given the importance of religion in Ethiopia, there were many opportunities to intertwine maternal and newborn health promotion within religious beliefs, values, and ceremonies.
- Although MCSP-NEGA developed and distributed demand creation monitoring and reporting tools to PHCUs. Obtaining accurate data in a timely manner was a serious challenge that could have been minimized if the tools and processes were tested and validated prior to implementation.
- Community engagement in supporting and monitoring service quality has the potential to address the humanization of care, allowing service providers to explore previously unrecognized quality service issues from the perspective of the client, and advance social accountability for quality care.

IX. Conclusion and Recommendations

The *Demand Creation Strategy* for MNCH-CBNC supports a systems-strengthening approach that builds the efforts of zonal, woreda, PHCU and kebele levels to improve MNCH-CBNC. Using multi-sectoral community platforms, such as strengthened KCPs, facilitated institutionalization of community empowerment approaches, and collective ownership. Moreover, integrating empowerment approaches into existing community platforms enabled large-scale implementation within a short period of time.

Key recommendations to FMOH and main MNCH-CBNC implementing partners include:

- Prioritize efforts to strengthen the KCPs to implement demand creation strategies at scale. The approach, once institutionalized in the PHCUs and KCPs, has the potential to be used for multitude of issues beyond MNCH-CBNC.
- Ensure supervision and mentoring support to strengthened KCPs from the PRTs and woreda health officials through integrating appropriate monitoring indicators in the integrated supportive supervision checklist.
- Engage faith-based leaders and key family decision-makers in MNCH-CBNC initiatives to influence social norms.
- Strengthen the HEW and HDA platforms to be effectively used for demand creation activities.
- Support the development and validation of key demand creation indicators for subsequent integration into the health management information system.
- Given demand creation strategies using community empowerment approaches require time to mature and show results, plan for a minimum of a 5-year timeline for successful implementation of demand creation activities.

X. Annexes (Attached separately)

Annex A: PHCU Monitoring Tool for KCPs: MNCH-CBNC Demand Creation Action

Annex B: Health Post/KCP Monthly Reporting Form for MNCH-CBNC Community Action

Annex C: Pregnant Women and Birth Registration Book/ Form

Annex D: Family Health Guide Question & Answer Brochure