

SAFE

Report 2017-2019

Technical Assistance to DFID-Funded
Trachoma Partners and FMoH

May 2019



Federal Democratic Republic of Ethiopia
Ministry of Health



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About: In 2016 the Ethiopian Federal Ministry of Health approached NALA to provide technical assistance to its National NTD Eradication program. A primary focus of this program is the elimination of trachoma from Ethiopia. In this role, NALA has supported trachoma partners in adopting preventive strategies to break the disease cycle and prevent blindness.

Executive Summary

This report provides an overview of F&E activities conducted by the DFID-funded trachoma partners from 2017-2019. Moreover, it outlines the most important findings and recommendations garnered from a Lessons Learned exercise on F&E that was conducted in the first quarter of 2019. This exercise included data review, school site visits, and interviews with implementing partners.

Background: Trachoma is the leading infectious cause of blindness in the world, and it disproportionately affects young children and women. This debilitating disease can cause pain, visual impairment, and irreversible blindness that decreases a person's ability to work and contribute to their family. Notably, Ethiopia has the highest prevalence of active trachoma globally, accounting for 38% of the global burden. For this reason, its elimination has been a target of the Ethiopian Federal Ministry of Health (FMoH) since 2013.

The World Health Organization (WHO) recommends the adoption of the SAFE strategy for sustainable trachoma elimination: **S**urgery, **A**ntibiotics, **F**ace washing, and **E**nvironmental improvement. Though Ethiopia has had notable achievements in the treatment of the disease through the S&A components, many NGOs have struggled to effectively implement the preventive (F&E) components. Successful trachoma elimination is dependent on implementing all components.

Project: In 2014, DFID appointed Sightsavers International (SSI) to manage the implementation of the SAFE strategy in four countries, including Ethiopia. Ethiopia's program focused on 51 endemic weredas in four priority regions with implementation carried out by four NGOs: Light for the World in Tigray, Orbis in SNNPR, The Carter Center in Amhara, and The Fred Hollows Foundation in Oromia. Despite successful progress in meeting goals for surgery and antibiotic distribution (S&A), the implementing NGOs lagged behind in carrying out sufficient interventions for F&E.

For this reason, in 2016 the Ethiopian Federal Ministry of Health (FMoH) invited NALA to support the four trachoma partners in designing and rolling out behavioral change and WASH interventions (F&E components), as well as strengthen coordination between the WASH and NTD sectors. As an additional support, the media company Synergy Habesha Films and Communication assisted with message creation, audience targeting, and graphic design for the project.

Key Findings: The following is a summary of key findings, with a more detailed description on page 13:

- ◆ Child-friendly materials increase student engagement and learning.
- ◆ Older children can take on more responsibility and lead on activities.
- ◆ Teachers need time to practice the lessons during the training.
- ◆ Commitment from the school principal and club coordinator is key.
- ◆ Training only two people per school may cause gaps in implementation.
- ◆ Per diem is an effective but unsustainable incentive.
- ◆ Regular follow up and supportive supervision are essential.
- ◆ Water access is a challenge in schools but not the determining factor for program success.
- ◆ Community programs rely too much on the HDA.
- ◆ Self-monitoring and habit formation are effective tools for individuals and schools.

- ◆ Simpler, more concise materials are more likely to be used.
- ◆ Significant gaps exist in monitoring and evaluation.
- ◆ Integration of the program into existing structures strengthens local ownership and sustainability.
- ◆ Everyone agrees that WASH-NTD coordination is a good idea, but motivation is lacking to make it happen.
- ◆ The people we train do not always have the leadership skills needed to push the process forward.
- ◆ Parents are the key link between the school and community.

Summary of Recommendations: Selected recommendations are below, with more detailed descriptions on page 15:

- ◆ Profile priority schools to provide extra supervision and support.
- ◆ Add more staff on zonal level to increase capacity.
- ◆ Create partnerships with local universities and high schools to enlist local volunteers.
- ◆ Seek partnerships within the WASH sector.
- ◆ Support schools in brainstorming WASH solutions.
- ◆ Follow up regularly with weaker schools and offer incentives for improvement.
- ◆ Train more than one teacher during the training.
- ◆ Engage the PTA.
- ◆ Train other community members (not just HDA) to lead on health initiatives.
- ◆ Strengthen engagement with the education bureau on the zonal and regional level.
- ◆ Integrate work into existing routines and systems in the government and schools.
- ◆ Assign clear roles and responsibilities for each actor in the project.
- ◆ Operationalize the WASH-NTD Coordination toolkit.
- ◆ Advocate for budget allocation by the government and partners for coordination activities.
- ◆ Create joint databases on disease prevalence, WASH/NTD partners, and WASH infrastructure.
- ◆ Identify champions of coordination and collect best practices.
- ◆ Develop clear monitoring guidelines that emphasize collection of qualitative data also.
- ◆ Use clear criteria to assess progress and share with schools and other interventions sites so that they can self-monitor.

Though the fight against trachoma is still ongoing, the project succeeded in laying the groundwork for ownership on the school and community level as well as increasing coordination between partners and sectors. Each partner approached the F&E components in a slightly different way, allowing for increased learning and the sharing of best practices between them. A key element to these successes was the unparalleled dedication of the NGO partners and the close support given by the government on the federal, regional, zonal, and wereda levels.



Highlights 2017-2019

Over the last two years, the project partners have worked to **create sustained behavior change** in high-need communities and **strengthen mechanisms for WASH-NTD coordination**. To date, all partners (LFTW, Orbis, Carter, and FHF/Caritas) have implemented school-based programs and also worked toward raising awareness and inspiring change on the community level.

School



2668 schools received support and training, reaching more than 1.2 million students.



4850 school staff were trained on how to run a trachoma program in their schools, with a focus on the health clubs.



NALA-designed materials and **Synergy Habesha visual aids** were used by nearly 80% of those trained.

Community



1400 kebeles were targeted in the 4 regions with a total population of 8.2 million people.



2359 community members were trained on an F&E approach, with a special focus on women from the Health Development Army (HDA) & health workers.



NALA-designed materials and **Synergy Habesha visual aids** were used by 99% of those trained.

WASH-NTD Coordination



WASH-NTD Task Forces were formed on the federal, regional (Amhara, Oromia, SNNPR, Tigray), and some zonal levels.



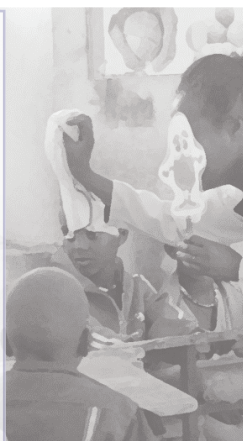
15 WASH-NTD Task Force meetings were held, bringing together various government ministries (WASH, BoFE, MoH, MoE) and NGOs.



NALA designed and piloted a WASH-NTD toolkit to be rolled out for use on the wereda level.



Partner Light for the World



Region: Tigray
Zones: South & Southeast
Weredas: 9
Kebeles: 181
Population: 1.29 million

Community: 523 trained
Schools: 326 engaged
School staff: 491 trained
Target audience: 149,944
WASH-NTD meetings: 2

NALA support: Design of school-based and community materials; Design and pilot of early childhood education program

About LFTW: Light for the World (LFTW) is a global disability & development organization with extensive operations in Ethiopia. As a respected NGO in the field of eye health, LFTW has supported Ethiopia in fighting trachoma by training eye care specialists, funding clinics, providing mobile outreach to remote areas, and distributing millions of doses of antibiotics. LFTW employs different staff for the S&A and F&E components, and they currently have one person placed on the regional level to supervise the F&E activities in the DFID-funded zone.

In Schools: LFTW has implemented the only school program that specifically targeted children below the age of 7. Since young children are at the highest risk of contracting trachoma, a specially designed curriculum for early childhood (Grades 0-1) was developed with the support of NALA and Early Starters International. It included the use of a puppet called "Toto" to build an emotional connection with the students and teach about trachoma prevention. In addition, teachers encouraged routines by asking students to check their faces and hands in the morning when they came in. Games, songs, and art activities were also a part of the program.

To test the program, a pilot of 5 schools was launched in 2017 with three rounds of training given by Early Starters over a period of 6 months. The pilot was unique in that school staff, Parent Teacher Association (PTA) members, and Health Development Army (HDA) volunteers all participated together. After a successful pilot, the program was cascaded to 300 schools in Tigray with a reinforcement training given by Early Starters to the teachers in March 2019.

In addition, a school program for older children (Grades 2-4) was launched in 300+ schools in 2018. This curriculum targeted health club coordinators and their student club members, with the goal of activating them to make changes within the school. This program included games and songs, and it also encouraged club members to lead on activities in the

school by conducting drama for the other students and completing small projects. This curriculum was developed by NALA and LFTW, with graphics illustrated by Synergy Habesha.

In the Community: NALA worked closely with LFTW to develop a training manual for the Health Development Army (HDA), along with a flipbook (illustrated by Synergy Habesha) to be used during household visits. After pre-testing, LFTW led a training of trainers (ToT) on the materials for wereda representatives in August 2018, who then cascaded it to HDA networks in 9 communities. Unfortunately, the community intervention was not as successful as the school intervention, as attendance was not high from the HDA members.

With the Government: LFTW enlisted representatives from the wereda health and education offices to take part in the trainings. The wereda representatives then led the ToTs for the school staff and community members, with the exception of the early childhood education pilot. However, there were often delays in cascading the trainings, and the wereda-led trainings varied in quality.

WASH-NTD Coordination: In Tigray, the WASH sector has worked independently from the health sector for many years. In addition, the NTD data for different diseases was stored in separate departments until recently. Due to persistent advocacy from LFTW's staff at the regional level and NALA's second-ee in the Tigray Regional Health Bureau, progress has been made. The government WASH experts are now more aware of the important connection of trachoma prevention to their work, and all NTD data is now stored in one department. Also, after a year of advocacy, a WASH-NTD Technical Working Group (TWG) was established during the last half of 2018. The TWG has already agreed to use disease prevalence indicators in WASH activities.

Key Successes:

- ◆ **New approaches to teaching young children:** Commonly in Ethiopia, teachers use a traditional approach to education with limited engagement from students. However, the school program encouraged the use of play and characters to make the children more active learners. Teachers shared that the students responded excitedly to the new methods. Some teachers even began to use the methodologies (such as the character Toto) to teach other non-trachoma material.
- ◆ **Self-monitoring and habit creation:** Teachers began to encourage self-monitoring by students by placing mirrors on the wall of the classroom so that students could check themselves when they entered. Students also created hand and face charts to better identify the difference between clean and dirty. The cleanliness checks became a part of the daily or weekly school routine. Mothers were also taught to use the mirror for face checks with their children.
- ◆ **Integrating school and community activities:** In the Early Starters pilot, the last two trainings combined school staff and community members (HDA, PTA) together. This integration proved successful in the pilot, as a stronger community could support a weaker school and vice versa.
- ◆ **Increased government coordination:** Despite many initial challenges, the WASH and NTD sectors are now communicating more often. Awareness within the government has been raised about the importance of joint indicators to reduce disease prevalence. In addition, the Technical Working Group has met and began to push the coordination process forward.

Gaps:

- ◆ **Reliance on wereda officials:** Wereda officials often have several competing priorities and differing capabilities. For this reason, wereda-led trainings often varied in quality and may have been shortened, thus not including all the techniques and practice in them. This gap left some teachers unprepared to properly implement the school program.
- ◆ **Implementation of school program:** The school program for upper elementary (grades 2-4) was not always integrated into the classroom. Many schools gave health education during the flag ceremonies, when not all students were there. Also, though lesson plans were given for the other teachers to use in the classroom, many teachers did not use them since they were not trained directly nor received per diem to do them.
- ◆ **Parent-Teacher Association (PTA):** With the ex-

ception of the Early Starters pilot, most schools did not engage the PTA members or parents in the health education program. Though lessons were included for the PTA in the school manual, field visits showed they were not often used. PTA members are an important link to the community and help raise funds for the school, which is vital to improving WASH conditions.

- ◆ **Reliance on HDA members:** The community program relied on HDA members. However, their attendance was not high as they are volunteers. The majority have families and farms to take care of, and without per diem there was not a strong motivating factor for them to take part in the program.
- ◆ **Monitoring & evaluation:** LFTW lacked the capacity to monitor all 300+ schools effectively, as they only had one field staff member for F&E. In addition, the community program was difficult to monitor. Except for the early childhood education pilot, no review meetings were held to evaluate the programs or progress on the interventions. This gap is partly due to the fact that the cascaded trainings happened only within the last few months.

Lessons Learned:

- ◆ **School program:** The manual for upper elementary (Grades 2-4) was considered too long by many teachers, and the cascaded trainings did not prepare them well. For this reason, LFTW recommends using the Early Starters materials up through grade 4. The activities are also relevant for upper elementary grades as well, and the manual is shorter and more accessible for the teachers.
- ◆ **Community program:** Instead of relying on the HDA, the community program should mobilize more teachers to lead on community initiatives. They are more respected in the community than the HDA and often more professional.

Going Forward:

- ◆ **WASH construction:** LFTW received funding to build WASH infrastructure in some of the schools. They plan to outsource the construction to local NGOs.
- ◆ **Review & evaluation meetings:** LFTW plans to meet with education and health representatives to evaluate the impact of their F&E interventions in the project area.
- ◆ **WASH-NTD coordination:** The wereda level toolkit has been finalized. Trainings are planned for the zonal and wereda levels.

Partner Orbis International



Region: SNNPR

Zones: Sidama and Hadiya

Weredas: 30

Kebeles: 906

Population: 5.16 million

Community Members: 1808 trained

Schools: 1465 schools engaged

School staff: 2929 trained

Target audience: 5.05 million

WASH-NTD meetings: 3

NALA support: Design of school-based and community materials; Support during training and follow up

About Orbis: Orbis is an international NGO dedicated to preventing and treating blindness in developing countries. Over the last 20 years, Orbis has worked in Ethiopia to train thousands of eye care professionals and distribute antibiotics to millions of people. In the DFID-funded SAFE program, they cover two zones in SNNP Region. Their field team includes two people in Hadiya Zone and four in Sidama, with staff covering all components of the SAFE strategy.

In Schools: Orbis's reach is the greatest of all the partners, encompassing over a million beneficiaries and more than 1400 schools. The school program includes intensive training of school staff with an emphasis on interactive and mulitmodal (visual, auditory, interpersonal) teaching methods. NALA supported Orbis with material development and supportive supervision during trainings and follow up. Synergy Habesha designed the visual aids after consultative meetings with the local community.

In June 2017, a pilot was carried out in 6 schools in Sidama and Hadiya zones. Following an evaluation of the pilot, the materials were adapted and the education program was rolled out to all weredas and 1465 schools. The trainings for the schools included two staff members from each school (school principal and club coordinator) as well as PTA members and kebele administrators.

In the last year, Orbis awarded a mini-media (loud-speaker) to the best-performing school in each district, as an incentive for project participation. The zonal staff chose the schools based on their performance during the monitoring visits as well as their good documentation of activities. As another added component to their school program, Orbis distributed 155 water tanks (5 per wereda) to address the lack of water access in some of the schools.

In the Community: The community program actively sought to empower community members to take the lead in promoting behavior change and improving WASH in their schools and homes. NALA worked with Orbis to develop community intervention materials, which targeted HEW and HDA members. Since launching the community program in Fall 2018, more than 1800 community members in 906 kebeles have been trained to date. However, the community implementation has not been as strong or as consistent as the school program. Many HDA members have missed or delayed activities because of competing priorities (such as agricultural activities).

With the Government: Orbis trained representatives from the education and health sectors on the wereda and zonal level, who were then responsible for training local teachers and community members. The resource person on the wereda level was responsible for monitoring and following up with the schools, and they prepared a summary report for each quarter that was shared during the quarterly review meeting. In 2019, Orbis also held a Transition Workshop for government officials to discuss how the ownership of the program should transfer to them. This workshop was held in Hadiya in January and in Sidama in February.

WASH-NTD Coordination: Orbis worked with NALA's secondee to launch a zonal level Task Force in Hadiya Zone. However, the launching of the Task Force in Sidama was rushed and held without NALA's representative. WASH NGOs were also invited to these events, but many did not attend. Though both sectors have separate priorities and budgets, the Task Force meetings brought them together to look at how to better integrate activities. Though there are challenges on the zonal level, there is positive momentum to create the platform on the lower levels where implementation occurs.

Key Successes:

- ◆ **Most expansive reach:** Orbis made it a goal to reach all the primary schools in the two zones and raise awareness throughout the target communities. Monitoring reports have shown that the program indeed reached all schools and that awareness has increased. Moreover, schools have reported improved facial cleanliness since the project's initiation.
- ◆ **Use of an evaluative and participatory process to develop the materials:** In March 2017, Synergy Habesha held consultative meetings in selected communities from all the DFID zones in order to find the most appropriate trachoma prevention messages and identify communication channels. Based off of these discussions, NALA and Synergy developed the school program for Orbis and the accompanying visual aids. These materials were tested in pilot schools in both zones. Staff followed up with the schools, evaluated the materials with field staff and beneficiaries, and modified them before rolling them out to all schools.
- ◆ **Child-friendly and comprehensive school program:** The school program motivated students with games, music, drama and illustrations. Also, it included materials for multiple members of the school community, including school clubs, teachers in the classroom, and parents.
- ◆ **Transition Workshop:** In the beginning of 2019, Orbis held a Transition Workshop for government officials in both zones in order to discuss how to most effectively transfer ownership to them. These efforts help support project sustainability.

Gaps:

- ◆ **Implementation of school program:** The program depended heavily on the student clubs, which resulted in weaker implementation in schools with less active clubs. In addition, many schools gave health education during the flag ceremonies, when not all students were there. Also by only training 2 staff from each school, there was a risk that the program would cease if either or both people left the school (as happened in some schools).
- ◆ **Reliance on HDA members:** The community program focused on HDA members. However, the HDA members had many competing priorities and did not always attend trainings or follow through with the health education.
- ◆ **Monitoring & evaluation:** Each school has a reporting sheet, and the principal sends it to the wereda office. The wereda resource staff then prepares a summary report for each quarter. However, not all schools reported on their activities and not all wereda staff were active in the project.

Some were more concerned with S&A as there are specific and clear indicators to trace, and it is harder and requires more time to monitor F&E.

- ◆ **Quantity over quality:** Orbis succeeded in reaching an impressive number of targets. However, sometimes the activities were rushed (such as in the formation of the Task Force), and they may have lost impact that could have been garnered from more careful planning and the participation of more actors. In addition, the reach of schools was hard to monitor with limited field staff. By focusing on high-priority schools, the program could have been strengthened with more thorough follow up and the addition of reinforcement trainings.

Lessons Learned:

- ◆ **Simplify materials:** NALA and Orbis developed a 4-page checklist to be used for monitoring of the schools by wereda staff. However, this checklist was too cumbersome, and staff did not want to complete it. For this reason, the checklist was shortened to 1.5 pages. In addition, the schools did not use the cards and workbooks as much as the posters and manuals. It may be best to give fewer, more impactful materials.
- ◆ **Establish a baseline before project starts:** The F&E activities started without a clear baseline to judge their impact. For this reason, Orbis used the first report as a baseline going forward. However, in the future they recommend to do it before beginning activities.
- ◆ **Engage the schools to reach the community:** Instead of training only the HDA, Orbis may instead try to establish a stronger link between the schools and the community. School staff can educate community members during community events or organize sanitation campaigns that also benefit the community. The PTA should be activated to do more during the program.

Going Forward:

- ◆ **Scale up:** Orbis plans to scale up the health education program and use the school materials for Gedeo zone as well.
- ◆ **Monitoring & evaluation:** Though no more trainings are planned for Sidama and Hadiya zones, Orbis plans to continue monitoring the activities there and follow up on the water tankers.
- ◆ **Radio messages:** They also plan to distribute a flash disk with radio messages for the schools that promote trachoma prevention. These messages were created in collaboration with Synergy Habesha.

Partner The Carter Center



Region: Amhara
Zones: North Wollo
Weredas: 14
Kebeles: 313
Population: 1.74 million

Schools: 756 engaged
School staff: 1045 trained
Target audience: 183,460
WASH-NTD meetings: 3

NALA support:
WASH-NTD coordination support; scoping & learning trips; future support for early childhood education

About Carter: Since 2001, the Carter Center has worked to control and prevent trachoma in Amhara Region. Carter has helped provide over half a million eyelid surgeries, supported distribution of millions of doses of antibiotics, and helped construct millions of household latrines. Since 2017, they have also implemented a health education program in schools. A trachoma program officer oversees the F&E activities in the region, which encompasses 10 zones (and not only the DFID-funded one). In the DFID zone, there are two zonal coordinators who oversee 7 wereda each and supervise all parts of the SAFE strategy implementation there.

In Schools: The primary focus of Carter's F&E program is the school-based intervention program, which is unique among the partners in that it is mostly integrated into existing structures. In 2016, Carter developed their education materials with the support of curriculum consultants. Together, they reviewed the regional annual plans for the schools from grades 1-4 and developed specific trachoma lessons to fit into the existing curriculum for environmental science. Overall the materials emphasize trachoma prevention through personal hygiene and environmental sanitation, with older students encouraged to find solutions for WASH problems in their own homes and communities.

In 2017, Carter launched its school trachoma program in all of its 10 zones in Amhara, covering more than 8000 schools. The DFID zone of North Wollo includes more than 750 schools. From each school, the principal and the environmental science teacher took part in a two-day training. Each school group received five materials: 1) teacher's manual with lesson plans and activities; 2) large flipbook with images related to specific topics; 3) registration book for the schools to track their activities; 4) report book for principals to summarize progress for quarterly reporting; and 5) flashdisk with 8 short and 8 long radio clips about trachoma.

Two other unique parts of Carter's school program include the anti-trachoma clubs and incentive structure. As part of the program, schools receive a directive to form an anti-trachoma club with recommended activities to do in the school and community. Also of note, each year Carter awards the 3 best-performing schools in each wereda based on specific criteria. The top-performing school is awarded a water tanker and the other two schools receive a radio.

In the Community: In selected kebeles, Carter staff conduct house-to-house visits to provide health education and assess latrine utilization. Carter also aims to reach the community through the schools. Several community activities are recommended for the anti-trachoma clubs to complete, and a few motivated club leaders have led activities in the community. However, the community outreach depends mostly on the commitment of the school and thus varies widely.

With the Government: Carter has also excelled in integrating their program into existing government routines. Due to Carter's effective advocacy, the Regional Education Bureau agreed to add trachoma lessons to their annual plan for primary environmental science. They will share the content with Carter to review and see if it is sufficient. On the wereda level, the education offices choose and prioritize schools for supportive supervision and awards. Trachoma indicators were also added to the checklists that cluster supervisors use when they visit the schools, thus making it a part of their monthly routine.

WASH-NTD Coordination: Carter has been actively involved in promoting WASH-NTD coordination at the regional and zonal levels in Amhara since 2017, with technical support from NALA. In 2018 Carter organized a WASH-NTD Learning Forum in Bahir Dar for 3 days. Carter has also supported the formation of the regional and zonal level Task Forces. Overall, there seems to be interest in coordination, but there is a lack of motivation from stakeholders and no clear leader to push the process forward.

Key Successes:

- ◆ **Integration into existing structures & routines:** Carter's program is the most integrated into existing school and government routines, which has led to higher acceptance of the program and more sustainability. With the trachoma lessons soon added to the annual school plans on the regional level, the health education will continue after Carter leaves. Also, by adding trachoma indicators to wereda checklists, monitoring will be able to continue past the program's end.
- ◆ **Radio program:** The radio program appears to be widely used by schools. The flashdrive includes 8 spot messages (3-5 minutes in length) and 8 radio programs (10-15 minutes long). Schools reported that they have used them during health lessons or have broadcasted them over the loudspeaker during breaks.
- ◆ **Incentives for performance based on clear criteria:** Each year, the three best schools from each wereda are awarded either a water tank or mini-media (loudspeaker) based on their performance. The wereda education office chooses the schools based on clear criteria that is also known to the schools. This supported monitoring by the health office and self-monitoring by schools. This activity has increased motivation for the program.
- ◆ **Regular MnE and supportive supervision:** Of all the partners, Carter has the most structured MnE system. Each month, the zonal coordinators visit 12 schools together with the wereda education office. These schools receive feedback on the progress of their program and recommendations for how to strengthen it. In addition, schools use a registration book to track weekly health education, activities, and facial cleanliness checks. A summary by the school is submitted to the education office using the reporting form on a quarterly basis. Quarterly and annual review meetings are held on the zonal level with all relevant wereda officers and focal points.

Gaps:

- ◆ **Community program:** As the house-to-house visits are conducted only in selected kebeles, most of the community outreach is accomplished through the schools. However, the execution of the community activities varies widely between schools. A number of schools have had no community activities.
- ◆ **Reliance on wereda officials:** On the wereda level, the staff is often less experienced than at higher levels. In addition, wereda officials often have several competing priorities and differing capabilities. For this reason, wereda-led activities have varied based on the commitment of the person

doing them. Sometimes they preferred to focus on the S&A components. In addition, Carter's program includes 168 wereda, which can be difficult to monitor.

- ◆ **Need for more colorful & child-engaging visuals:** The flipbook uses photos and not illustrations. Colorful images and characters could better motivate younger children.
- ◆ **Coordination with WASH partners on implementation level:** Despite efforts to coordinate WASH and NTD on the regional and zonal levels, there is still a gap on the implementation level. Some schools have programs with both Carter and a WASH partner, and these activities are not often coordinated.

Lessons Learned:

- ◆ **Language of MnE materials:** Many of the monitoring tools are in English, including the registration book for the school and the cluster supervisor checklists. Since English may be a barrier for some people, Carter is currently translating these materials to Amharic to increase understanding and completion.
- ◆ **Reinforcement training for teachers:** Two years after the initial training, the cluster supervisors led a reinforcement training for schools. However, the quality of the training varied widely. Also many teachers resisted the training because no per diem was offered to participants from the town (only those who traveled). A reinforcement training is planned for the fall with per diem offered to all participants.
- ◆ **Engage kebele and wereda administrators:** Community acceptance is higher if local administrators are involved.

Going Forward:

- ◆ **School-based program:** Though some activities will be handed over to the government, Carter plans to continue health education in the schools after June 2019.
- ◆ **Addition of trachoma lessons to regional curriculum:** The Carter Center is in discussion with the Regional Education Bureau to add trachoma lessons to the curriculum in the future.
- ◆ **Training of pre-service teachers:** Carter is also interested in partnering with local teachers' colleges and training pre-service teachers on trachoma prevention.

Partner The Fred Hollows Foundation

Partner Caritas Ethiopia



Region: Oromia
Zones: East Hararghe
Weredas: 14 targeted
Kebeles: 40 targeted
Population: 3.66 million

Community Members: 28 trained
Schools: 120 schools engaged
School staff: 385 trained
Target audience: 200,000
WASH-NTD meetings: 4

NALA support: Section and activity about trachoma added to CHAST manual; Support and development of community theater pilot

About FHF: The Fred Hollows Foundation (FHF) is an international development NGO that works towards eliminating avoidable blindness. FHF works in Ethiopia's most populous region, Oromia, where they and their partners have performed tens of thousands of eye surgeries, distributed millions of doses of antibiotics, and trained thousands of community health workers and teachers in the SAFE strategy. They partner with the WASH NGO Caritas to support the F&E elements of their program.

About Caritas: Caritas is a confederation of Catholic development, relief, and social service organizations. In Ethiopia, a key focus of their national program is on the WASH sector, with the goal of ensuring access of poor populations to safe drinking water, adequate sanitation, and improved hygiene. They address these gaps at the community and school levels, with children acting as promoters of change. Caritas uses an educational program they developed specifically for children called "Children Hygiene and Sanitation Training" (CHAST).

In Schools: FHF is unique in that it has partnered with a WASH NGO (Caritas) to implement the school program. They selected only 15 schools per district in order to increase the impact of the interventions. Interestingly, FHF-Caritas oversaw two different school hygiene programs: Caritas's CHAST program and the Super School of 5 (SSo5) program. Some schools had the CHAST program, which included lessons spread out over 2-3 months. Other schools received the intensive 21-day program for SSo5.

The CHAST program includes a school manual with differentiated lessons for lower and upper elemen-

tary school students. CHAST focuses on good hygiene behaviors and practice through the use of child-friendly methodologies, such as puppets, characters, games, role play, and songs. NALA added a trachoma-specific chapter to be included in the CHAST materials. School clubs form an integral part of this program, with student clubs delivering health messages to the community through drama and music.

The SSo5 program uses superhero characters to engage children and teach them the importance of washing their hands and faces. Students are further motivated with games, songs, dances, and competitions. The program begins with stakeholder workshops in the wereda, followed by cascaded school trainings. A unique strategy from this program is the inclusion of parent sensitization workshops, which are given by school principals before the program starts in the school. During this workshop, parents and teachers discuss the importance of good hygiene to health and then identify roles and responsibilities for each group. In addition, there is a checklist that children take home on Fridays for their parents to fill about healthy behaviors.

In the Community: The main mode of reaching the community has been through school children. As part of the CHAST program, the school clubs deliver health messages to the community. In the SSo5 program, parents are engaged throughout the process, and they are considered to be the main community link. In addition, the SSo5 teachers are enlisted to visit the community during the weekend and deliver health messages. However, the implementation of these activities has varied based on the commitment of the schools.

In the first quarter of 2019, Caritas launched a pilot to train community theater groups to be trachoma health

messengers. NALA and Synergy Habesha supported them with the development and launch of this initiative. The pilot recruited three theater groups through the Culture & Tourism Bureau and trained them on how to use role play, music, folklore, and the 6 hats methods to teach community members about disease prevention. The groups will visit a different kebele each week and conduct a community mobilization activity.

With the Government: From the beginning, FHF allocated a part of the budget to specifically cover the cost of joint supervision visits with zonal and wereda officials, in order to encourage as much local participation as possible. A memorandum of understanding (MoU) with the government has helped ensure their ownership of parts of the project. FHF has worked with the health and education offices to integrate the program into their own monitoring routines. Caritas also has a strong relationship with the water office and has recently been coordinating with the Culture & Tourism bureau for the community theater pilot.

WASH-NTD Coordination: The partnership between FHF and Caritas is an encouraging example of WASH-NTD coordination between NGOs. As a WASH partner, Caritas had the resources to construct WASH infrastructure in some of the schools. Through their partnership with FHF, they are now including trachoma-related material in their education program.

In the government sector, some progress has been made on the regional level. However, a lack of clarity exists as to how coordination should look on the zonal and wereda levels. More guidance from the federal ministry may ease this coordination gap.

Key Successes:

- ◆ **WASH-NTD partnership:** FHF and Caritas have had a productive partnership that benefitted from both the WASH experience of Caritas and the trachoma focus of FHF. Their collaboration can serve as an example to encourage collaboration between other WASH and NTD actors.
- ◆ **Parent sensitization workshops:** The SSo5 program succeeded in successfully engaging parents throughout the program. In the beginning, parents attended a workshop with school staff aimed at promoting good hygiene and ownership of the program. Also, the workshop effectively brought together both teachers and parents to discuss roles and divisions of responsibilities.
- ◆ **Checklists for parents:** The school program also included the parents in the M&E framework. Each week, children took home a checklist for their parents to fill. In this way, parents were actively involved in monitoring their own children and households, giving them more ownership over

their progress.

- ◆ **Clear division of roles:** FHF succeeded in clearly defining roles and responsibilities between themselves, Caritas, and the government. They used memoranda of understanding (MoU) to ensure clarity and ownership from each actor.

Gaps:

- ◆ **Scope vs depth:** Unlike the other partners, FHF only covered 120 schools. They decided to limit their scope in order to improve monitoring of the project and deepen the impact of the work. However, did enough schools receive the F&E component to make a lasting change in the zone?
- ◆ **Community engagement:** The community element of the program relied heavily on the schools, with the assumption that children and/or parents would be the messengers of change. However, schools varied in how much they involved the wider community in the program. The pilot was an important initiative to reach more community members, but it has not yet expanded beyond a few districts.
- ◆ **Lack of clear guidelines from government:** In the government sector, FHF and Caritas were not as successful in supporting coordination below the regional level. Clear guidelines from the federal government would help to give a framework for this work.

Lessons Learned:

- ◆ **Budget allocation:** From the beginning of the project, the budget should include a sum for joint monitoring visits with the government. This ensures that these joint endeavors take place and that the government is an active part of the M&E.
- ◆ **Capacity building:** Capacity building should be included in the ToT to ensure that the people trained (local leaders, health workers, school staff) have the necessary skills and confidence to push the project forward. The ToTs can include leadership training and role play on possible challenges they may face.

Going Forward:

- ◆ **Evaluation of community theater project:** Caritas will follow up on the pilot with representatives from the Culture & Tourism bureau. Based on the results, they will decide whether to scale the pilot up and/or make changes to it.
- ◆ **Collaboration with other WASH actors:** FHF is planning to build new partnerships with other WASH actors in their project areas, following their successful endeavor with Caritas.

Key Findings & Lessons Learned



1

Child-friendly materials increase student engagement and learning: Young children (ages 1-9) are the most vulnerable group for trachoma infection. School programs that used games, songs, illustrations, puppetry, and demonstrations were successful at engaging young minds. The character Toto seemed especially effective.

2

Older children can take on more responsibility and lead on activities: In some schools, older children (Grades 3 and above) led activities to teach the other students through drama and games. They also helped with small projects in the schools, including sanitation campaigns and painting hygiene messages.

3

Teachers need time to practice the lessons during the training: Some of the school materials included methodologies and activities that were unfamiliar to the teachers. The project teams noticed that when teachers did not have sufficient time to practice in the trainings, then they did not do all the recommended activities in the school. Increasing practice time for teachers led to better implementation.

4

Commitment from the school principal and club coordinator is key: Schools may receive the same training, materials, and follow-up but still perform very differently. A key reason rests on the commitment of the school staff to the program. If a principal and/or club coordinator is especially motivated, then the program will be far more successful. In addition, the principal is a key link to the community and can strengthen the school-community connection.

5

Training only two people per school may cause gaps in implementation: Most school programs only focused on training the school principal and one teacher/ club coordinator. However, in some areas, the principals and teachers move schools often. Then no one within the school is trained to lead the program. In addition, the non-trained teachers may not feel that it is their responsibility to teach the trachoma lessons.

6

Per diem is an effective but unsustainable incentive: When school staff and community members are paid per diem to participate in the trainings, then they feel more responsibility to the program. Without per diem, many have refused to participate. However, when the government takes ownership of the project, then the per diem payments are not likely to continue.

7

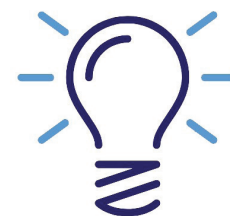
Regular follow up and supportive supervision are needed to ensure program's success: Through regular follow up, the program staff could identify weaker schools that needed strengthening. They could better assess the gaps in the program and adapt as needed.

8

Water access is a challenge in schools but not the determining factor for program success: Many schools suffered from a lack of clean water, which is a clear obstacle as access to water is needed to improve hygiene and sanitation. However, schools with water were not always the best-performing schools, and some of the best-performing schools lacked access to water. The commitment of the school staff was a more important factor. For example, in water-poor schools, dedicated staff organized students to bring in water.

- 9 Community programs rely too much on the HDA:** Overall, the Health Development Army (HDA) was not a successful channel for teaching the community about trachoma prevention, due to the fact they are unpaid volunteers and have other responsibilities. In addition, they often lack education and influence in the community and may not be well-respected as health messengers.
- 10 Self-monitoring and habit formation are effective tools for individuals and schools:** For students, facial cleanliness checks encouraged improved hygiene when they became a part of the weekly or daily school routine. Another especially effective method was engaging students in assessing their own hygiene by using a mirror with them and letting them determine if their own face was clean. These strategies also worked on the school level. With clear criteria for the monitoring visits, schools could self-assess if the WASH conditions were adequate.
- 11 Simpler, more concise materials are more likely to be used:** Long checklists and extensive manuals were seen as “too much” by teachers and officials. They more readily accepted materials that were shorter and more focused.
- 12 Significant gaps exist in monitoring and evaluation:** While all NGOs tracked the number of schools and community members trained, the actual impacts were more difficult to determine. In general, behavior change is difficult to monitor and assess. Also, the NGOs covered hundreds of schools and thousands of students. With a small field staff, it was difficult to conduct more intensive surveys of schools and students. Therefore, a thorough impact assessment of the program is missing and may not be possible with limited baseline data.
- 13 Integration of program into existing structures strengthens local ownership and sustainability:** When the materials and activities were integrated into existing structures, there were accepted more quickly. For example, adding the trachoma lessons to the annual plan for environmental science encouraged the teachers to do the lessons during the class time (and not during flag ceremonies). Including trachoma indicators into wereda checklists improved monitoring and gave ownership of it to wereda officials. In this way, the program is also more sustainable as these structures will still exist after the project’s end.
- 14 Everyone agrees that WASH-NTD coordination is a good idea, but motivation is lacking to make it happen:** The WASH and NTD sectors may have overlapping goals and project areas, but their different priorities and budgets continue to limit coordination. Despite progress on forming Task Forces and promoting coordination processes, there is still a lack of energy in pushing the process forward. There is no clear actor to take the lead and follow up on coordination efforts.
- 15 The people we train (community and local government) do not always have the leadership skills needed to push the process forward:** Currently, most of the trainings consist of trachoma-related information and the practice of new methodologies. However, the program may benefit greatly by adding in more capacity-building and leadership skills development into the ToTs. For example, HEWs and local officials can roleplay on how to deal with different challenges that may arise. Also, participants can be tasked with making their own plans with clear division of roles and responsibilities.
- 16 Parents are the key link between the school and community:** Programs that involved parents from the beginning (by including them in trainings or sensitization workshops) were more successful at engaging them throughout the program. Parents are important to the program’s success as they can ensure the practice of healthy behaviors at home as well. Also, parents hold a special role in the school, as they are often responsible for raising funds for school improvements.

Challenges & Recommendations



Focus Area	Recommendations
1. Field Capacity <i>Challenge: Lack of field staff causes limited downstream implementation</i>	<p>1.1 Profile priority schools: Provide training to all the schools, but give additional support (such as supportive supervision and small-scale WASH) to schools identified as highest need.</p> <p>1.2 Add more staff at zonal level: Currently, all the programs have more staff on the national level than in the field. Add more staff to support implementation and monitoring.</p> <p>1.3 Create partnerships with local universities and high schools: Train local volunteers to support implementation in the schools.</p> <p>1.4 Seek partnerships within the WASH sector: WASH actors often have more resources and can support infrastructure and implementation in the most challenging schools.</p>
2. School Interventions <i>Challenges: Inexperienced teachers often teach youngest grades; lack of WASH in schools; lack of commitment and/or effort from school staff; weak link between school and community programs</i>	<p>2.1 Allow sufficient time for practice during trainings: Train teachers on how to use materials and methodologies that are child-friendly and encourage play and emotional connection. Allow sufficient time during the trainings for teachers to practice the activities and become more comfortable with them.</p> <p>2.2 Support schools in brainstorming WASH solutions: Possible solutions can include a water rotation with students bringing water from home, raising money from students to hire a janitor, and engaging the PTA in fundraising.</p> <p>2.3 Follow up regularly with weaker schools and offer incentives for improvement.</p> <p>2.4 Train more than one teacher during the trainings: For example, one teacher can lead on the school program and one can work with the community.</p>
3. Community <i>Challenges: Lack of engagement from HEW and HDA; men are not targeted though they build latrines; many schools do not have community activities</i>	<p>3.1 Train other community members to lead on health initiatives: Religious leaders are well-respected and influential in many communities. Agricultural extension workers can help engage the men.</p> <p>3.2 Engage the PTA: The PTA can be an important link to connecting the school and community. Include them in school trainings. Encourage the health clubs to do an activity for the parents on Parents' Day.</p> <p>3.3 Develop leadership skills of trainees: Empower the training participants with tools and skills to push the process forward on their own.</p>

Focus Area	Recommendations
<p>4. Government Ownership</p> <p><i>Challenges: Lack of commitment from wereda officials; wereda-led trainings may not be effective; follow up may not be sufficient</i></p>	<p>4.1 Strengthen engagement with the education bureau on the zonal and regional level: By receiving government support and involvement on the higher levels, wereda-level officials will be more open to actively working together.</p> <p>4.2 Integrate work into existing routines and systems: Add indicators to existing structures (such as checklists) so that the work is already a part of their routine.</p> <p>4.3 Allocate part of the budget for joint supervision visits from the start of the project: This will ensure that the visits will take place and encourage the local government to support the program.</p> <p>4.5 Assign clear roles and responsibilities for each actor in the project: This can be discussed jointly during a stakeholders' meeting and formally delineated in an MoU signed by all parties.</p>
<p>5. WASH-NTD Coordination</p> <p><i>Challenges: Many platforms are not active; meetings do not often result in actions; data for WASH and NTDs is stored separately</i></p>	<p>5.1 Operationalize toolkit: Train zonal and wereda staff on how to use the coordination tools and give examples of how it was done effectively.</p> <p>5.2 Advocate for budget allocation by government and partners: Insert relevant indicators into the planning cycle. For example, if there is money to build a well, look for areas with high disease prevalence.</p> <p>5.3 Conduct supervision visits in the region: Use checklists related to WASH and NTD that any visitor from the regional health bureau can use when visiting a site.</p> <p>5.4 Create joint databases: Compile data on disease prevalence, WASH/NTD partners, and WASH infrastructure for each region. Use the same language across platforms.</p> <p>5.5 Identify champions and collect best practices: Find champions and record their work: what works and what does not work. Share with relevant stakeholders as practical examples.</p> <p>5.6 Receive clear guidelines and consistent support from the federal level: Partners want to maintain the momentum of coordination beyond initial meetings. Clear guidelines and more active support from the higher levels will help this process.</p>
<p>6. Monitoring & Evaluation</p> <p><i>Challenges: Lack of baseline data; lack of surveys on impact; limited manpower for monitoring; hard to define right indicators</i></p>	<p>6.1 Use clear criteria to assess progress and share with schools and other intervention sites: They can then self-monitor and be more prepared for supervision visits.</p> <p>6.2 Empower local governments to take the lead in the monitoring process: Provide the support needed to ensure they are the ones leading the monitoring process.</p> <p>6.3 Develop clear monitoring guidelines that emphasizes collection of qualitative data also: Collect case studies and interview beneficiaries.</p> <p>6.4 Partner with research institutes on small projects to assess impact.</p>

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