Final Evaluation

ATJK Water, Education, Health and Environmental Awareness (ATJK WEHEA)

ADRA Norway 09NOR-DEV001

BY

Dr. Peter Kiriri

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Executive Summary

The goal of ATJK WEHEA Project was to improve the livelihoods of 42,692 local villagers in Oromiya region in Ethiopia through improved health, education, environmental awareness and women with better problem-solving capacity. In aiming for the above goal, by the end of the project the following objectives were to be achieved for the respective five project components (water, education, health and environmental awareness and women):

1. 3,414 in ATJK have access to potable water;
2. 600 students (grades 1-4) have access to basic education in 3 separate Kebeles in ATJK district;
3. 26,829 local villagers have increased knowledge in basic health, hygiene and family planning, and practice methods of improved sanitation, health and hygiene;
4. 26,829 villagers have increased environmental awareness and practice methods to mitigate environmental degradation;
5. Women in 17 villages of ATJK have enhanced knowledge about relevant issues and enhanced problem-solving capacity through the formation of local women groups.

The purpose of the final evaluation was to collect information to determine the implementation and achievement of the objectives of the project. Specifically, the evaluation was guided by several objectives that included:

- Assess project performance at each level (activities, outputs, outcomes and goal) against the indicators set in the latest version of the logframe;
- Identify possible unexpected events of significant character (positive and/or negative) outside the project that have contributed to the project's progress or lack of progress;
- Investigate whether there were unexpected results (positive and/or negative) that were not part of the original project plan;
- Draw lessons learnt and/or describe relevant experiences that resulted in a change of strategies/ methods in future interventions;

A mixed evaluation design was adopted. The evaluation design adopted incorporated both qualitative and quantitative techniques in data collection in order to identify the baseline values. Various data collection methodologies were used including review of project documents, focus group discussions, key informant interviews, and observation. A proportionate to population sampling (PPS) and systematic sampling method was used to ensure equity in household distribution and representation in the final sample. The sample size identified for the evaluation was 371 households distributed in the Kebeles proportionately to size. A total of 385 responses were recorded, spread across the enumeration areas.

The Tables below provide the findings in comparison with the baseline findings and based on the project objectives.

Objective No 1. By the end of the project, 3,414 people in ATJK have access to potable Water

The ATKJK project intended to reach 3,414 people within the project with potable water. As a result of the rehabilitation of the 2 deep water wells and subsequent water infrastructure put in place, 3,632 people were reached representing a target achievement of 106.4%. This number excludes those from neighboring Kebeles who were also using the installed water facilities.

Furthermore, in pursuit of sustainability of the water projects, two water committees were established and trained in maintenance of the water infrastructure. The table below indicates some of the results under this objective.

Variable	Responses	Baseline Frequency	Baseline Percentage	Final Frequency	Final Percentage
Source of Water	Piped Water	-	71	-	78.1
	River	-	6	-	7.3
	Lake	-	8	-	6.5
Walking distance to the closest water source	Less than an hour	148	60.1	79	68.1
	One hour	54	22	22	19.0
	Two hours	32	12.9	8	6.9
	Three hours or more	12	5	7	6.0
Frequency of fetching water	More than twice daily	83	34	105	28.0
	Once daily	139	57	240	63.9
	Every two days or more	24	10	31	8.2
Follow correct way of drinking water management	Yes	114	46.3	31	8.3
	No	132	54.7	344	91.7

Objective No. 2: By the end of the project, 600 students (grades 1-4) have access to basic education in 3 separate kebeles in ATJK district.

In pursuit of this objective, 3 school building committees were established in the 3 Kebeles earmarked for elementary schools support by the project in Urgo Mecheferia, Reji and Aneno Shisho Kebeles. The 3 committees were involved in construction of the 3 schools in the 3 Kebeles. At the end of the project, 694 students had access to basic education as a result of the 3 schools constructed and equipped with learning facilities like desks and blackboards. This was an achievement of 115.7%. The table below presents other key results under this objective.

Variable	Responses	Baseline Frequency	Baseline Percentage	Final Frequency	Final Percentage
Walking distance to reach to the nearest school	One hour or less	233	94.7	309	91.4
	Two hours	13	5.3	25	7.4
Reasons for not attending school	School is located away	2	7.8	26	7.2
	I don't feel the need	51	84.4	11	3.1
Have any of your children dropped from school?	Yes	35	18.1	56	14.5
	No	158	81.9	290	75.5
Reasons for drop out?	Low academic performance	3	8.6	11	3.1
	Because of poor health	1	2.9	13	3.6
	Needed for household labour	13	37.1	2	0.6
	Preparing for marriage	1	2.9	2	0.6
	Other	16	45.7	10	2.8

Objective No. 3: By the end of the project, 26,829 local villagers have increased knowledge in basic health, hygiene and family planning, and practice methods of improved sanitation, health and hygiene.

In order to achieve the above objective, the project targeted to train 35 CBRHAs, 90 local government staff and 17 TBAs in health promotion including HIV/AIDS awareness, hygiene and family planning. These targets were achieved by 100% for CBRHAs, 33.3% local government staff and 100% TBAs. Through the trained personnel the project was able to reach 490,908 local villagers (This figure is higher than the total population of the 17 Kebeles. Separate awareness meetings were organized for different messages and as a result same people counted for say HIV/AIDS and awareness would have been counted again at a hygiene and sanitation awareness meeting).

In order to improve hygiene, the project targeted to provide 100 VIP latrines. This was achieved by 100%. The table below presents other key results under this objective.

Variable	Responses	Baseline Frequency	Baseline Percentage	Final Frequency	Final Percentage
Ever attended HE lesson for hygiene?	Have attended	151	61.4	332	87.1
	Never attended	217	38.6	49	12.9
Wash hands before	Wash	202	82.1	371	96.4

Variable	Responses	Baseline Frequency	Baseline Percentage	Final Frequency	Final Percentage
handling food?	Do not wash	43	17.9	14	3.6
Hand washing after using latrine	Wash	178	72.4	320	83.1
	Do not wash	56	27.6	65	16.9
Do you use soap for washing hands?	Use soap	179	72.8	282	75.2
	Do not use soap	113	27.2	93	24.8
Primary way of feces disposal	Pit latrine at house	135	55	108	28.1
	Open field	99	40	95	24.7
	Communal Latrine	5	4.9	9	4.6
Vaccination status of children	Vaccinated	216	87.8	194	89.4
	Not vaccinated	30	12.2	23	10.6
Who assisted last delivery	T/TBA	56	25	80	38.8
	Family/ neighbour	158	70.5	101	49.0
	Health workers	10	4.5	20	9.7
Diarrhoea or vomiting in< 5 yrs children during the past 2 weeks	Present	44	16	43	16.7
	Not present	236	84	215	83.3
Treatment used for Diarrhoea	ORS	14	32		46.5
	Home based ORS	6	14		11.6
What causes Diarrhoea	Eating contaminated foods	173	70	189	73.3
	Drinking unclean water	150	61	141	54.7
	Do not know	54	22	44	17.1
Cough/difficulty in breathing in <5 during last 2 weeks	Present	54	19	60	23.3
	Not present	226	81	198	76.7
Treatment used for the cough	Traditional medicine	10	19	3	11.5
	Modern medicine	28	52	23	88.4
Knowledge about family planning	Heard	228	92.3	299	87.7
	Never heard	18	7.7	42	12.3
Ever use of FP methods	Ever used	88	35.8	161	53.8
Current users of FP methods (CPR)	Users	72	30.9	134	44.8
FP methods used by current users	Pills	35	49	13	8.1
	Depo-Provera injection	34	47	95	59.0
	Norplant	1	1	6	3.7
	Calendar method	7	10	10	6.2
Awareness of HIV/AIDS	I have heard	221	89.5	325	84.4
	I haven`t heard	25	10.5	52	13.5

Variable	Responses	Baseline Frequency	Baseline Percentage	Final Frequency	Final Percentage
Knowledge on mode transmission of HIV/AIDS	Unprotected sex	190	77.2	273	84.0
	Mother to child	14	5.7	37	11.4
	Sharp objects/materials	186	75.6	283	87.1
	Blood transfusion	45	18.3	145	45.5
Knowledge on prevention methods of HIV/AIDS	Abstain from sexual activity	104	42	253	77.8
	Loyalty to partner	128	52	262	80.6
	Use condom	38	15	142	43.7
	PMTCT	13	5		54.2

Objective No. 4: By the end of the project, 26,829 villagers have increased environmental awareness and practice methods to mitigate environmental degradation.

In order to achieve this objective, the project targeted at training 14 CBREAs and 30 government officials on environmental awareness and protection. From the project records, 110 CBREAs were trained while no local government officer was trained. The project through the CBREAs had planned to train 26, 829 villagers in environmental awareness and protection. A total of 273,896 villagers were trained (This figure is higher than the total population of the 17 Kebeles. Separate awareness meetings were organized for different messages and as a result same people counted for say soil conservation awareness would have been counted again at a compost preparation awareness meeting).

Other key deliverables of the project under this objective included selling 800 energy saving stoves to the villagers and distributing for planting indigenous trees and fruits. About 812 energy saving stoves were purchased by the villagers. about 180,110 seedlings were distributed to the villagers for planting against a target of 15,000 seedlings. The table below presents other key results under this objective.

Variable	Responses	Baseline Frequency	Baseline Percentage	Final Frequency	Final Percentage
Source of energy for cooking	Firewood	245	99.6	298	78.2
	charcoal	1	0.4	6	1.6
Heard about energy saving stoves	Heard	198	80.5	308	81.7
	Never heard	63	19.5	69	18.3
Harmful environmental practices	Deforestation	226	91.9	343	89.1
	Burning	63	25.6	157	40.8
	Overgrazing	43	17.5	54	14.0
Practiced composting	Practiced	187	76	129	33.5
Planted tree seedlings from ADRA	Planted	59	24	216	56.1
	Never planted	187	76	169	43.9

Objective 5: Women in 17 villages of ATJK have enhanced knowledge about relevant issues and enhanced problem-solving capacity through the formation of local women groups.

Under this objective, 17 women groups were to be established, one in each Kebele and they were expected to meet on a monthly basis (612 meetings in the project life).On the other hand, 17 IGD sessions were to be held annually (51 sessions in the project life). Due to some changes in the political legal environment, this objective was affected as most of the activities planned under it were deemed to be against the "Charities and Societies Proclamation Law" (CSO law) adopted in January 2009, which criminalized human rights activities undertaken by Ethiopian organizations that received more than ten percent of their funding from abroad.

As a result, only 7 women groups were established against 17 and 15 meetings held against 612 meetings. for IDG sessions, only 12 were held in the last two quarters of 2011 against a target of 51 IDG sessions.

Recommendations

Several recommendations can be drawn from the final evaluation:

- In programme implementation, there should be a well-articulated monitoring and evaluation framework in place. Tracking of results versus needs/objectives should also be at the 3 levels of a results chain (output, outcome and impact) as opposed to being at the output level only. Also the need to ensure that the indicators used are direct measures of results and that the same can be tracked over the project period based on the intervention.
- It is also recommended that any other initiatives to address issues of health and hygiene should consider strongly interventions focused on Behavioural Changes. This was due to the fact that there were efforts in building the capacity of the communities on various desired practices yet the changes were not so fundamental compared to the baseline values.
- The use of community-owned resource persons should be continued and strengthened due to the various advantages of such an approach. Strategies should be designed to enable them commit more to the project intentions.
- Working with the government ministries at the local levels should also continue. As ADRA Ethiopia fulfils its deliverables such as school construction, the government and community should be encouraged to take the schools to another level. This would include their contribution to more classes. Ideally, the government and community should be encouraged to match the contributions by ADRA.
- Since there still existed households with school-going children at home, the project, in any similar undertaking should address the issues of school enrolment and attendance. They should focus on creating awareness on the importance of education and should devise a lobbying mechanism that involves the heads of Kebeles and other local leaders to sensitize parents on the need to afford their children education and discourage child livestock tendering.

- Since a majority of the households did not treat their water before drinking, it is recommended that the project should adopt a Hygiene Promotion strategy as well as creating awareness on the need to treat water. Though the community may not have resources to buy water treatment chemicals, local solutions could be promoted as alternatives.
- Similar projects on maternal health should focus on safe delivery with the help of trained health care personnel. As evidenced, most deliveries were at home with the help of a friend or relative. While they sought antenatal care from government health facilities, the same was not exhibited during delivery. Awareness should be created and enhanced in the need to have a professional assisting in the delivery.
- Though the contraceptive prevalence rate was found have increased from the baseline levels, there were still gaps in knowledge on the use of family planning and misconceptions on the same including the need for more children. They should have been more awareness on the reasons and techniques of family planning to address such gaps.
- Since most of the women had heard about HIV/AIDS, focus in similar projects should be on educating women on the various methods of transmission especially on knowledge of mother-to-child HIV transmission. Misconceptions on HIV/AIDS transmission and prevention should also be given extra attention as it was evident that the same existed within the project area.

SECTION ONE: INTRODUCTION

1.0 Introduction and Background of the Project

1.1 Background of the Project

Ethiopia still remains one of the poorest and most populated countries in Africa, with an estimated population of 78.3 million people (2008).[1] Approximately 83% of the people live in rural areas (2003)[2], where many of the most basic needs are unavailable to the average person. Poverty is uniformly distributed throughout the country's rural areas, and both the incidence and the severity of this poverty is higher in rural than in urban areas.[3]

The intervention region has an arid climate with a flat and poorly cultivated landscape. Owing to erratic rainfall (less than 600 mm per year) and subsistence farming, the area is predisposed to chronic food shortage. The main livelihood of people living in this harsh environment is breeding of livestock and the farming of maize, haricot beans and sorghum.

A needs assessment was carried out in March 2008 by ADRA Ethiopia in consultation with experts from different government line departments, and a number of problems and development gaps were identified. It was found that the most serious problem facing the people of Adami Tulu Jido Kombolcha (ATJK) district was lack of potable water. In order to alleviate this problem, the government had drilled three deep wells in the proposed intervention area; however they lacked water distribution points, water reservoir and cattle trough. One of them also lacked a motorized pump.

Besides the serious water shortage, the people of ATJK had limited access to education, their knowledge of basic health and hygiene was poor, HIV/AIDS was increasingly becoming a problem and their limited resources were steadily but surely diminishing.

Deforestation was one of the main causes for the diminishing resources. Environmental degradation was a serious issue, due to the fact that no other energy source was available in the villages besides the firewood obtained by cutting down local trees. Many areas had been stripped of vegetation, which caused problems such as erosion, reduction of biodiversity and climate change. Human waste was also having a detrimental effect on the environment. Fly-borne diseases from human feces caused widespread sickness and even death.

The timeframe of the project was from January 1st, 2009 to December 31st, 2011 (3 years). The project targeted directly rural farmers and their dependents in 17 Kebeles, in a remote part of ATJK district. The total population living in the target area amounted as of the start date to 42,693 people, distributed equally among the Kebeles.

1.2 Project Goal

[1] http://en.wikipedia.org/wiki/Ethiopia
[2] http://www.ruralpovertyportal.org/english/regions/africa/eth/statistics.htm
[3] http://www.ruralpovertyportal.org/english/regions/africa/eth/index.htm

Improved livelihood of 42,692 local villagers in Oromiya region in Ethiopia through improved health, education, environmental awareness and women with better problem-solving capacity

1.3 Project Objectives and outputs

In aiming for the above goal, by the end of the project the following objectives were to be achieved for the respective five project components (water, education, health and environmental awareness and women):

1. 3,414 in ATJK have access to potable water;
2. 600 students (grades 1-4) have access to basic education in 3 separate kebeles in ATJK district;
3. 26,829 local villagers have increased knowledge in basic health, hygiene and family planning, and practice methods of improved sanitation, health and hygiene;
4. 26,829 villagers have increased environmental awareness and practice methods to mitigate environmental degradation;
5. Women in 17 villages of ATJK have enhanced knowledge about relevant issues and enhanced problem-solving capacity through the formation of local women groups.

1.4 Project Outputs

By the end of the project the following results (outputs) were to be achieved in each component:

Water:

1.a) 2 deep-water wells rehabilitated
1.b) 2 water committees established and trained in maintenance

Basic Education:

2.a) 3 school building committees established
2.b) 3 school buildings constructed

Health, Hygiene and Family Planning:

3.a) 35 Community Based Rural Health Agents (CBRHAs) trained in health promotion including HIV/AIDS awareness (only in the 7 "new" kebeles) and family planning
3.b) 30 local government staff trained in health promotion, HIV/AIDS prevention and awareness
3.c) 26,829 local villagers trained in basic health & hygiene issues and family planning
100 VIP latrines provided
3.d) 17 local Traditional Birth Attendance trained in TBA training including HIV/AIDS awareness

Environment:

4.a) 14 Community Based Rural Environmental Agents (CBREAs) trained in environmental awareness and protection
4.b) 30 local government staff trained in environmental awareness and protection
4.c) 26,829 local villagers trained in environment awareness and protection.
4.d) 800 energy-saving stoves purchased by villagers
4.e) 15,000 indigenous trees and fruit seedlings distributed

Women:

5.a) 17 women's groups are established (one in each village)
5.b) 17 women's groups meet on a monthly basis
5.c) 17 intergenerational dialogue (IGD) sessions are held annually

1.5 Purpose of Evaluation

The purpose of the final evaluation was to collect information to determine the implementation and achievement of the objectives of the project.

1.6 Specific Objectives of the Evaluation

The evaluation was guided by several specific objectives that included:

- Assess project performance at each level (activities, outputs, outcomes and goal) against the indicators set in the latest version of the logframe;
- Identify possible unexpected events of significant character (positive and/or negative) outside the project that have contributed to the project's progress or lack of progress;
- Investigate whether there were unexpected results (positive and/or negative) that were not part of the original project plan;
- Draw lessons learnt and/or describe relevant experiences that resulted in a change of strategies/ methods in future interventions;

Besides addressing the specific objectives, the final evaluation also included a comprehensive analysis of the project based on the five fundamental criteria based on the OECD/DAC evaluation criteria which included: quality and relevance of design; effectiveness; efficiency of planning and implementation; impact; sustainability.

SECTION TWO: EVALUATION METHODOLOGY

2.1 Evaluation Design

A mixed evaluation design was adopted. This was because there is no single evaluation method that can document and explain the complexity and richness of a project. The evaluation design adopted incorporated both qualitative and quantitative techniques in data collection in order to identify the baseline values. Various data collection methodologies were used including review of project documents, focus group discussions, key informant interviews, and observation.

As an evaluation design, triangulation was used for all areas of focus of the baseline evaluation. Triangulation is the combination of two or more data sources, investigators, methodological approaches, theoretical perspectives, or analytical methods within the same evaluation. For the baseline evaluation, multiple triangulation was used which included data triangulation, investigator triangulation, methodological triangulation and analytical triangulation. There were several reasons for the choice of triangulation in this evaluation. Triangulation aids in quality control and helps in ensuring the completeness of data; balance and objectivity in an evaluation; reliability of the data (the degree the collected data is consistent among different observers or same observer at different times), and; Validity of the results (the extent to which provided data reflects the reality).

2.2 Sampling Design

In order to ensure representativeness, a multistage sampling process was used involving the use of several sampling methods. A proportionate to population sampling (PPS) and systematic sampling method was used to ensure equity in household distribution and representation in the final sample. A number of steps were followed.

Step 1: Determination of population:

The population of this was evaluation was considered as the number of households within the target Kebeles (Villages) for the Project. According to the Woreda Administration, the project area had a population of about 50,371 residents. There were about 10,075 households within the project target areas. The table below lists the study population distribution.

Step 2: Cluster Sampling

Cluster Sampling was used where the households in the population were clustered based on the Kebele as indicated in the table above. There were 17 clusters of covering the Kebeles.

Table 1: Household Population Distribution per Kebele

Kebele	Total Population	Households	Percent
Walin Bula	3487	697	6.9
Qamo Garbi	2233	447	4.4
Wayiso Qanchara	2276	455	4.5
Anano Shisho	7183	1437	14.3
Abayi Danaba	4962	992	9.8
Dodicha	4766	953	9.5
Urgo Mechefera	3632	726	7.2
Adansho Barmota	1073	215	2.1
Adansho Gogessa	1165	233	2.3
Danbi Adansho	2320	464	4.6
Reji	1729	346	3.4
Chitu Geto	3385	677	6.7
Elelan Ababu	1796	359	3.6
Laliso Dambe	1998	400	4.0
Naka	1090	218	2.2
Bara Hobicho	2578	516	5.1
Jela Aluto	4698	940	9.3
Total	**50371**	**10075**	**100**

Step 3: Probability Proportional to Size (PPS) Sampling

PPS as a sampling technique was used in the household surveys since the probability of selecting a sampling unit (household) is proportional to the size of its population. PPS gives a probability (random, representative) sample. It was most useful since the Kebeles varied considerably in household numbers. It also assured that those in larger Kebeles had the same probability of getting into the sample as those in the smaller Kebeles, and vice verse.

Step 4: Systematic Sampling

To ensure a complete representation on the population, after determining the sample size in each Kebele through PPS, the households were determined using the systematic sampling method. The sample was chosen by selecting a random starting point and then picking every n^{th} household in succession. The n^{th} household was determined by identifying the sampling interval, by dividing the cluster/ Kebele size N by the sample size n and rounding to the nearest integer.

Step 5: Sample Size Determination

The appropriate sample size was determined by use of a sample calculation formula below.

$$n = \frac{(z^2pq)}{e^2}$$

Where

n = sample size

z = confidence level (95% - 1.96)

p and q = probabilities of success and failure respectively (p = 0.5; q (1-p) = 0.5)

e = desired level of precision at 0.5

Using the formula

$$n = \frac{(z^2pq)}{e^2} = \frac{(1.96)^2\,(0.5)(0.5)}{(0.05)^2} = \mathbf{385}$$

Based on the formula, a sample of 385 was derived. However, since the population of households was finite and known, there was need to calculate an exact sample size by using a formula that statistically adjusts the sample size taking into consideration the population (N) of 10,075 households as indicated in the formula below.

$$n = \frac{n}{1 + \frac{(n-1)}{N}}$$

$$n = \frac{n}{1 + \frac{(n-1)}{N}} = \frac{385}{1 + \frac{(385-1)}{10{,}075}} = 371$$

The sample size identified for the evaluation was 371 households distributed in the localities proportionately to size as indicated in the Table below.

Table 2: Sample Size Distribution

Kebele	Total Population	Households	Sample Size
Walin Bula	3487	697	26
Qamo Garbi	2233	447	16
Wayiso Qanchara	2276	455	17
Anano Shisho	7183	1437	53
Abayi Danaba	4962	992	36
Dodicha	4766	953	35
Urgo Mechefera	3632	726	27
Adansho Barmota	1073	215	8
Adansho Gogessa	1165	233	9
Danbi Adansho	2320	464	17
Reji	1729	346	13
Chitu Geto	3385	677	25
Elelan Ababu	1796	359	13
Laliso Dambe	1998	400	15
Naka	1090	218	8
Bara Hobicho	2578	516	19
Jela Aluto	4698	940	35
Total	**50371**	**10075**	**371**

2.3 Data Collection

Several data collection methods were used in line with the data triangulation evaluation design. The use of multiple sources of data collection and tools ensures reliability of the data collected. By combining multiple/mixed methods, the evaluation was able to overcome the weakness or intrinsic biases and the problems that come from single-method and single-observer studies. The different methods helped to obtain confirmation of findings through convergence of different perspectives at which point the perspectives convergence was seen to represent reality. The main methods of data collection methods used are discussed below.

2.3.1 Document Reviews

Existing documents were reviewed to provide insights into the project through an exploratory research. Records were collected from outside (external of ADRA) and within (internal) of the project setting. The existing documents provided a setting that could not be observed or noted in another way. This information was found in documents associated with the project as provided by ADRA Norway and ADRA Ethiopia. Other documents that provided information included those from the Government of Ethiopia and its agencies and other development agencies like UNICEF, World Health Organization and UNDP. Documents reviewed were mainly:

- Narrative project proposal
- Project Baseline Evaluation
- Midterm Evaluation
- Quarterly reports
- Annual reports
- Project Log frame
- Project Budget
- Detailed Implementation plans
- Other documents identified as relevant for understanding the project and its context.

2.3.2 Focus Groups Discussions (FGD)

Focus group discussions were done with the community members to provide insight into their views about the various baseline indicators whose information was sought. The focus groups were used to generate data and insights that were unlikely to emerge without the interaction found in a group. A total of 6 FGDs were conducted in different Kebeles and focusing on different group of participants and as informed by selected interventions. The FGD participants were selected purposively from the target project Kebeles. The FGDs addressed all project areas including Education for women and children, HIV/AIDS, livelihoods and environmental hygiene. In order to collect the desired data, several FGD Guides were developed and are attached in the Appendix.

2.3.3 Key Informant Interviews (KII)

KII are qualitative, in-depth interviews of people selected for their first-hand knowledge about a topic of interest. In the baseline evaluation, some Key Informants were identified and information sought from them. Several KII Guides were developed to aid in the data collection based on the area of expertise of the respondent. Some of the Key Informants included the heads of the Woreda's Water, Education, Health, Agriculture, Environment and the Project Staff.

2.3.4 Surveys

Primary household data was collected through a survey. A questionnaire that was developed and pretested was the main tool in data collection. It addressed all the key intervention areas and had both open and closed ended questions. The questionnaire had several sections addressing household characteristics, household education, water and sanitation, hand washing practices, HIV/AIDS, family planning, child health, maternal health and environmental awareness. From the sampling design, 371 households had been identified as the sample size and were targeted for the questionnaire.

2.3.5 Data Collection Methods, Tools and Sample

As discussed in the sections above, various data collection methods were used supported by relevant tools. The choice of the methods and tools were highly influenced by the objectives of the evaluation. The adopted approach in data collection management is presented in Table 3 below.

Table 3: Data collection Methods, Tools and Sample

Data collection method	Data collection tool	Targeted
Document Review	Checklist	Various documents
Focus Group Discussion	FGD Guide	6 FGDs
Key Informant Interviews (KII)	Interview Guide	5 KII
Household Survey	Questionnaire	371 Households

2.4 Fieldwork Management

In order to ensure a successful data collection exercise, 15 qualified data collectors were recruited. The research assistants were trained on qualitative and quantitative data collection techniques after which the questionnaire was pretested and adjusted based on feedback. For supervision 3 ADRA Project Staff were incorporated. The staff were also taken through training on monitoring and evaluation prior to the data collection exercise. Quality control of data was two pronged: field quality control by both the supervisor and consultant and central office quality control by the consultant and data entry clerks.

2.5 Data Analysis and Presentation

Once the fieldwork was completed, the data was edited before entry. Data processing and analysis was undertaken using the Statistical Package for Social Scientists (SPSS version 19.0) software. Descriptive statistics were computed to examine the state of the different baseline variables. For the qualitative data obtained from key informant interviews, focus group discussions and unstructured interviews, content analysis was used to establish recurring patterns, trends and relationships. Presentation of the findings is in line with the objectives of the evaluation and as stated in the TOR. For the quantitative data from the household survey, the findings were presented in the form of frequency distributions, cross-tabulations, socio economic variables (age, gender, education).

2.6 Organization of the Report

This report is organized and presented in two main sections; the preliminary pages which includes the executive summary, abbreviations, table of contents, etc, and; the body of the report which presents an introductory chapter on Ethiopia and the project including the purpose of the evaluation, the second chapter on the evaluation methodology, the third chapter on the evaluation findings, the fourth chapter on conclusions and recommendations. The last section is the appendices which provide the TOR and other relevant documents.

SECTION THREE: EVALUATION RESULTS

3.1 Introduction

Section 3 details the findings of the evaluation. The section addresses the response rate, socio-demographic characteristics of the evaluation sample and finally an analysis based on the final evaluation objectives.

3.2 Response Rate

As indicated in the section on sampling, a sample size of 371 households were selected as being representative of the population in the 17 Kebeles. A total of 385 responses were recorded, spread across the enumeration areas. Danbi Adansho Kebele topped the list, while the least number of responses was picked from Laliso Dambe Kebele. The overall response rate was 104% while all the Kebeles recorded a response rate above 95%. Some Kebeles recorded a response of over 100% as a result of having no clear boundaries among the Kebeles and in some instances based on work plans which ensured a research assistant had sufficient workload within a village where it was not possible to transfer to another area within the same day. Again a high response rate was encouraged for insurance factors within the sampling domain and where a higher rate than 100% may not affect the results were it maintained at the 100% level. This information is presented in Table 4 below.

Table 4: Response Rate

Kebele	Households	Percent	Sample	Response	Response %
Walin Bula	697	6.9	26	26	101.6
Qamo Garbi	447	4.4	16	16	97.5
Wayiso Qanchara	455	4.5	17	20	119.7
Anano Shisho	1437	14.3	53	52	98.5
Abayi Danaba	992	9.8	36	38	104.3
Dodicha	953	9.5	35	34	97.1
Urgo Mechefera	726	7.2	27	30	112.5
Adansho Barmota	215	2.1	8	8	101.3
Adansho Gogessa	233	2.3	9	9	105.2
Danbi Adansho	464	4.6	17	21	123.2
Reji	346	3.4	13	13	102.3
Chitu Geto	677	6.7	25	26	104.6
Elelan Ababu	359	3.6	13	13	98.6
Laliso Dambe	400	4.0	15	14	95.3
Naka	218	2.2	8	8	99.9
Bara Hobicho	516	5.1	20	24	120.0
Jela Aluto	940	9.3	35	33	95.6
Total	**10075**	**100**	**371**	**385**	**104.1**

3.3 Quality and Relevance of Design

During the evaluation the key evaluation criteria of relevance was addressed. This criterion broadly set out to identify as to what extent the objectives were relevant to the needs of the beneficiaries. It sought to identify the extent to which the projectaddressed beneficiary community needs related to: water, health, education, environmental and intergenerational coexistence in the 17 Kebeles under focus. The analysis of context and an adequate needs assessment are of particular importance for promoting relevant and appropriate responses. Such have an effect on the extent to which the planning, design and implementation of interventions takes into account local context.

From an analysis of project documents and interviews conducted with the project implementers, it was evident that a formalized needs assessment was conducted in March 2009 by ADRA Ethiopia in partnership with different Government line departments. Among the issues identified included: that the most serious problem facing the people of ATJK was the lack of potable water; limited access to education; low levels of knowledge of basic health and hygiene; increasing impacts of HIV/AIDS, and deforestation which is one of the main causes for the diminishing resources.

The project in pursuit to address the needs identified, developed goals and objectives which were directly linked to the needs. Indeed, the activities and outputs of the programme were consistent with the overall goal and the attainment of the project's objectives. The same were consistent with the intended impacts and effects of the project. It was therefore imperative to note that the WEHEA project was designed to address the perceived issues facing the target communities through the various interventions.

The choice of geographical scope was appropriate for the project since the 17 Kebeles had some levels of homogeneity in relation to the issues focal to the project. The communities here lived in abject poverty and shared similar cultural beliefs that in some instances worked against their improved standards of living. The population scope under plan was also appropriate based on the broad desired goals. For an integrated intervention it was appropriate to target women, various community players, caregivers, government, partners and other stakeholders.

3.4 Effectiveness

This section is organized and presented based on the objectives of the project. The section will highlight quantitative findings from the household survey and then provide a comparison between the baseline values and the final evaluation values.

3.4.1 Education

The objective under education was to ensure that 600 students (grades 1-4) have access to basic education in 3 separate Kebeles in ATJK district. This was to be achieved through the construction of 3 school buildings and establishing 3 school building committees.

In terms of the outputs for this objective, 694 students (grades 1-4) had access to basic education against a target of 600 students through the 3 schools constructed. As planned, 3 school building committees were established. This is indicated in the table below.

Table 5: Project Performance on Education Intervention

Activity	Target	Achieved	Percent Achievement
Students with access to basic education in 3 separate Kebeles	600	694	115.7
School building committees established	3	3	100.0
School buildings constructed	3	3	100.0

The objective of this section was to identify some of the final output values that contribute to achievement of the above indicators in pursuit for the goals enshrined in the MDGs and EFA. The target respondents for this section were chosen in line with the project focus. They included women with children of between ages 7 – 18 years which are considered as pertinent ages to school going.

3.4.2.1 School Attendance

Information on the number of women whose children are enrolled or not enrolled in school is presented in the Table below. A majority (64.5%) of the respondents indicated that their children between 7 – 18 years were in school while another 35.5% indicated that their children were not in school. Though a majority of the women gave a positive response, the remaining percentage is a significant figure to worry about. In terms of level of education, 87.6 of the children were in primary schools while another 12.4 were in secondary schools as indicated in Figure 5b below.

Table 6a: School Attendance

	Frequency	Percent
Yes	223	64.5
No	123	35.5
Total	346	100

Table 6b: School Attendance in Primary and Secondary Schools

Education Level	Number of Children	Percent
Primary	900	87.6
Secondary	127	12.4
Total	1027	100

3.4.2.2 Reasons for not Attending School

The 35.5% of the women who claimed that their children were not in school gave various reasons to justify their claim. The nature of their source of livelihood was the most influential reason as the study revealed. Given that it is a pastoralist society, 37.4% of the respondents had not taken their children to school so that they could look after their livestock. Distance from school garnered 19.8%, while 13.0% of the respondents said that illness hindered their young ones from attending school. The other significant reason the women gave was lack of money/ poverty: 8.4% of the respondents gave this reason, while a similar 8.4% saw no need for sending children to school.

Table 7: School Attendance

Reason	Frequency	Percent
Distance from schools	26	19.8
No schools in the area	1	0.8
Domestic duties	10	7.6
Marriage	0	0.0
Famine/ lack of food	4	3.1
Lack of money	11	8.4
Illness	17	13.0
Looking after livestock	49	37.4
Parents not interested – see no need for schooling	11	8.4
Passage rights	1	0.8
Pregnancy	1	0.8
Total	131	100

3.4.2.3 Any Child Dropped From School

It was revealed in the research that not many children dropped out of school once enrolled. This assertion is supported by a majority of 290 respondents translating to 83.8%. About 16.2% of the respondents however claimed that their children had dropped out of school.

Table 8: School Attendance

	Frequency	Percent
Yes	56	16.2
No	290	83.8
Total	346	100

3.4.2.4 Reasons for Dropping from School

A range of answers were given by the respondents regarding the reasons for their children dropping out of school. Poor health took the highest score of 34.2% while 28.9% of the respondents claimed that their children got discouraged by their poor academic performance and

thus consequently found no reason to continue pursuing their studies. Financial inability informed a response of 21.1%, parents citing their inability to pay school fees. The other reasons were pregnancy, early marriage, belief that schooling is a time wastage and fear of parents over the safety of their female children in school.

Table 9: School Attendance

Reason	Frequency	Percent
Passage rights (eg FGM and boy's circumcision)	0	0
Poor academic performance	11	28.9
It's a waste of time	2	5.3
Poor health	13	34.2
Lack of fees	8	21.1
Safety for the girl child	1	2.6
To get married	2	5.3
Pregnancy	1	2.6
Totals	**38**	**100**

3.4.2.5 Distance to Nearest Elementary School

The respondents were asked to approximate the distance their children took to reach school. A majority of them (68.6%) took less than half an hour while another 22.8% an hour, 7.4% took about two hours and 1.2% took three hours. The table below presents this information.

Table 10: School Attendance

Distance to School	Frequency	Percent
Less than half an hour	232	68.6
One hour	77	22.8
Two hours	25	7.4
Three hours	4	1.2
Total	338	100.0

3.4.2.6 Comparison of Final Evaluation with Baseline Values

The table below provides a comparison of the findings of the final evaluation versus those of the baseline. A comparison between baseline and final evaluation indicates mixed results in as far as education is concerned. Though not significant, it can be concluded that most children in the households surveyed traveled less than one hour to reach school than it was at baseline. Same change can be observed in the percentage of those who have children who have dropped from school. In terms of reasons why children dropped from school, it was found that low academic performance and poor health/nutrition were key factors as opposed to the need for household labour as expressed at baseline.

Table 11: Comparison of Final Evaluation with Baseline Values on Education

Variable	Responses	Baseline Frequency	Baseline Percentage	Final Frequency	Final Percentage
Walking distance to reach to the nearest school	One hour or less	233	94.7	309	91.4
	Two hours or more	13	5.3	25	8.6
Reasons for not attending school	School is located away	2	7.8	26	20.6
	I don't feel the need	51	84.4	11	8.4
Have any children dropped from school	Yes	35	18.1	56	16.2
	No	158	81.9	290	83.8
Reasons for drop out	Low academic performance	3	8.6	11	28.9
	Because of poor health/nutrition	1	2.9	13	34.2
	Needed for household labour	13	37.1	2	5.3
	Preparing for marriage	1	2.9	2	5.3
	Other	16	45.7	10	26.3

3.4.2 Water and Sanitation

The objective under water and sanitation was to ensure that about 3,414 beneficiaries in ATJK have access to potable water. This was to be achieved through the rehabilitation of 2 deep-water wells and ensuring that 2 water committees were established and trained in maintenance of the wells.

In terms of the outputs for this objective, 3,632** villagers were reached against a target of 3,414 through the 2 water wells rehabilitated. For sustainability of the water wells, two water committees were established and trained in water management. This is indicated in the table below.

Table 12: Project Performance on Water Intervention

Activity	Target	Achieved	Percent Achievement
No. of villagers with access to potable water	3,414	3,632	106.4
Deep-water wells rehabilitated	2	2	100.0
Water committees established and trained in maintenance	2	2	100.0

** These were the direct beneficiaries. It was estimated that the project would also avail water to 1,670 beneficiaries outside the project intervention area.

The MDG goal is to reduce by half, between 1990 and 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation. The World Fit for Children goal calls for a reduction in the proportion of households without access to hygienic sanitation facilities and affordable and safe drinking water by at least one-third.
The indicators used in the baseline survey were as follows:

- Availability of improved drinking water source - an improved drinking-water source is one that by the nature of its construction adequately protects the source from outside contamination, in particular from faecal matter.
- Use of adequate water treatment method
- Use of improved sanitation facilities - an improved sanitation facility is one that hygienically separates human excreta from human contact.
- Sanitary disposal of child's faeces

The Environmental Health Project suggests that the following four essential household practices are key to the reduction in Diarrhoea and other water related diseases:

- Practice safe drinking water management in the household (includes the use of an improved water source, safe water storage, and possibly water treatment at the point-of-use;
- Wash hands properly with soap (or local alternative) at critical times (includes the availability of a place for hand washing and soap);
- Dispose of all faeces safely – especially those of young children who cannot easily use a toilet; and
- Practice safe food management in the household.

The section below will address the issues highlighted in bullets 1 and 2 above.

3.4.2.1 Main Source of Water for Domestic Use

The head of the households were requested to state the main source of drinking water in their households for domestic use. From the analysis, tap/piped water was the main source of water for the residents, as supported by 78.6% of the respondents while 5.7% of the interviewed respondents claimed that they sourced their water from protected wells. About 6.5% of them got their drinking water from lakes or dams. This information is presented in Table below.

Table 13: Main Source of Water for Domestic

Sources of Water	**Frequency**	**Percent**
Public Tap	302	78.1
Protected Well	22	5.7
Unprotected Well	2	0.5

Rainwater Collection	6	1.6
River/Stream	28	7.3
Dam/Lake	25	6.5
Total	385	100

3.4.2.2 Frequency of Fetching Water

The respondents were asked to indicate how often they fetched water for the household use. Most people (65.7%) fetched water once daily. Those who fetched water more than twice daily were 26.9%. The same trend was maintained in the observation made with people who fetched water every two days or more.

Table 14: Frequency of Fetching Water

Frequency of fetching water	**Frequency**	**Percent**
Once daily	247	65.7
More than twice daily	101	26.9
Every two days or more	28	7.4
Total	376	100.0

3.4.2.3 Means of Fetching Water

About 69.6% of the households used animal carts to ferry water from the source to their households. Another 30.4% households carried the water on their backs. The use of animal carts would probably be as a result of the distance to the service point. The table below presents the information.

Table 15: Means of Fetching Water

	Frequency	**Percent**
Carry on back	116	30.4
Animal cart	266	69.6
Total	382	100.0

3.4.2.4 Time Taken to Fetch Water

During the evaluation, the respondents were asked to indicate the time it took to get to the water source and back to their households if they fetched water on the back or using an animal drawn cart. The objective of this was to estimate the distance to water source and the productive time utilized in search of water. From the analysis, it was evident that a majority of the residents (68.1%) who ferried water on the back took less than half an hour to reach their homes while another 19% took approximately an hour to reach their homes. A minority of 6.9% and 6% took two hours and three hours or more respectively to reach their homes.

Table 16: Time to Water Point and Back

	Frequency	Percent
Less than half an hour	79	68.1
One hour	22	19.0
Two hours	8	6.9
Three hours or more	7	6.0
Total	116	100.0

3.4.2.5 Role of Fetching Water

A majority of the residents (80.3%), who fetch water for the household, were adult women aged above 15 years. In contrast, men of the same age constituted 7.1%. The study also revealed that 9.2% of those who fetched water for the household were female children less than 15 years of age. Their counterpart males (of less than 15 years of age), constituted 3.4%. It is evident, from the research results that more females either above 15 years of age or not, are the ones who fetched water for their households more often than their male counterparts.

Table 17: Role of Fetching Water

	Frequency	Percent
Adult woman age 15+ years	305	80.3
Adult man age 15+ years	27	7.1
Female child under 15	35	9.2
Male child under 15	13	3.4
Total	380	100.0

3.4.2.6 Water Treatment Practices

Safe drinking water is a basic necessity for good health. Unsafe drinking water can be a significant carrier of diseases such as trachoma, cholera, typhoid, and schistosomiasis (or snail fever). Drinking water can also be polluted by chemical, physical, and radiological contaminants with harmful effects on human health. In addition to its association with disease, access to drinking water may be particularly important for women and children, especially in rural areas, who bear the primary responsibility of carrying water, often over long distances.

The respondent household heads were asked whether they did anything to the water to make it safer to drink. A majority of the people in the research area do nothing to the water they collect from the source to make it safer for human consumption. About 91.7% of the interviewed respondents supported this assertion while 8.3% did make their water safe for drinking as presented in the table below.

Table 18: Ensuring Water is Safe for Drinking

	Frequency	Percent
Yes	31	8.3
No	344	91.7
Total	375	100.0

3.4.2.7 Water Treatment Methods

The respondents employed various mechanisms of making their water safe for consumption. Though few of the respondents adopted this practice, 4.0% used sand water filter to purify their water. Another 2.1% of the respondents boiled their water, while others strained through a cloth, used solar disinfection method or let the water stand and settle. The community ought to be sensitized on the importance of purifying water for drinking and also the best and cheap ways of doing it.

Table 19: Water Treatment Methods

	Frequency	Percent
Boil	8	2.1
Water Guard / Aqua Tabs/Bishan Gari	3	0.8
Strain it through a cloth	3	0.8
Use water filter (sand filter.)	15	4.0
Solar disinfection	1	0.3
Let it stand and settle	1	0.3

3.4.2.8 Sanitation

Inadequate disposal of human excreta and personal hygiene is associated with a range of diseases including Diarrhoeal diseases and polio. Availability of improved sanitation facilities for excreta disposal include: flush to a piped sewer system, septic tank, or latrine; pit latrine with slab, and composting toilet.

Existence and Type of Toilet Facility

As a hygienic practice, the existence and usage of toilet facility for household members is important. In this case, the respondents were required to indicate what type of toilet facility was available for use by their household members. It was evident from the analysis that a significant number of the households (41.3%) had no toilet facilities of any kind. They practiced open defection in the bushes and fields, a phenomenon that escalates the spread of diseases. About 23.4% of the respondents however use pit latrines without slabs, while 4.7% used pit latrines, but with slabs. Another, 24.7% of the residents used open pits while 3.9% had VIP toilet facilities in

their homes. It is noticeable that 2.1% of the respondents refused to comment on the subject matter. The table below provides a summary of toilet facilities.

Table 20: Household Toilet Facility

	Frequency	Percent
VIP Toilet	15	3.9
Pit latrine with slab	18	4.7
Pit latrine without slab	90	23.4
Open pit	95	24.7
No facility, bush or field	159	41.3
Non Response	8	2.1
Total	385	100.0

Disposal of Stools

As a hygiene indicator, it was imperative to know how the households disposed of stools of the young children (0 – 3 years) who could not use a latrine or other toilet facilities. Information on disposal of feces of children aged 0-3 years of age is presented in Table below. Safe disposal of a child's feces is disposing of the stool, by the child using a toilet or by rinsing the stool into a toilet or latrine.

The research revealed that 40.1% of the respondents left stools of young children aged 0 – 3 years on bare ground while 31.6% threw them outside the yard. About 19.9% of those interviewed disposed the stools of their children into toilets and latrines. Another 4.6% of the residents buried the stools in the yard, while 3.9% of the population cited that their children have learnt to use the toilets.

Table 21: Disposal of Stools

Mode of Disposal	Frequency	Percent
Children always use toilet or latrine	11	3.9
Thrown into the toilet or latrine	56	19.9
Thrown outside the yard	89	31.6
Buried in the yard	13	4.6
Left on the ground	113	40.1
Total	282	100

3.4.2.9 Comparison of Final Evaluation with Baseline Values

The table below provides a comparison of the findings of the evaluation versus those of the baseline.

Table 22: Comparison of Final Evaluation with Baseline Values

Variable	Responses	Baseline Frequency	Baseline Percentage	Final Frequency	Final Percentage
Source of Water	Piped Water	-	71	-	78.1
	River	-	6	-	7.3
	Lake	-	8	-	6.5
Walking distance to the closest water source	Less than an hour	148	60.1	79	68.1
	One hour	54	22	22	19.0
	Two hours	32	12.9	8	6.9
	Three hours or more	12	5	7	6.0
Frequency of fetching water	More than twice daily	83	34	105	28.0
	Once daily	139	57	240	63.9
	Every two days or more	24	10	31	8.2
Follow correct way of drinking water management**	Yes	114	46.3	31	8.3
	No	132	54.7	344	91.7
Primary feces disposal method	Pit latrine at house	135	11.9	108	28.1
	Open field	99	83.3	95	24.7
	I haven`t heard	5	4.9	9	4.6

** The figures indicate a worsening state in terms of drinking water management. However, this could be attributed to the high level obtained at baseline which may require interrogation as it not within the range as determined by other evaluations. According to various studies in Ethiopia and specifically Addis Ababa, less than 23% of the urban poor treat their water. In a study by JSI in four areas in Ethiopia, it was found that in Orimiya region (same region with WEHEA project), about 89.8%[4] did not treat water before drinking. The average for the four regions (Amhara, Oromiya, SNNP and Tigray) studied was 93% which indicates only 7% treated their water. This is closer to the 8.3% achieved during the final evaluation

[4] The Last Ten Kilometers Project. 2009. Baseline Household Health Survey: Amhara, Oromiya, SNNP and Tigray. JSI Research & Training, Inc., Addis Ababa, Ethiopia.

3.4.3 Health, Hygiene and Family Planning

The objective here was to ensure that 26,829 local villagers have increased knowledge in basic health, hygiene and family planning, and practice methods of improved sanitation, health and hygiene. This was to be achieved through ensuring that: 35 Community Based Rural Health Agents (CBRHAs) were trained in health promotion including HIV/AIDS awareness and family planning; 90 local government staff were trained in health promotion, HIV/AIDS prevention and awareness; 26,829 local villagers trained in basic health & hygiene issues and family planning; 100 VIP latrines provided; 17 local Traditional Birth Attendants trained in TBA training including HIV/AIDS awareness. The results under this objective are as presented in the Table below.

Table 23: Project Performance on Health, Hygiene and Family Planning Interventions

Activity	Target	Achieved	% Achievement
Community Based Rural Health Agents (CBRHAs) trained in health promotion	35	35	100.0
Local government staff trained in health promotion, HIV/AIDS prevention and awareness	90	90	33.3
Local villagers trained in basic health & hygiene issues and family planning	26,829	490,908*	1829.8*
VIP latrines provided	100	100	100.0
Local Traditional Birth Attendance trained in TBA training including HIV/AIDS awareness	17	17	100.0

* This figure is above the total population of all the Kebeles. It is an indication of people who attended the different sessions organized under this objective. There were a total of 6 sessions and one person could have attended all the sessions and counted again in these sessions and thus the high number of villagers presented.

3.4.3.1 Hand Washing Habits

In this section, the objective was to assess the hand washing practices within the households in the localities. The intention is to understand whether they washed hands, when and how.

Hand washing is a critical hygiene intervention to interrupt the transmission of diseases such as Diarrhoea and respiratory infections. It is most effective when done using water and soap after visiting a toilet or cleaning a child, before eating or handling food and, before feeding a child. Monitoring correct hand washing behavior at these critical times is challenging. A reliable alternative to observations or self-reported behavior is assessing the likelihood that correct hand

washing behavior takes place by observing if a household has a specific place where people most often wash their hands and observing if water and soap (or other local cleansing materials) are present at a specific place for hand washing.

3.4.3.2 Health Education Session/Training on Personal Hygiene

A majority of the resident's had attended training forums on personal hygiene. About 87.1% of the residents had been trained, while 12.9% of the residents had never attended such fora. This is presented in table below.

Table 24: Ever attended Health Education Session/Training

	Frequency	Percent
Yes	332	87.1
No	49	12.9
Total	381	100.0

3.4.3.3 Prevalence of Hand Washing

A confident majority of 99.2% of the residents washed their hands. This could be attributed to the enlightenment received from attending hygiene training sessions that the residents acquired. However, 0.8% of the residents still did not wash their hands before meals.

Table 25: Prevalence of Hand Washing

	Frequency	Percent
Yes	378	99.2
No	3	0.8
Total	381	100.0

3.4.3.4 Hand Washing Occasions

When prompted to indicate when they washed their hands, 96.4% of the respondents indicated that they wash their hands before eating. About 92.7% of the respondents went ahead to wash their hands after meals. Another 85.2% of washed their hands before cooking. About 61.0%of the residents washed their hands after visiting the toilet.

Table 26: Hand Washing Occasions

	Frequency	Percent
Before Eating	371	96.4
After Eating	357	92.7
Before cooking	328	85.2
Before feeding the child	124	32.2
After the toilet	235	61.0
After child defecating	85	22.1
Before holding the child	66	17.1

3.4.3.5 Hand Washing Agent

On whether the households had any soap or detergent in the household for washing hands, about 75.2% indicated they had while another 24.8% did not have any cleansing agent. This is presented in table below.

Table 27: Existence of Washing Agent

	Frequency	Percent
Yes	282	75.2
No	93	24.8
Total	375	100

3.4.3.6 Washing Agent Used

For the members of the households who had indicated they had some hand washing agent in their households, a question was asked requiring them to indicate the exact agent they used to clean their hands. About 70.4% of the respondents used bar soap to clean their hands while 4.7% used either powder, liquid or paste detergents whenever they cleaned their hands. It is noteworthy that the residents have employed traditional or locally obtained cleansing agent while washing their hands.

Table 28: Washing Detergent in use

Washing Agent	Frequency	Percent
Bar soap	271	70.4
Detergent (Powder / Liquid / Paste)	18	4.7
Ash / Mud / Sand	85	22.1
Other (specify)	62	16.1

3.4.3.7 Comparison of Final Evaluation with Baseline Values

The table below provides a comparison of the findings of the evaluation versus those of the baseline.

Table 29: Comparison of Final Evaluation with Baseline Values

Variable	Responses	Baseline Frequency	Baseline Percentage	Final Frequency	Final Percentage
Ever attended HE lesson for hygiene?	Have attended	151	61.4	332	87.1
	Never attended	217	38.6	49	12.9
Wash hands before handling food?	Wash	202	82.1	371	96.4
	Do not wash	43	17.9	14	3.6
Hand washing after using latrine	Wash	178	72.4	320	83.1
	Do not wash	56	27.6	65	16.9
Do you use soap for washing hands?	Use soap	179	72.8	282	75.2
	Do not use soap	113	27.2	93	24.8

3.4.4 Maternal Health

According to WHO, Maternal health refers to the health of women during pregnancy, childbirth and the postpartum period. While motherhood is often a positive and fulfilling experience, for too many women it is associated with suffering, ill-health and even death. This period presents important opportunities for reaching pregnant women with a number of interventions that may be vital to their health and well-being and that of their unborn child. Better understanding of foetal growth and development and its relationship to the mother's health has resulted in increased attention to the potential of antenatal care as an intervention to improve both maternal and newborn health. For example, if the antenatal period is used to inform women and families about the danger signs and symptoms and about the risks of labour and delivery, it may provide the route for ensuring that pregnant women do, in practice, deliver with the assistance of a skilled health care provider. Matenal Health is also a critical entry point for HIV prevention and care, in particular for the prevention of HIV transmission from mother to child.

The purpose of this section is to identify the levels of awareness of the women in the households aged between 15 – 49 years who have had a live birth in the last 3 years prior to the beseline survey. It was also intended to identify possible practices within the same health area. From the analysis, about 55.9% of the women respondents had a live birth in the last 3 years.

Table 30: Existence of a Live Birth in the last 3 Years

	Frequency	Percent
Yes	209	55.9
No	165	44.1
Total	374	100.0

3.4.4.1 Consultation during Pregnancy

UNICEF and WHO recommend a minimum of at least four antenatal care visits during pregnancy. Indeed, 70.5% of the respondents had sought antenatal care during their previous pregnancy. About 29.5% of the mothers did not make any attempts to get antenatal care.

Table 31: Consulted During Pregnancy

	Frequency	Percent
Yes	146	70.5
No	61	29.5
Total	207	100.0

3.4.4.2 Persons Consulted During Pregnancy

The respondents were asked to indicate who they consulted during their pregnancy. Most of the women consulted Health Extension Workers with about 73.2% of the women. Community health workers aided 23.5% of the mothers while a slight 3.3% were assisted by friends, relatives and neighbours.

Table 32: Persons Consulted During Pregnancy

	Frequency	Percent
Community Health Workers	36	23.5
Health Extension Workers	112	73.2
Friends/Neighbors/Relatives	5	3.3
Total	153	100.0

3.4.4.3 Place Where the Mothers Visited for Antenatal Care

The study sought to reveal the exact place where the relevant respondents acquired antenatal care from. About 66.7% of the respondents visited health centres while 31.5% visited health posts. Only 1.2% of the respondents went to hospitals, while 0.6% of acquired antenatal care from private clinics. The proximity of health centres and health posts to the respondents informed the

reason for their high scores. The cost of the service is also a significant factor that informs the choice of the point of service, the sole reason for the low score for privately owned clinics

Table 33: Place Visited for Antenatal Care

	Frequency	Percent
Health Post	51	31.5
Health Centre	108	66.7
Hospital	2	1.2
Private Clinic	1	0.6
Total	162	100.0

3.4.4.4 Place/Facility of Delivery of Last Child

Three quarters of all maternal deaths occur during delivery and the immediate post-partum period. The single most critical intervention for safe motherhood is to ensure a competent health worker with midwifery skills is present at every birth, and transport is available to a referral facility for obstetric care in case of emergency. A World Fit for Children goal is to ensure that women have ready and affordable access to skilled attendance at delivery. The indicators are the proportion of births with a skilled attendant and proportion of institutional deliveries. The indicator for skilled attendant at delivery is also used to track progress toward the Millennium Development target of reducing the maternal mortality ratio by three quarters between 1990 and 2015.

From the analysis, most of the respondents (92.1%) in the 17 Kebeles gave birth at home. Only about 6.1% of them delivered in government owned hospitals, clinics and health posts while 1.9% of the respondents made their last delivery at private hospitals and clinics.

Table 34: Facility of Child Delivery

	Frequency	Percent
Home	197	92.1
Government Hospital/Post/Clinic	13	6.1
Private Hospital/Clinic	4	1.9
Total	214	100.0

3.4.4.5 Assistance with Child Delivery

The survey included a number of questions to assess the proportion of births attended by a skilled attendant. A skilled attendant includes a doctor, nurse, midwife or auxiliary midwife. The Table below shows the type of personnel available at delivery by selected characteristics. The research revealed that a high percentage of mothers do not go to formal institutions to deliver

their children. About 38.8% of the residents in the research area held that they gave birth at home with the aid of Trained Traditional Birth Assistants. Only 49.0% of the respondents interviewed claimed that they gave birth at home with the assistance of relatives or friends. 5.8% of the respondents were assisted by nurses and midwives while 3.4% were helped by doctors. Health extension workers assisted 0.5% of the mothers give birth, while 2.4% of the mothers gave birth on their own.

Table 35: Person Assisted with Child Delivery

	Frequency	Percent
Doctor	7	3.4
Nurse/Midwife	12	5.8
Health Extension Workers	1	0.5
Trained Traditional Birth Assistants	80	38.8
Relative/Friend	101	49.0
Self Assisted	5	2.4
Total	206	100.0

3.4.4.6 Vaccination Programmes

The fourth Millennium Development Goal (MDG) is to reduce child mortality by two thirds between 1990 and 2015. Immunization plays a key part in the progress towards attainment of this goal. Immunizations have saved the lives of millions of children in the three decades since the launch of the Expanded Programme on Immunization (EPI) in 1974. Worldwide, there are still 27 million children not reached by routine immunization and as a result, vaccine-preventable diseases cause more than 2 million deaths every year. A World Fit for Children goal is to ensure full immunization of children under one year of age at 90 per cent nationally, with at least 80 per cent coverage in every district or equivalent administrative unit.

In the evaluation, mothers or care givers of children below three years of age were asked whether they had heard about vaccination programmes, a majority (95.4%) of the household members expressed that they had heard about the programmes. However, 4.6% of the people living in the enumerated Kebeles had never heard about vaccination programmes.

Table 36: Awareness of Vaccination Programmes

	Frequency	Percent
YES	206	95.4
NO	9	4.6
Total	216	100.0

3.4.4.7 Child Vaccination

Approximately 89.4% of the mothers who gave birth during the three years preceding the final evaluation indicated that their children had been vaccinated. Only 10.6% reported not having their children vaccinated as indicated in the Table below.

Table 37: Prevalence of Vaccination

	Frequency	Percent
Yes	194	89.4
No	23	10.6
Total	217	100.0

3.4.4.1 Comparison of Final Evaluation with Baseline Values

The table below provides a comparison of the findings of the evaluation versus those of the baseline.

Table 38: Comparison of Final Evaluation with Baseline Values

Variable	Responses	Baseline Frequency	Baseline Percentage	Final Frequency	Final Percentage
Knowledge about EPI	I have heard	241	95.1	206	95.4
	I haven`t heard	5	4.9	9	4.6
Vaccination status of children	Vaccinated	216	87.8	194	89.4
	Not vaccinated	30	12.2	23	10.6
Who assisted last delivery	T/TBA	56	25	80	38.8
	Family/ neighbour	158	70.5	101	49.0
	Health workers	10	4.5	20	9.7
	Self Assisted	-	-	5	2.4

3.4.5 Child Health

Improving the health of children is of critical importance in the fight against poverty and in pursuit to achieving A World Fit for Children. The MDGs aim at reducing by two thirds the mortality rate among children under five by 2015 compared to 1990. In addition, the World Fit for Children calls for a reduction in the incidence of diarrhoea by 25 per cent.Improving the education and health level of children is a core in the goals of the EWC Programme. It was therefore important that the baseline identify the levels of child health management issues and in specific Diarrhoea and other child ailments like coughs.

Diarrhoea is the second leading cause of death among children under five worldwide. Most diarrhoea related deaths in children are due to dehydration from loss of large quantities of water and electrolytes from the body in liquid stools. Management of diarrhoea – either through Oral

Rehydration Salts (ORS) or a Recommended Home Fluid (RHF) - can prevent many of these deaths. Preventing dehydration and malnutrition by increasing fluid intake and continuing to feed the child are also important strategies for managing diarrhoea. In order to assess this component, 3 key indicators are normally used. The indicators are:

- Prevalence of diarrhoea
- Use of Oral rehydration therapy (ORT)
- Use of home management of diarrhoea

3.4.5.1 Prevalence of Diarrhoea

The respondents were requested to indicate whether their children had had diarrhoea in the last two weeks. Of the 258 mothers interviewed, 16.7 % confirmed that their children, in the last two weeks, had contracted diarrhoea. The remainder 83.3% denied their children contracting diarrhoea over the last two weeks.

Table 39: Prevalence of Diarrhoea

	Frequency	Percent
Yes	43	16.7
No	215	83.3
Total	258	100.0

3.4.5.2 Diarrhoea Treatment

For those who had indicated their children had a diahhrhoea episode, the survey asked them to inidcate what they gave for to address the same. About 46.5% had used a pre-packed ORS fluid for diarrhoea treatment, while only 11.6% of the respondents used locally made oral rehydration salts.

Table 40: Diarrhoea Treatment

Treatment	Percent
A pre-packaged ORS fluid for diarrhoea	46.5
Home based ORS	11.6

3.4.5.3 Causes of Diarrhoea

The survey inquired as to the understanding of the respondents on the causes of diarrhoea and the following findings were made: When interviewed, 73.3% of the mothers attributed eating spoiled or dirty foods as a possible cause of diarrhoea, while another 54.7% linked it to drinking unclean water. 17.1% of the mothers believed that personal hygiene is a significant cause and the same number did not know or were ignorant of the cause of the condition.

Table 41: Knowledge on Causes of Diarrhoea

Cause	Frequency	Percent
Eating spoiled/dirty food	189	73.3
Drinking unclean water	141	54.7
Personal Hygiene	44	17.1
DK	44	17.1

3.4.5.4 Coughs in Children

Pneumonia is the leading cause of death in children and the use of antibiotics in under-5s with suspected pneumonia is a key intervention. A World Fit for Children goal is to reduce by one-third the deaths due to Acute Respiratory Infections (ARI). Children with suspected pneumonia are those with an illness with a cough accompanied by rapid or difficult breathing and whose symptoms are NOT due to a problem in the chest and a blocked nose. To ensure the problem is addressed it is imperative to identify the knowledge levels and practices among the women with children by addressig several indicators including:

- Prevalence of suspected pneumonia
- Care seeking for suspected pneumonia
- Antibiotic treatment for suspected pneumonia
- Knowledge of the danger signs of pneumonia

The Table below presents respondents who had identified children with a cough during the two weeks preceding the survey. Overall, 23.3% per cent of the respondents indicated that they had observed coughs in children during the two weeks prior to the survey, while 76.7% did not.

Table 42: Prevalence of Coughs in Children

Observed Coughs	Frequency	Percent
Yes	60	23.3
No	198	76.7
Total	258	100.0

Further, all mothers/caretakers of children who had coughs in survey were asked whether they had sought any advice or had received any medical assistance. About 56.7% of the mothers/caretakers reported having sought help while 43.3 had not sought any treatment when their children fell ill of the disease.

Table 43: Health Seeking Behaviour

	Frequency	Percent
Sought Medical help	26	43.3
Did not seek any help	34	56.7
Total	60	100.0

Health centres and posts seem to be the most preferred places of treatment for mothers whenever their children fell sick. About 61.5% of the respondents took their children to these health centres and posts, while 15.4% resorted to private hospitals or clinics for treatment. Cost of treatment as well as proximity to service points seems to inform the preference of the parents. An equal percentage of mothers (11.5%) took their ill children to private pharmacies, and traditional practitioners respectively.

Table 44: Health Facility Visited

	Frequency	Percent
Health Centre/Post	16	61.5
Private Hospital/Clinic	4	15.4
Private Pharmacy	3	11.5
Traditional Practitioner	3	11.5
Total	26	100

3.4.4.5 Comparison of Final Evaluation with Baseline Values

The table below provides a comparison of the findings of the evaluation versus those of the baseline.

Table 45: Comparison of Final Evaluation with Baseline Values

Variable	Responses	Baseline Frequency	Baseline Percentage	Final Frequency	Final Percentage
Diarrhoea or vomiting in< 5 years children during the past 2 weeks	Present	44	16	43	16.7
	Not present	236	84	215	83.3
Treatment used for Diarrhoea	ORS	14	32	*	46.5
	Home based ORS	6	14	*	11.6
What causes Diarrhoea	Eating contaminated foods	173	70	189	73.3
	Drinking unclean water	150	61	141	54.7
	Do not know	54	22	44	17.1
Cough/difficulty in breathing in <5 during last 2 weeks	Present	54	19	60	23.3
	Not present	226	81	198	76.7
Treatment used for the cough	Traditional medicine	10	19	3	11.5
	Modern medicine	28	52	23	88.4

3.4.6 Family Planning

A World Fit for Children goal is to ensure access by all couples to information and services to prevent pregnancies that are too early, too closely spaced, too late or too many i.e., unwanted pregnancies. Appropriate family planning is important to the health of women and children by:

- Preventing pregnancies that are too early or too late;
- Spacing the period between births; and
- Limiting the number of children.

Details on the current use of contraception are shown in the subsequent section. It addresses awareness, knowledge and practices in as far as family planning in the Kebeles is concerned. This section was only intended to the married women between ages 15 and 49 as ideally this is the group that would be required to know and practice family planning.

3.4.6.1 Awareness of Family Planning

For the purpose of this question, the married women alone constituted the sample size. When asked whether they had ever heard of family planning prior, 87.7% of them gave a positive response, while 12.3% of them denied knowledge of family planning as indicated in the Table below.

Table 46: Awareness of Family Planning

	Frequency	Percent
Have heard of FP	299	87.7
Never heard of FP	42	12.3
Total	341	100.0

3.4.6.2 Source of Information on Family Planning

A majority of the women heard of family planning methods from Health Extension Workers with about 74.6%, followed by Community Health Volunteers with about 18.7%. Almost 8% of the respondents did not remember where they heard about family planning techniques from. Trained Traditional Birth Attendants and friends scored 1.0% and 4.3% each respectively as espoused by the interviewed women.

Table 47: Source of Information on Family Planning

Source	Frequency	Percent
Community Health Volunteers	56	18.7
Health Extension Workers	223	74.6
Trained Traditional Birth Attendants	3	1.0
Friends	13	4.3
Don't Know	4	1.3
Total	299	100.0

3.4.6.3 Usage of Family Planning Methods

Family planning programs, which offer a range of contraceptive choices to couples, have led to sharp increases in the use of contraceptives. Moreover, effective family planning and economic growth together have a synergistic effect in helping to raise contraceptive prevalence and reduce fertility. When interviewed, 53.8% of the women had used Family Planning methods in their lifetime. About 46.2% of the respondents had never attempted to use any Family planning methods.

Table 48: Usage of Family Planning Methods

	Frequency	Percent
Yes	161	53.8
No	138	46.2
Total	299	100

3.4.6.4 Women Currently on Family Planning

The objective of this question was to determine whether the respondents had taken any measures to avoid any pregnancy. About 44.8% of the mothers were currently using family planning methods (Contraceptive Prevalence Rate (CPR) of 44.8). Another 55.2% of the respondents were not using any of the family planning methods at the time of the survey.

Table 49: Currently Using Family Planning

	Frequency	Percent
Yes	134	44.8
No	165	55.2
Total	299	100.0

3.4.6.5 Family Planning Techniques in Use

The choice of contraceptive to prevent pregnancy varies across the divide. The table below outlines what kinds of methods the women adopted in attempts to prevent pregnancy. The study revealed that the most favourite method applied by the women is the injection with 59% of the respondents using this method. This was followed by the Pill with 8.1%. Tying in third position are LAM and observance of the monthly cycle calendar. In each of these methods, 6.2% of women were using the methods. The survey further stated that 3.7% used Norplant method while IUD was embraced by the least of all, at 1.9%. About 11.2% of the respondents declined to comment on the matter.

Table 50: Family Planning Techniques in Use

	Frequency	Percent
Female Sterilization	6	3.7
IUD	3	1.9
Injection	95	59.0
Norplant	6	3.7
Pill	13	8.1
LAM	10	6.2
Calendar	10	6.2
Non Response	18	11.2
Total	161	100

3.4.6.6 Reasons for Not Practicing Family Planning

The women who were not and had never used family planning were asked to indicate the reasons thereof. The most popular reason (held by about 19.4%) was that contraceptives had side effects. The need of the women to have many children also was cited by 17.6% of the women respondents. Ignorance of what family planning entailed led to its avoidance by 8.5% of the women while religious and cultural practices prohibited 6.7% of the women.

Table 51: Reasons for Not Practicing Family Planning

	Frequency	Percent
We want to have many children	60	17.6
I do not know about family planning	29	8.5
Contraceptives are not available in the area	7	2.1
My religion/culture prohibits use of contraceptives	23	6.7
Contraceptives have side effects	66	19.4

3.4.6.7 Comparison of Final Evaluation with Baseline Values

The table below provides a comparison of the findings of the evaluation versus those of the baseline.

Table 52: Comparison of Final Evaluation with Baseline Values

Variable	Responses	Baseline Frequency	Baseline Percentage	Final Frequency	Final Percentage
Knowledge about family planning	Heard	228	92.3	299	87.7
	Never heard	18	7.7	42	12.3

Ever used of FP methods	Ever used	88	35.8	161	53.8
Current users of FP methods (CPR)	Users	72	30.9	134	44.8
FP methods used by current users	Pills	35	49	13	8.1
	Depo-Provera injection	34	47	95	59.0
	Norplant	1	1	6	3.7
	Calendar method	7	10	10	6.2

3.4.7 HIV/AIDS

One of the most important prerequisites for reducing the rate of HIV infection is accurate knowledge of how HIV is transmitted and strategies for preventing transmission. Correct information is the first step toward raising awareness and giving women people the tools to protect themselves from infection.

Misconceptions about HIV are common and can confuse women and hinder prevention efforts. Different regions are likely to have variations in misconceptions although some appear to be universal (for example that sharing food can transmit HIV or mosquito bites can transmit HIV). The UN General Assembly Special Session (UNGASS) on HIV/AIDS called on governments to improve the knowledge and skills of its citizen to protect them from HIV. The indicators to measure this goal as well as the MDG of reducing HIV infections by half include improving the level of knowledge of HIV and its prevention, and changing behaviors to prevent further spread of the disease. The HIV questions were administered to women aged 16 years and above to test HIV awareness, knowledge, prevention, treatment, level of stigmatization and testing.

3.4.7.1 HIV/AIDS Awareness

When asked whether they had heard about HIV/AIDS or not, 84.4% of the respondents did know about the illness, while 13.5% had never heard about it. About 2.1% of the interviewed women did not comment on the matter. A red alarm is sounding over the members of the population who have never heard of the virus as indicated in the Table below.

Table 53: Ever Heard of HIV/AIDS

	Frequency	Percent
Yes	325	84.4
No	52	13.5
Non Response	8	2.1
Total	385	100.0

3.4.7.2 Source of information on HIV/AIDS

The research investigated further where those respondents who are aware of the infection heard it from. As outlined in the table hereunder, the community meetings had the highest score of 50.2% of the respondents. Next were the health centres and health posts. It was voted for by 37.2% of the respondents. Community health volunteers were also a source as stated by 28.3% of the women. Radio/Television played a contribution too in enlightening the masses on the illness to about 17.2% of the interviewed women. This information is presented in the table below.

Table 54: Source of information on HIV/AIDS

	Frequency	Percent
Peer/Friends	73	22.5
Radio/Television	56	17.2
Mosque/Church	12	3.7
Community Health Volunteers	92	28.3
Community Meetings	163	50.2
Health Post/Centre	121	37.2
School	29	8.9

3.4.7.3 Transmission of HIV/AIDS - Perceived Causes

Women were asked whether they knew of the causes of HIV transmission. The knowledge was tested by asking them to state at least three ways of transmission. Information on knowledge of HIV transmission is presented in the Table below. The three most stated methods of transmission included: sharing contaminated sharp objects like needles/other sharps with 87.1%; having unprotected sex with a HIV positive person at about 84%, and; exposure to infected blood at 45.5%. This information is provided in table below.

Table 55: Awareness of HIV/AIDS

n=325	**Frequency**	**Percent**
Exposure to infected blood	145	45.5
Mother to child - pregnancy	37	11.4
Mother to child - birth/delivery	32	9.8
Mother to child - breastfeeding	30	9.2
Any type of sex	68	20.9
Unprotected sex with HIV positive person	273	84.0
Sharing contaminated sharp objects like needles/ other sharps	283	87.1
Person can get HIV from mosquito bites	7	2.2
Can get infected with HIV through Witchcraft	2	0.6
As a result of sinning	2	0.6

3.4.7.3 Awareness on HIV/AIDS Prevention

One indicator which is both an MDG and UNGASS indicator is the percentage of women who have comprehensive and correct knowledge of HIV prevention and transmission. Women were asked whether they knew of the main ways of preventing HIV transmission – having only one faithful uninfected partner and using a condom every time one had sex. Promoting safer sexual behaviour is critical for reducing HIV prevalence. The use of condoms during sex, especially with non-regular partners, is particularly important for reducing the spread of HIV. Information on knowledge of preventing HIV transmission is presented in Table below.

The women intimated that indeed people can reduce getting the Aids virus by having just one sex partner who has had no sex partner with about 80.6%. Another 12.6% thought that this was not a method to reduce HIV/AIDS. About 6.8% of the mothers did not know whether this clause is true or not. Almost 43.7% of the women do believe that proper use of condoms during sex can reduce the infection of AIDS. About 24.9% of them indicated that the use of condoms could not prevent HIV/AIDS transmission and another 31.4% didnt know. On whether people can prevent themselves from getting the AIDS virus by abstaining from sex, about 77.8% of the respondents responded affirmatively to the statement. Another 18.8% denied this statement while, 3.4% of those interviewed did not know.

Table 56: Awareness of HIV/AIDS Preventive Measures

Preventive Measures (n=325)	Yes	No	Don't Know
Can prevent AIDS by having one uninfected partner who has no other partners	80.6	12.6	6.8
Can people reduce their chance of getting the AIDS virus by using a condom properly every time they have sex?	43.7	24.9	31.4
Can people prevent themselves from getting the AIDS virus by abstaining from sex?	77.8	18.8	3.4

3.4.7.4 HIV/AIDS Misconceptions

This section presents the percentage of women who could correctly identify misconceptions concerning HIV/AIDS. The indicator is based on the two most common and relevant misconceptions, that HIV can be transmitted by supernatural means and mosquito bites. The table also provides information on whether women know that HIV cannot be transmitted by sharing food, and the possibility for a healthy looking person to have AIDS virus.

Of the interviewed women, only 9 per cent thought that HIV/AIDS can be transmitted through witchcraft and supernatural means, while almost 77 percent of them do not believe in supernatural power influence over the spread of the disease. About 14% of the respondents did

not know whether or not witchcraft or other supernatural powers can get a person infected with the virus. Of the interviewed women in the Kebeles, 38.2 per cent rejected the common misconception that a person can get HIV from mosquito bites while 37.8% were of the view that mosquitoes can trnasmit HIV/AIDS.

A large majority of the women (79.7%) indicated that one cannot get HIV/AIDS by sharing food with a person who has the aids virus. A slight 10.5% of the women however believed that sharing food with an infected person can transmit the disease to an uninfected person. About 9.8% of the women do not know whether this could happen or not.

When asked whether skin contact like a handshake with an infected person can pass the virus, 81.4% of the women indicated that this cannot happen. Only 9.9% of them thought that skin contact with an HIV/AIDS infected person can transmit the virus. Still, 9.3% of the respondents did not know the truth of the subject matter.

Of the interviewed women in the Kebeles, 55.7% believed that a healthy looking person cannot have the virus while a about 27.4% were of the view that a healthy-looking person can be infected with HIV/AIDS. Another 16.9% didnt know whether this was possible or not.

Table 57: HIV/AIDS Misconceptions

	Yes	No	Don't Know
Can get infected with HIV through Witchcraft or supernatural means	8.9%	76.9%	14.2%
Can a person get HIV from mosquito bites	37.8%	38.2%	24%
Can get AIDS virus by sharing food with a person who has AIDs virus	10.5%	79.7%	9.8%
Can a healthy looking person have AIDS virus	27.4%	55.7%	16.9%
Can people get the aids virus by skin contact e.g. shaking hands with a person who has the aids virus?	9.9%	81.4%	9.3%

Details on knowledge of mother-to-child HIV transmission are presented in the table below. Knowledge of mother-to-child transmission of HIV is an important first step for women to seek HIV testing when they are pregnant to avoid infection of the baby. Women should know that HIV can be transmitted during pregnancy, delivery, and through breastfeeding.

Overall, 54.2 per cent of women knew that HIV could be transmitted from mother to child during pregnancy 56.9% during delivery and 56.9% during breastfeeding as indicated in the Table below.

Table 58: Awareness of Mother-to-Child Transmission

	Yes	No	Don't Know
During Pregnancy	54.2%	20.3%	25.5%
During Delivery	56.9%	16.6%	26.5%
By Breastfeeding	56.9%	13.5%	29.5%

3.4.7.5 Attitudes towards Those with HIV/AIDS (Stigmatization)

The indicators on attitudes toward people living with HIV measure stigma and discrimination in the community – and gauge the care, support and protective environment available to the population living with HIV/AIDS. Stigma and discrimination are low if respondents report an accepting attitude on the following four statements:

i) I would buy fresh vegetables from a vendor who is HIV positive;
ii) A female teacher who is HIV positive should be allowed to teach in school;
iii) I would not keep HIV status of a family member a secret.

Information on attitudes towards people living with HIV/AIDS is presented in the table below. Among women who have heard about HIV/AIDS, only 54.2% who agreed that a teacher with AIDS virus should be allowed to continue teaching while about 31.7% did not support this. About 51.7% would not buy food from a shopkeeper or a food seller who has HIV/AIDS. Over 45 per cent reported that if a family member was sick with HIV/AIDS they would want to keep it a secret. The information is indicated in the table below:

Table 59: Attitudes towards People Living With HIV

	Yes	No	Don't Know	Total
A teacher with AIDS virus should be allowed to continue teaching	54.2%	31.7%	1%	100 %
Would buy food from a shopkeeper or a food seller who he/she knows has HIV/AIDS	42.1%	51.7%	6.8%	100%
If a member of a household had AIDS would you keep it a secret	45.2%	49.2%	5.6%	100%

3.4.7.6 Knowledge and Practice in Regards to HIV/AIDS Testing

Another important indicator is the knowledge of where to be tested for HIV and use of such services. Voluntary counseling and testing (VCT) is now acknowledged as an effective strategy for HIV prevention. HIV testing through VCT or in clinical settings is essential for access to AIDS care.

In order to gauge the coverage of HIV testing, the women were asked if they had ever been tested to see if they had the AIDS virus. Those who had been tested were asked whether they had received their results. Information on whether they have ever been tested is presented in the Table below. Only 44.6% of the respondents had been tested while the others had not been tested (55.4%).

Table 60: HIV/AIDS Testing Status among the Respondents

	Frequency	Percent
Yes	145	44.6
No	180	55.4
Total	325	100.0

3.4.7.7 Knowledge on where to go for HIV/AIDS Testing

The survey revealed that 27.7% of the respondents did not know the places where they could get tested, while 72.3% of them knew. The findings are outlined in the table below.

Table 61: Table Knowledge on where to go for HIV/AIDS Testing

	Frequency	Percent
Yes	235	72.3
No	90	27.7
Total	325	100

3.4.7.8 Comparison of Final Evaluation with Baseline Values

The table below provides a comparison of the findings of the evaluation versus those of the baseline.

Table 62: Comparison of Final Evaluation with Baseline Values

Variable	Responses	Baseline Frequency	Baseline Percentage	Final Frequency	Final Percentage
Awareness of HIV/AIDS	I have heard	221	89.5	325	84.4
	I haven`t heard	25	10.5	52	13.5
Knowledge on mode transmission of HIV/AIDS	Unprotected sex	190	77.2	273	84.0
	Mother to child	14	5.7	37	11.4
	Sharp objects/materials	186	75.6	283	87.1
	Blood transfusion	45	18.3	145	45.5

Knowledge on prevention methods of HIV/AIDS	Abstain from sexual activity	104	42	253	77.8
	Loyalty to partner	128	52	262	80.6
	Use condom	38	15	142	43.7
	PMTCT	13	5		54.2

3.4.8 Environmental Awareness

Environmental degradation is increasingly becoming a global concern. As such it was one of the objectives of the project. The project intended that about 26,829 villagers have increased environmental awareness and practice methods to mitigate environmental degradation. In order to achieve this objective, the project targeted to train 14 CBREAs, 30 Local government staff and 26,829 local villagers in environment awareness and protection. From the evaluation of documents, 110 CBREAs were trained; no local government staff was trained, and; 273,896 villagers were trained in environment awareness and protection. in order to protect the environment, 812 energy saving stoves were distributed and 180,110 seedlings were distributed to the local villagers for planting. This information is contained in the table below

Table 63: Project Performance on Environmental Awareness and Protection

Activity	Target	Achieved	% Achieved
Community Based Rural Environmental Agents (CBREAs) trained in environmental awareness and protection	14	110	785.7
Local government staff trained in environmental awareness and protection	30	0	0.0
Local villagers trained in environment awareness and protection.	26,829	273,896*	1020.9*
Energy - saving stoves purchased by villagers	800	812	101.5
Indigenous trees and fruit seedlings distributed	15,000	180,110**	1200.7**

*This figure is above the total population of all the Kebeles. It is an indication of people who attended the different sessions organized under this objective. There were a total of 6 sessions and one person could have attended all the sessions and counted again in these sessions and thus the high number of villagers presented.

**This high number of seedlings against target is attributed to the approach undertaken by the project to work together with the government whereby the government provided land while the project provided the seeds and labour. This result was also boosted by the compulsory environment week for all government officers which focused on conservation and protection.

3.4.8.1 Environmental Awareness Campaign Attended

All the women were asked to indicate whether they had attended any environmental awareness forum like seminars, workshops or meetings. About 74.8% indicated that they had attended while 25.2% indicated that they had not as indicated in table below.

Table 64: Attended Environmental Awareness Campaign

	Frequency	Percent
Yes	288	74.8
No	97	25.2
Total	385	100.0

3.4.8.2 Involvement in Environmental Conservation

It is the responsibility of every citizen to conserve the environment, and not to engage in any practices that result in environmental degradation of any sort. The women were asked whether they were involved in conserving the environment. About 60.5% indicated that they were involved in conserving the environment while 39.5% indicated that they were not involved as indicated in table below.

Table 65: Involvement in Environmental Conservation

	Frequency	Percent
Yes	233	60.5
No	152	39.5
Total	385	100.0

3.4.8.3 Level of Involvement in Environmental Conservation

Environmental conservation is a broad subject that entails a number of activities. The respondents were asked to indicate the activities they were involved in. About 58.2% of the residents conserved the environment by planting trees. Another 33.5% of the residents were involved in composting as well as in cleaning the surroundings. In terms on burning of rubbish as an environmental conservation method, 20.3% of the interviewed residents were involved in this activity.

Table 66: Level of Involvement in Environmental Conservation

	Frequency	Percent
Tree Planting	224	58.2
Composting	129	33.5
Cleaning surroundings	129	33.5
Burning rubbish	78	20.3
DK / Not sure	50	13.1

3.4.8.4 Harmful Practices

The women respondents were asked to indicate what they thought were the harmful environmental practices. The objective of this question was to test their knowledge levels of the same. About 89.1% of the women stated that deforestation was a harmful practice. Another 40.8% and 14% identified burning and overgrazing respectively as harmful practices to the environment. This information is presented in the Table below.

Table 67: Harmful Practices to the Environment

	Frequency	Percent
Deforestation	343	89.1
Burning	157	40.8
Overgrazing	54	14.0
Not sure	16	4.2

3.4.8.5 Source of Energy for Cooking

The most common source of energy for cooking in the community was wood as indicated by 78.2% of the respondents while 17.6% of them used straws, shrubs and grass. Animal dung and charcoal was used by 1.8% and 1.6% of the population respectively. Kerosene was the least used source of cooking energy with 0.8% of the respondents identifying it.

Table 68: Source of Energy for Cooking

	Frequency	Percent
Kerosene	3	0.8
Charcoal	6	1.6
Wood	298	78.2
Straws/shrubs/grass	67	17.6
Animal dung	7	1.8
Total	381	100.0

3.4.8.6 Knowledge about Energy Saving Stoves

Energy saving stoves help in environmental conservation by reducing the amount of charcoal and wood used for cooking. When asked whether they have heard about energy saving stoves, 81.7% of them responded to the affirmative. Only 18.3% of the interviewed mothers had never heard of energy saving stoves.

Table 69: Awareness of Energy Saving Stoves

Heard about Energy Saving Stoves	Frequency	Percent
Yes	308	81.7
No	69	18.3
Total	377	100

3.4.8.7 Possession of Energy Saving Stoves

Although 81.7% of the respondents have heard about energy saving stoves, only 21.8% of them had them against 78.2% as indicated in the table below.

Table 70: Possession of Energy Saving Stoves

	Frequency	Percent
Yes	67	21.8
No	241	78.2
Total	308	100

3.4.8.8 Existence of Energy Saving Stove

The research assistants were required to observe the existence of the stove among those who said they had. The research revealed that only 25.8% of the interviewed women from the community have observed the existence of the energy saving stoves. 74.2% have never seen the stoves work before.

Table 71: Observed Energy Saving Stove

	Frequency	Percent
Yes	56	83.5
No	11	16.5
Total	67	100.0

3.4.8.9 Comparison of Final Evaluation with Baseline Values

The table below provides a comparison of the findings of the evaluation versus those of the baseline.

Table 72: Comparison of Final Evaluation with Baseline Values

Variable	Responses	Baseline Frequency	Baseline Percentage	Final Frequency	Final Percentage
Source of energy for cooking	Firewood	245	99.6	298	78.2
	Charcoal	1	0.4	6	1.6
	Others	0	0.0	77	20.2
Heard about energy saving stoves	Heard	198	80.5	308	81.7
	Never heard	63	19.5	69	18.3
Harmful environmental practices	Deforestation	226	91.9	343	89.1
	Burning	63	25.6	157	40.8
	Overgrazing	43	17.5	54	14.0
Practiced composting	Practiced	187	76	129	33.5
Planted tree seedlings from ADRA	Planted	59	24	216	56.1
	Never planted	187	76	169	43.9

3.4.9 Women

This objective was intended to enhance the knowledge about relevant issues and problem-solving capacity through the formation of local women groups. The role of women in families and communities cannot be downplayed. This extends to their role in conflict and problem solving. ATJK WEHEA intention was to use women groups and intergenerational dialogue sessions to build the capacity of villagers and enhance their problem solving skills. The project had a target of establishing 17 women groups. Each of this group was expected to meet monthly. On the other hand, 51 IGD sessions were planned for the entire project time scope. Due to some government restrictions, women's group formation and meetings and Intergenerational Dialogue sessions (IGD) could not be held according to schedule as a result of a government circular ordering the suspension of all community-level meetings in the run-up to the election held in May 2010. Activities that were also perceived as "women empowerment" were politically very sensitive since the adoption of the "Charities and Societies Proclamation Law" (CSO law) adopted in January 2009, which criminalized among other things campaigning for gender equality. The project however changed tact on this objective and achieved some minimal results as indicated in the table below.

Table 73: Project Performance on Women Intervention

Activity	Target	Achieved	% Achieved
Women's groups are established (one in each village)	17	7	41.2
Women's groups meet on a monthly basis	612	15	2.5
Intergenerational dialogue (IGD) sessions are held annually in each Kebele	51	12	23.5

3.5 Efficiency (Cost Effectiveness)

This section tries to find out whether the available financial resources and other inputs were used in the most economical way to achieve desired results. It will also address whether there were any opportunities that existed between projects that could have improved resource use. It is important to note that the discussion here does not address issues that can or could be addressed in a financial audit.

From interviews conducted and documents analyzed it was evident that funds were disbursed in a timely manner to ADRA Ethiopia. However, at the project level, there were some delays in disbursing funds from the head office. In terms of financial management, ADRA Ethiopia had a financial system that ensured the use and accountability of financial resources and as such the budgeted and provided funds were used accordingly.

Most of the project objectives were to be achieved through the use of community-owned resources (for example, labour, building materials, etc) and resource persons (CBREAs and CBRHAs) as well as government officers. This was a very efficient way to achieve desired results by empowering government officers and community resource persons who would in turn reach the different target groups within the Kebeles. Even in the long term, any skills and competencies acquired by the government officers and community resource persons would benefit the society wherever such officers and community members were posted or worked. It would have not been possible for the project officers to do so directly and thus the strategy chosen was the most appropriate.

The project had a lean staff composed of the project manager, a project officer, accountant and a monitoring and evaluation officer. While these were the staff proposed and utilized in the project, it was noted that the geographical scope of the project would have required perhaps an additional project officer. This was also identified in interviews with staff where gaps of performance and or follow-ups with some interventions and beneficiaries were limited by the staff compliment.

Though the project had an M&E officer, there was limited in-field monitoring. The project did not have an M&E plan. However, as mentioned before a needs assessment had been undertaken before inception. This was followed by a baseline and a midterm evaluation. There were annual reports generated and submitted to the donor as required. Findings from the evaluation activities were used to inform planning and reorient the project towards achievement of its goals.

There existed a good relationship between the Addis office and the project office. However there were some gaps that would have been addressed for better performance. From interviews with project staff, they felt that the Addis office did not support them adequately in terms of feedback giving especially after submission of quarterly and annual reports. Also, as mentioned before, the process of releasing funds and replenishing petty cash took long. This affected the working of the project officers.

In terms of relationships with key stakeholders, the project developed and maintained the same. There was a good working relationship between the project and the Head of the District, the heads of the Kebeles, and heads of various government ministries in the Woreda including Water, Health, Environment, Agriculture and Education. This was evidenced by the various officers interviewed during the evaluation.

3.6 Impact

The ATJK WEHEA project had attained remarkable results and impacts in the area of operation. It contributed to the achievement of a number of outcomes that supported various national and

global targets. Some of the immediate impacts as previously discussed are presented in the table below:

Table 74: Project Impacts per Objective

Outputs	Target	Achieved	% Achieved
Objective 1: 3,414 people in ATJK have access to potable water			
No of villagers with access to potable water	3414	3632	106.4
Deep-water wells rehabilitated	2	2	100.0
Water committees established and trained in maintenance	2	2	100.0
Objective 2: 600 students (grades 1-4) have access to basic education in 3 separate kebeles in ATJK district			
Students with access to basic education in 3 separate kebeles	600	694	115.7
School building committees established	3	3	100.0
School buildings constructed	3	3	100.0
Objective 3: 26,829 local villagers have increased knowledge in basic health, hygiene and family planning, and practice methods of improved sanitation, health and hygiene			
Community Based Rural Health Agents (CBRHAs) trained in health promotion	35	35	100.0
Local government staff trained in health promotion, HIV/AIDS prevention and awareness	30	30	100.0
Local villagers trained in basic health & hygiene issues and family planning	26829	490908[5]	1829.8
VIP latrines provided	100	100	100.0
Local Traditional Birth Attendance trained in TBA training including HIV/AIDS awareness	17	17	100.0
Objective 3: 26,829 villagers have increased environmental awareness and practice methods to mitigate environmental degradation			
Community Based Rural Environmental Agents (CBREAs) trained in environmental awareness and protection	14	110	785.7
Local government staff trained in environmental awareness and protection	30	0	0.0
Local villagers trained in environment awareness and protection.	26829	273896[6]	1020.9
Energy - saving stoves purchased by villagers	800	812	101.5
Indigenous trees and fruit seedlings distributed	15000	180110	1200.7
Objective 5: Women in 17 villages of ATJK have enhanced knowledge about relevant issues and enhanced problem-solving capacity through the formation of local women groups			
Women's groups are established (one in each village)	17	7	41.2
Women's groups meet on a monthly basis	612	15	2.5

[5] This number is excessively high due to multiple counting of seminar participants over the project period
[6] Refer to footnote 5

Intergenerational dialogue (IGD) sessions are held annually in each Kebele	51	12	23.5

In the education sector, through the construction of schools, the project impacted on school enrollments, retention and helped improve the quality of education. As evidenced in the visits and discussion with school committees, a notable increase in numbers was recorded due to availability of classrooms, desks and ablution blocks. With increased enrollment, retention and quality this would contribute to the empowerment of the households and thus improve on their livelihood.

In terms of water, the rehabilitated water wells provided households with clean water. This also helped reduce the distance to water points thus enabling families more time for other productive activities. It also meant that less time was used to fetch water and thus children were allowed to enroll and remain in school as a result as opposed to being removed from school to fetch water. The availability of clean water also ensured that the incidences of water borne diseases were reduced.

The project had an impact on basic health, hygiene and family planning. Through interventions in maternal health, HIV/AIDS and family planning, some of the households were now practicing methods that enabled them to live better lives. This was visible among the respondents. From the focus group discussions held the community members displayed an understanding of key hygiene issues as well as application of the same. With an informed community there is a likelihood of adopting better health practices whose impact on the family would be evident.

Increased levels of awareness and practices in environmental management also had an impact on the environment. Involvement in management of the environment through tree planting and use of energy saving stoves had an impact on arresting deforestation. The project had succeeded in the provision and usage of energy saving stoves. Such provisions were to have a long lasting effect in the families as they used the same on a daily basis. From interviews the families were able to indicate the extent to which they had reduced their fuel usage and thus demand for the same. This ensured that less wood was used. Some villagers had also resulted in use of alternative sources of fuel which were byproducts of a particular process, for example cow dung/animal waste and straw from farm produce which previously did not have such a use. The villagers indicated that as a result of the energy saving stoves, less time was used to search for cooking fuel. It can therefore be concluded that as a result, the saved time was utilized in farming and children who would have otherwise been engaged in search of firewood were able to attend school.

3.7 Sustainability

In this section, the various sustainability mechanisms adopted by ATJK WEHEA Project and their relevance are evaluated. The section also addresses the extent to which the project and

service delivery can continue once the support of an intervention has ceased. In pursuit of this, it is critical to develop an understanding of the concept of sustainability and its dimensions.

Sustainability can be viewed from different perspectives. It is defined differently by different people. It can be defined as *the continuation of community health or quality of life benefits over time*. Sustainability is a holistic concept – the ability to create lasting improvements in health and well-being for an extended period of time despite ongoing changes in funding sources, program models, service providers, community demographics and other factors. From this context, sustainability can be viewed in three ways: Financial sustainability, institutional/organizational sustainability and service sustainability. Long-term sustainability is about ensuring that the positive results that the project achieved are continued for years to come despite all of the changes that may occur in the environment in which ATJK WEHEA Project was operating.

3.7.1 Financial Sustainability

Financial sustainability looks at a long-term perspective to financing activities, cultivating multiple diverse sources of revenue to maintain financing at sufficient levels. It is about being able to generate sufficient income to meet operating payments, financial commitments and, where applicable, to allow growth while maintaining service levels. Although self-sufficiency is the ultimate goal, in the nearer term financial sustainability is the ability of a project to mobilize and efficiently use local and supplementary external resources on a reliable basis to achieve current and future target levels of project performance.

In terms of ATJK WEHEA water projects, financial sustainability was ensured through the community creating a common fund that was managed by water committees. The community members who utilized water from the projects paid a standard fee which went into the common fund. The funds collected were used for operating and maintenance expenses of the deep water wells. The project also saw some schools acquire some land for farming to support income generating activities for the schools. This led to growing of crops which, when sold, helped cover some of the school's operating expenses. The farming activities were also used to train pupils on effective farming practices.

3.7.2 Institutional/Organizational Sustainability

In order to ensure organizational sustainability, it was imperative for ADRA to build the capacity of the community members and government as well. This was partly influenced by the fact that at the completion of the project all equipment and buildings are owned by the community and/or government. Organizational sustainability ensures continuity of efforts towards achievement of the long-term goals of a project. This would ensure that the community owned the project. Community ownership leads to project support and development of community-owned structures to manage such projects.

ADRA helped create water and education committees who were in charge of the deep water wells and schools respectively. ATJK WEHEA also helped in setting up village committees in order to give ownership of the project to the villages. The village, water and school building committees in the Kebeles were trained and sensitized on their roles and responsibilities. The organizational strategy was also reinforced by the training and use of community volunteers in health and environment.

3.7.3 Service sustainability

Service sustainability means that the services provided, and/or the impact made, continue long after the original or primary donor funding is withdrawn. This can be achieved by building and sustaining a broad-based community support and by cultivating key champions within the communities. This to a very commendable extent was visible during the evaluations. ADRA worked with community structures to reach the grassroots and empowered them through capacity building. ADRA through its project officers trained community own resource persons (CORPs) on health and environment who in turn trained the community members. The CORPs included key champions and opinion shapers in the communities such as traditional birth attendants, community health workers, village health workers and government employees in education, health and environment. Such a strategy ensures community support and ownership of the interventions and would continue beyond the lifetime of the project.

Cardinal to service sustainability was the close and ongoing relationship ADRA had established with governmental offices which were involved in the project design, implementation and follow up during implementation. This was critical since some projects like education and health were handed over to the government. The activities related to health were taken over by the government's health units towards the end of the project. Similarly, the schools constructed were handed over to the government. As a service sustainability strategy, the government through the Education Department was mandated to assign teachers for the schools after the handover, and to pay their salaries and ensure that education was offered free of charge as outlined by the government strategy to meet the Millennium Development Goals.

3.8 Cross-Cutting Issues

3.8.1 Gender

By the nature of the project and its objective, a gender-sensitive approach was important. Though the project was more focused to offering services to women and children, the nature of the interventions ensured all were served. Apart from working with women groups to ensure reach of intervention, there were no defined strategies developed and implemented targeting specifically to the women and girl child. It could only be extrapolated that since the project worked with women groups at the community level, it was able to ensure that the marginalized gender were reached and provided with the intervention as required. Some but not all data was tracked by use of indicators disaggregated by gender.

A gender-based approach would require integrating gender dimensions into a project through the interventions and activities undertaken. This would require designing specific interventions to reach groups of men and women, according to their specific needs. As for design and impact, gender-sensitive indicators that capture gender related changes in society over time should have been developed.

3.8.2 Conflict Sensitivity

The project was in an area of relative peace. As it is said, the absence of war does not mean peace, it was then important to evaluate to what extent there was success in mainstreaming peace among community members. The project played a critical role in strengthening the "connectors" and weakening the "dividers" among social groups within the local community. Water resources can be a cause of conflict in most societies. However, the project provided water and empowered the community members to come together to contribute and own the water interventions. In this case, the water as a shared resource was more of a connector. The laying of water pipeline improved relations by connecting those who used the water. The same was seen in education and health where the supported facilities provided a point of meetings between the parents and children thus solidifying relationships. The women and village groups also provided connectors to those in the project area. Other elements of interest within the Kebeles that provided spaces for the community to work together included the tree planting occasions and the capacity building events organized by the ATJK WEHEA project staff.

Through the above mentioned, it can be seen that the project also contributed to weakening the dividers by addressing possible sources of conflict and strengthening the connectors. However, one of the dividers had been identified in the project design but was never successfully addressed. This was the age and generational gaps that existed within the Kebeles. While it was the intention of the project to have IDG discussions, the same was not possible due to government involvement and banning of the formation of women groups and therefore affecting the holding of the IDGs.

3.8.3 Climate or environmental impact

In terms of climate or environmental impact, the project did contribute to environmental protection as seen from its design and the activities undertaken. As discussed and enumerated elsewhere in this report, environmental protection was one of the objectives of the project. Planting of trees and avoiding degradation by cutting of trees was practiced. The projected supported planting of trees and enabled the community members to have energy saving stoves thus protecting the environment.

3.8.4 Strengthening of civil society

In terms of strengthening civil society, the project was able to achieve some mixed results. Through the implementation of the water and education interventions, community based committees in charge of water and education were formed and trained on their roles. However, as mentioned before, the interventions on women groups formation and functioning was affected by government directives on civil society organizations.

3.8.5 Coordination with government/other NGOs

As presented under the relevant sections, the ATJK WEHEA project was designed based on the priorities of the Government of Ethiopia and in broad support of the MDGs. The design and implementation of the project initiatives was done in close coordination with the Kebele Heads and government line ministries in the Woreda and Kebeles. The project team, though not incorporated in the project design, developed collaborations with other NGOs especially in terms of crises like disease outbreak in a Kebele. However, a more strategic approach should have been used in collaborating with other NGOs so that synergy could be achieved in the different activities that the NGOs were involved in.

3.8.6 Mainstreaming disability

Mainstreaming disability in the development agenda is a strategy for achieving equality for persons with disabilities and as espoused by the UNs goal of equality following the adoption of the Convention on the Rights of Persons with Disabilities. The project did not have a specific strategy or intervention towards disability. However by providing water, health and education interventions and facilities, ATJK WEHEA contributed to improving the lives of those who may have been disabled in the community.

SECTION FOUR: CONCLUSIONS AND RECOMMEDATIONS

4.1 Conclusions

4.1.1 Quality and Relevance of Design

On relevance it can be concluded that the design was of quality as it identified the most critical needs in the community and developed a strategy to address the same. The project in pursuit to address the needs identified, developed goals and objectives which were directly linked to the needs.

4.1.2 Effectiveness

The project was effective in its deliverables. Most of the stated objectives were met and where they were not was as a result of factors that the project could not control. Such was in the case of formation of women groups and undertaking IDGs. These two activities were affected by a government policy on groupings and civil societies.

Under education, the project achieved its goal of constructing 3 school buildings and establishing 3 school building committees in 3 different Kebeles. In terms of water interventions, the objective under water and sanitation was to ensure that about 3,424 beneficiaries in ATJK have access to potable water. This was to be achieved through the rehabilitation of 2 deep-water wells and ensuring that 2 water committees were established and trained in maintenance of the wells. In comparison to baseline values, the project increased the number of people sourcing their water from piped sources. More people were seen to walk shorter distances to water sources than at baseline. In terms of drinking water management, the findings indicated a worse off situation than compared to baseline. However, the use of pit latrines as a method of fecal disposal had improved from the baseline indicating that a lesser population was using open fields for defecation.

In health and hygiene, the project met its objectives in training the CBRHAs and local government staff in health promotion. At the final evaluation, more community members were recorded to have attended health and hygiene trainings, were washing hands before handling food and after using latrines and used soap for washing hands than at baseline.

In terms of maternal health, it can be concluded that most of thewomen sought antenatal care during their pregnancy from communty health workers and Health Extension Workers. However, over 90% of the respondents delivered at home with very few in health facilities. Family/neighbours and traditional birth attendants assisted most of the pregnant women in

delivering. This underscores the importance of TTBA as it seems that they were the most accessible to pregnant women. For vaccination, there was a slight increase in knowledge about EPI, vaccination status of children at the final evaluation compared to the baseline.

The evaluation also found out that most women used ORS for treating diarrhoea at the end of the evaluation compared to the baseline. Levels of knowledge on what causes diarrhoea had increased as well. Again most women were found to use less traditional medicine to treat coughs and more modern medicine as compared to baseline values.

In terms of family planning, there was a decrease in knowledge about family planning at final evaluation compared to baseline. However, the final evaluation recorded more of those who had ever used and currently using FP methods than baseline meaning that the Contraceptive Prevalence Rate (CPR) had increased to 44.8 from 30.9 at baseline.

The study also found that there was a slightly higher percentage of those aware of HIV/AIDS at the baseline than final evaluation. However, knowledge of the different modes of transmissions had increased. Knowledge on prevention methods of HIV/AIDS was remarkably high at final evaluation compared to baseline.

At the final evaluation fewer households were using firewood as compared to the baseline. This indicates a shift to other sources and supports the initiatives to educate the households on alternative sources of fuel and use of energy saving stoves. There were also an increased number of households that had planted trees at the end of the project.

4.1.3 Efficiency (Cost Effectiveness)

On efficiency, it can be concluded that there existed a robust financial system though some delays in funds disbursement from ADRA Ethiopia head office to the project office affected delivery of services. The project developed and used efficient methods like the involvement and empowering of CORPs as well as government officers. Though the project had an M&E officer, there was limited in-field monitoring which was not guided by any M&E plan.

4.1.4 Impact

The ATJK WEHEA project had attained remarkable results and impacts in the area of operation. It contributed to the achievement of a number of outcomes that supported various national and global targets including improvement in access, quality and retention of pupils in schools; more households with increased access to clean and safe drinking water; improved quality of life through family planning and health knowledge, and; environmental protection as a result of increased awareness on environmental management practices; among others.

4.1.5 Sustainability

In terms of sustainability, it can be concluded that the project achieved financial sustainability, institutional/organizational sustainability as well as service sustainability. This was based on its project design that considered sustainability and mainstreamed strategies to ensure the same in its implementation. Key to this was community and government involvement in design and implementation as well as capacity building of these two key stakeholder groups.

4.1.5 Cross Cutting Issues

On cross cutting issues, the project was deemed as being gender sensitive. It also contributed to conflict reduction by strengthening of connectors and reducing of the strength of dividers. There was contribution to climate/environmental impact through the various activities undertaken. However the project did not achieve its intended designs on the civil society and women groups as there were government restrictions on assembly.

4.2 Recommendations

Several recommendations can be drawn from the final evaluation:

- In programme implementation, there should be a well-articulated monitoring and evaluation framework in place. Tracking of results versus needs/objectives should also be at the 3 levels of a results chain (output, outcome and impact) as opposed to being at the output level only. Also the need to ensure that the indicators used are direct measures of results and that the same can be tracked over the project period based on the intervention.
- It is also recommended that any other initiatives to address issues of health and hygiene should consider strongly interventions focused on Behavioural Changes. This was due to the fact that there were efforts in capacity building the communities on various desired practices yet the changes were not so fundamental compared to the baseline values.
- The use of community-owned resource persons (CBRHAs and CBREAs) should be continued and strengthened due to the various advantages of such an approach. Strategies should be designed to enable them to commit more to the project intentions
- Working with the government ministries at the local levels should also continue. An ADRA Ethiopia fulfils its deliverables such as school construction, the government and community should be encouraged to take the schools to another level. This would include their contribution to more classes. Ideally, the government and community should be encouraged to match the contributions by ADRA.
- Since there still existed households with school going children at home, the project, in any similar undertaking should address the issues of school enrolment and attendance. They should focus on creating awareness on the importance of education and should devise a lobbying mechanism that involves the heads of Kebeles and other local leaders to sensitize parents on the need to afford their children education and discourage child livestock tendering.

- Since a majority of the households did not treat their water before drinking, it is recommended that the project should adopt a Hygiene Promotion strategy as well as creating awareness on the need to treat water. Though the community may not have resources to buy water treatment chemicals, local solutions could be promoted as alternatives.
- Similar projects on maternal health should focus on safe delivery with the help of trained health care personnel. As evidenced, most deliveries were at home with the help of a friend or relative. While they sought antenatal care from government health facilities, the same was not exhibited during delivery. Awareness should be created and enhanced in the need to have a professional assisting in the delivery.
- Though the contraceptive prevalence rate was found have increased from the baseline levels, there were still gaps in knowledge on the use of family planning and misconceptions on the same including the need for more children. There should have been more awareness on the reasons and techniques of family planning to address such gaps.
- Since most of the women had heard about HIV/AIDS, focus in similar projects should be on educating women on the various methods of transmission especially on knowledge of mother-to-child HIV transmission. Misconceptions on HIV/AIDS transmission and prevention should also be given extra attention as it was evident that the same existed within the project area.

APPENDICES

Appendix I: Terms of Reference

Final Evaluation

Terms of Reference (ToR) for the Final Evaluation Team

09NOR-DEV001

ATJK Water, Education, Health and Environmental Awareness Project (ATJK WEHEA)

I. CONTEXT

1.1 Project Background

Ethiopia still remains one of the poorest and most populated countries in Africa, with an estimated population of 78.3 million people (2008).[7] Approximately 83% of the people live in rural areas (2003)[8], where many of the most basic needs are unavailable to the average person. Poverty is uniformly distributed throughout the country's rural areas, and both the incidence and the severity of this poverty is higher in rural than in urban areas.[9]

The intervention region has an arid climate with a flat and poorly cultivated landscape. Owing to erratic rainfall (less than 600 mm per year) and subsistence farming, the area is predisposed to chronic food shortage. The main livelihood of people living in this harsh environment is breeding of livestock and the farming of maize, haricot beans and sorghum.

A needs assessment was carried out in March 2008 by ADRA Ethiopia in consultation with experts from different government line departments, and a number of problems and development gaps were identified. It was found that the most serious problem facing the people of Adami Tulu JidoKombolcha (ATJK) district continues to be the lack of potable water. In order to alleviate this problem, the government had drilled three deep wells in the proposed intervention area; however they lack water distribution points, water reservoir and cattle trough. One of them also lacked a motorized pump.

Besides the serious water shortage, the people of ATJK have limited access to education, their knowledge of basic health and hygiene is poor, HIV/AIDS is increasingly becoming a problem and their limited resources are steadily but surely diminishing. The average family lacks the capacity or ability to do much about their current situation and, unless well-planned assistance is provided, many of these people may face sickness, starvation and imminent death.

Deforestation is one of the main causes for the diminishing resources. Environmental degradation is a serious issue, due to the fact that no other energy source is available in the villages besides the firewood obtained by cutting down local trees. Many areas are stripped of vegetation, which causes problems such as erosion, reduction of biodiversity and climate change. Human waste is also having a detrimental effect on the environment. Fly-borne diseases from human feces cause widespread sickness and even death.

Furthermore, the women in the Oromiya region (where ATJK is located) are commonly victims of the female genital mutilation (FGM).[10] The culture of ATJK and neighboring districts is such that a young

[7] http://en.wikipedia.org/wiki/Ethiopia
[8] http://www.ruralpovertyportal.org/english/regions/africa/eth/statistics.htm
[9] http://www.ruralpovertyportal.org/english/regions/africa/eth/index.htm
[10] This traditional malpractice is supported by superstitious religious leaders, as well as the majority of old women and young boys,18.6% of which expressed the wish to marry a circumcised woman; 29.7% of mothers support that the practice should

girl is circumcised a couple of weeks before or after her wedding. The girls are around 15-19 years old when this procedure is performed.[11]

1.2 Project Objectives and Components

The timeframe of the project is from January 1st, 2009 to December 31st, 2011 (3 years). The total budget is ETB 5,278,662, and the funds were provided by Norad (Norwegian Agency for Development Cooperation) and ADRA Norway.

In the preliminary stages of the preceding project – *Integral Rural Community Development* (hereafter IRCD) – it had become clear that, to adequately address the main problems of the villages, interventions in several sectors had to be considered. If individuals lack basic needs such as food and water, for instance, they become less inclined to realize the importance of education and consider the long-term effects of deforestation. Thus people remain trapped in a poverty cycle, and no sustainable progress takes place. Based on this realization, the IRCD project was designed using an integrated approach, addressing the areas of water, education, health and environmental awareness.

In the above mentioned assessment carried out in March 2008 for the ATJK region, it was found that needs in these different areas still persisted: schools need to be built and equipped, the population lacks basic health care services, the vegetation continues to be destroyed for firewood consumption and, most critically, water shortage continues taking its toll on the health of the people. Thus the follow-on intervention pursued the same kind of holistic approach as the previous one, building on the experience and lessons learned obtained from the past.

The project targeted directly rural farmers and their dependents in seventeen kebeles, in a remote part of ATJK district. Part of this intervention region overlaps with that of the IRCD project, namely ten kebeles: ElelenAbabu, AdanshoBarmoto, LelisoDambbe, DanebeAdansho, AdanshoGogessa, ChituGeto, Rreji, Naka, Bara Hobicho, and Wolnbulla. In addition to those, seven further kebeles (where no previous intervention had taken place) were selected: QamoGarbi, AnanoShisho, WayissoCancarra, UrgoMecefera, AbayiiAdanaboo, Dodaichaa, and GolbaAluto. The total population living in the target area amounted as of the start date to 42,693 people, distributed equally among "old" and "new" kebeles.

The reasons for continuing the intervention in the ten "old" kebeleswere manifold: relative isolation as far as transport accessibility is concerned (which enhances vulnerability); the remoteness of the area implied very limited assistance from the government and other NGOs; the population was more spread apart, which implied less spillover effects and information flows, thus requiring a longer intervention to ensure sustainability; they were the most chronically food-insecure kebeles and are still enrolled in PSNP[12] program (as opposed to the others graduating away from it); they had very limited access to health services (women in need of any reproductive health service have to walk one day or wait for the infrequent public transport); finally, as far as environment is concerned, these kebeles were found to produce most charcoal for household and market consumption in ATJK.

The selection of the additional "new" kebeles was made based on geographical location (close proximity to the previous intervention area) and the fact that these kebeles are also in a remote part of the ATJK District, thus receiving limited assistance from the government and other NGOs.

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continue because it is "a good culture", as stated by 71.8%. (Source: survey conducted in a district neighboring ATJK called ArsiNegele&Shashemene, by ADRA Ethiopia's FGM prevention program, 2006; people in these two districts are of similar socio economic pattern.)

[11]The most common type of FGM is such that the clitoris is totally removed, as well as some tissue from the labia minora sometimes. About 87% of women in Oromiya are circumcised (Ethiopia, DHS 2005) (of which 2.5% are infibulations - the severest form with cutting of all clitoris, labia majora, labia minora and then sewing it back leaving only tiny opening for menses).

[12]PSNP is a government initiative targeting the most vulnerable communities focusing on building community assets and decreasing loss of assets at household level in times of crisis and shock. Most communities benefited from this intervention in the past three years and have already graduated out from the program.

The project is designed as follows:

Goal

Improved livelihood of 42,692 local villagers in Oromiya region in Ethiopia through improved health, education, environmental awareness and women with better problem-solving capacity

Objectives and outputs (refer to Appendix E – Logical Framework Matrix)

In aiming for the above goal, by the end of the project the following objectives will be achieved for the respective five project components (water, education, health and environmental awareness and women):

1. 9,831 in ATJK have access to potable water;[13,14]
2. 1,200 students (grades 1-4) have access to basic education in 3 separate kebeles in ATJK district;
3. 26,829 local villagers have increased knowledge in basic health, hygiene and family planning, and practice methods of improved sanitation, health and hygiene;
4. 26,829 villagers have increased environmental awareness and practice methods to mitigate environmental degradation;
5. Women in 17 villages of ATJK have enhanced knowledge about relevant issues and enhanced problem-solving capacity through the formation of local women groups.

By the end of the project the following results (outputs) will be achieved in each component:

Water:

1.c) 2 deep-water wells rehabilitated
1.d) 2 water committees established and trained in maintenance

Basic Education:

2.c) 3 school building committees established
2.d) 3 school buildings constructed

Health, Hygiene and Family Planning:

3.d) 35 Community Based Rural Health Agents (CBRHAs) trained in health promotion including HIV/AIDS awareness (only in the 7 "new" kebeles) and family planning
3.e) 30 local government staff trained in health promotion, HIV/AIDS prevention and awareness
3.f) 26,829 local villagers trained in basic health & hygiene issues and family planning
100 VIP latrines provided
3.d) 17 local Traditional Birth Attendance trained in TBA training including HIV/AIDS awareness

Environment:

4.f) 14 Community Based Rural Environmental Agents (CBREAs) trained in environmental awareness and protection
4.g) 30 local government staff trained in environmental awareness and protection
4.h) 26,829 local villagers trained in environment awareness and protection.
4.i) 800 energy-saving stoves purchased by villagers
4.j) 15,000 indigenous trees and fruit seedlings distributed

Women:

[13] About 1,670 of these beneficiaries reside outside the intervention area, in villages which neighbor the village where the wells will be rehabilitated.
[14] It is possible that the SPHERE standard of 15 liters/person/day may not be reached for those residents living farther away, which may collect only the amount needed for drinking and cooking purposes.

5.d) 17 women's groups are established (one in each village)
5.e) 17 women's groups meet on a monthly basis

17 intergenerational dialogue (IGD) sessions are held annually

II. EVALUATION GOALS AND ISSUES TO BE STUDIED

2.1 Final Evaluation

2.1.1 Evaluation's main goals:

i. Assess project performance at each level (activities, outputs, outcomes and goal) against the indicators set in the latest version of the logframe;

ii. Identify possible unexpected events of significant character (positive and/or negative) outside the project that have contributed to the project's progress or lack of progress;

iii. Investigate whether there were unexpected results (positive and/or negative) that were not part of the original project plan;

iv. Draw lessons learnt and/or describe relevant experiences that will result in a change of strategies/ methods in future interventions, and verify whether they are common to other local organizations engaged with the same thematic area/ beneficiary population;

v. Mention the evaluations that took place in the run-up to the project or during the project period, and identify the extent to which they resulted in changes/improvements to the project implementation or design;

vi. Describe and assess the cooperation between ADRA Ethiopia and ADRA Norway, esp. the latter's added value to the project; emphasize sharing of responsibility and work, dialog, meeting arenas and competence building of ADRA Ethiopia by ADRA Norway;

vii. Assess the plans for future intervention and make recommendations in light of the findings of the current evaluation.

2.1.2 Issues to be covered:

Besides clearly addressing these main objectives, the final evaluation will also include a comprehensive analysis of the project based on the following five fundamental criteria based on the OECD/DAC evaluation criteria (which may or may not overlap with the objectives laid out above): quality and relevance of design; effectiveness; efficiency of planning and implementation; impact; sustainability. The specific questions to be addressed are provided below. The inferences being draw must always be underpinned by sufficient analysis/justification.

Quality and Relevance of Design

1.a) To what extend were the objectives relevant to the needs of the beneficiaries?

Effectiveness

2.a) To what extent were the purposes of the project achieved? Refer to quantitative assessments as far as possible (baseline values and end-line values of the indicators). Include also qualitative assessments e.g. opinions on the project's effectiveness based on impressions and interviews with direct and indirect beneficiaries (both male and female), government employees, local leaders, community members etc.

2.b) What were the major factors influencing the achievement or non-achievement of each objective?

2.c) Describe any major failures of the project, explaining why they have occurred.

2.d) Describe any unforeseen impacts (whether positive or negative).

2.e) Identify any exceptional experiences that should be highlighted e.g. case studies, stories, best practice.

Efficiency of Planning and Implementation

3.a) Were activities cost-efficient?

3.b) Was the project implemented in the most efficient way compared to alternatives?

3.c) Did the project have the right HR skills, resources and systems in place to achieve the objectives?

3.d) Does the project have a good set of M&E plans? Was monitoring data collected as planned, stored and used to inform future plans?

3.e) How were working relationships within the team (including not only the project team but also the supporting staff from the Addis office)?

3.f) How were working relationships with stakeholders e.g. government offices, local leaders, community members etc.

Impact

4.a) To what extent has the project succeeded in improving family livelihood and reducing vulnerability of the beneficiary population?

4.b) Is there significant evidence of improvement in the overall health of the population? Do children enjoy better perspectives for the future due to improved access to/quality of education? Is there substantial awareness on issues of environmental protection? Do local women enjoy better capacity to solve their daily problems?

Sustainability

5.a) What is the social and political acceptance of the project?

5.b) To what extent are the benefits of the project likely to continue after donor funding ceased?

5.c) What were the major factors which influenced the achievement or non-achievement of sustainability of the project?

2.1.3 Cross-cutting issues:

- *Gender*: did the project pursue a gender-sensitive approach?
- *Conflict sensitivity*: did the project succeed in strengthening the "connectors" and weakening the "dividers" existing among social groups within the local community? Did the project inadvertently cause any tensions, or did it contribute to further peace and harmony among people in or around the intervention area?
- *Climate or environmental impact*: did the project make any direct or indirect contribution to environmental protection? If so, how? Were there any negative environmental impacts of the project?
- *Strengthening of civil society*: did the project contribute to the strengthening of civil society (in the local community or at a higher level)? If so, how?

- *Coordination with government/other NGOs*: did the project fit with the government's priorities and official plans and goals? Did ADRA Ethiopia, particularly the project team, seek to cooperate and coordinate efforts with other NGOs active in the same intervention area?

2.2 Intended use of results

The most straightforward use of the evaluation results is expected to be in terms of future project design and implementation, particularly of follow-up projects in the same geographical and/or thematic area. The evaluation report is likely to be accessed mostly by ADRA Ethiopia and ADRA Norway; nevertheless it will be made available to all interest parties.

In this sense the report will also be used as a key accountability tool, not the least to the main project donor, namely Norad, which will post it on its website for free download. Thus the results will potentially achieve a broader public and be useful to other NGOs engaged in similar areas of work.

2.3 Comments on the ToR

For the purpose of improving ADRA Norway's and ADRA Ethiopia's skills on drafting ToRs, the evaluation team should include in the final report a section with comments on the current ToR, taking into account the following aspects: Were the objectives of the evaluation and issues of interest formulated in a clear way? Is the ToR internally consistent? Were there important issues that the ToR was silent on? Were there any redundancies? Were there any sections missing? Were the resources allocated for the evaluation (timeframe, HR and budget) sufficient to appropriately address the issues raised by the ToR?

III. EVALUATION PRINCIPLES

The evaluation will be guided by the following ethical rules/considerations:

- *Openness* – of information given, to the highest possible degree to all involved parties;
- *Publicity/public access* – to the results when there are not special consideration against this;
- *Broad participation* – the interest parties should be involved when relevant/possible;
- *Reliability and independence* – the evaluation should be conducted so that findings and conclusions are correct and trustworthy.

IV. METHODOLOGY AND ACTIVITIES

The final evaluation will rely on a quantitative survey and qualitative methods, counting with the involvement of the main project stakeholders. Specifically, the following main activities will be carried out (this list is not necessarily chronological, nor exhaustive, and should be adapted by the evaluation team as needed):

3.1 Review of project documentation: Review, as necessary, basic project documents (Norad and ADRA project proposals, logframe, budget and M&E plan), DIPs, quarterly narrative and financial reports, audit reports, final evaluation of preceding project (IRCD), midterm evaluation report, MoU with the Ethiopian government, government's policy documents, key written communication between ADRA Ethiopia and ADRA Norway/ Ethiopian government and other documents seen as relevant for understanding the project and its outcomes.

3.2 Preparation: At a preliminary phase, the evaluation team will perform thorough stakeholder identification and develop survey questionnaires, qualitative evaluation tools for focus group discussions (FGDs) and key informant interviews (KIIs). Examples of stakeholders are: ADRA

Ethiopia's staff members, government offices (e.g. ministry of health, local government etc.), local community members and representatives etc. The evaluation team will also develop a detailed plan for the evaluation, including activity schedule.

3.3 Quantitative survey, field visits, focus group discussions (FGDs) and key-informant interviews (KIIs): (i) Random sampling and implementation of the survey; *in situ* visit of the project for observation and inspection of activities and outputs (pictures should be taken if necessary); (ii) In-depth interviews with key informants identified by the evaluation team; (iii) Focus-group discussions with key stakeholders or groups. Selected groups may be invited to more in-depth discussions, triggered by using visual/ PRA (participatory rural appraisal) tools such as Venn diagrams, matrix and ranking. "Most significant change (MSC)stories" constitutes a further qualitative evaluation method that may be used.

3.4 Data analysis and drafting of the final evaluation report

V. DELIVERABLES AND TIMELINE

4.1 Deliverables

The following outputs are to be delivered by the evaluation team:

- *Preparation documents*: main documents that used to guide the evaluation process and specific activities, specifically stakeholder analysis, evaluation tools for selected FGDs and KIIs, evaluation plan and activity schedule.
- *Oral/Power Point presentation*: the evaluation team will present to the management and key staff of ADRA Ethiopia the main preliminary findings, conclusions and recommendations.
- *Final evaluation report*

  The content of the report should include at minimum:

  - ✓ Executive summary
  - ✓ Summary of project/project activities
  - ✓ Evaluation methodology
  - ✓ Results and findings
  - ✓ Discussion, including lessons learned
  - ✓ Conclusions and recommendations
  - ✓ Comments on the ToR

  The appendices should include, besides other pertinent technical or supporting documentation, the following:

  - ✓ The final evaluation team's ToR
  - ✓ A list of places visited
  - ✓ A list of documents reviewed
  - ✓ A list of persons interviewed
  - ✓ Data collection instruments
  - ✓ Pictures with observable changes

4.2 Timeline (tentative)

Phase	Main Activities

Desk research and pre-mission	Review of documents
Planning and Preparation	Stakeholder analysis, development of evaluation tools and of the evaluation plan and activity schedule for the field research
Field research	Implementation of survey, project visit to assess project performance, carry out FGDs, KIIs etc.
Data analysis	Evaluation team analyzes main findings, identify critical issues, outlines main conclusions and recommendations and develops an action plan
Debriefing	Oral presentation to ADRA Ethiopia management and key staff, discussing the preliminary findings of the evaluation
Submission of draft evaluation report	Evaluation team submits the draft report to ADRA Norway for appraisal
ADRA Norway provides feedback to the report	
Evaluation team submits final draft report	

VI. EVALUATION TEAM COMPOSITION AND QUALIFICATION

External consultant: Responsible for conducting the evaluation and drafting the report, according to the terms established by the current ToR. The external evaluator will have to collaborate with local assistants in terms of data collection and will receive support and information from the local project manager as well as the programs director. The external evaluator may also communicate and collaborate to a certain extent with the project desk officer in ADRA Norway.

The evaluator should have the following qualifications:

a) Experience conducting evaluations in the development sector and preferably of similar community development projects;
b) Experience with measuring qualitative results linked to WASH, education, health and HIV/AIDS and environment;
c) M&E field project experience;
d) Knowledge of the situation in Ethiopia and preferably work experience from Ethiopia;
e) Preferably some prior knowledge of ADRA's work;
f) Fluent in English (oral and written).

Assistant:
ADRA Ethiopia will provide at least one assistant from the program department to assist the evaluator in collection and documentation of data from the interviews, group discussions, collecting MSC stories, and providing any other assistance needed by the evaluator to facilitate his/ her task.

The assistant should have the following qualifications:

a) Background in development projects including literacy, HIV/AIDS, micro credit;

b) Relevant Bachelor degree;
c) Microsoft Office software knowledge;
d) Locally based;
e) Preferably previous experience with evaluations;
f) Fluent in English (oral and written).

Translator:
The translator will translate from the local language(s) to English and vice-versa if the evaluator is not from Ethiopia. The translator will accompany the evaluator in the field to interview beneficiaries of the project.

ADRA Ethiopia:
ADRA Ethiopia will be responsible for providing all the required information and documents to the evaluator. The project manager will also assist the evaluator in terms of logistics (accommodation, transport, visa, etc.), will identify and hire a translator if needed, and help in setting up the interviews. ADRA Ethiopia will provide the working space for the evaluator during his stay.

Appendix II: Data Collection Instruments

ATJK WATER, EDUCATION, HEALTH AND ENVIRONMENTAL AWARENESS (ATJK WEHEA) PROGRAMME
HOUSEHOLD SURVEY

Informed Consent

Hello. My name is _____. I am working with the ATJK Water, Education, Health and Environmental Awareness (ATJK WEHEA) programme team of ADRA in this area. We are conducting a survey of households in this area In order to get more information about WEHEA issues in your Kebele. Your household has been selected by chance from all households in the area. The information you provide will be useful to find out the status of quality of life in your Kebele, and will be used to plan future programs in this area and also in the country.
Participation in the survey is voluntary, and you can choose not to take part. All the information you give will be confidential.

If you have any questions about the survey, you can ask me, my survey field supervisor who is here with the survey team, or one of the development workers at ADRA in Ethiopia. At this time do you have any questions about the survey?

INSTRUCTIONS:

1. Ask the following questions the women head of the household in reproductive age group (15-49 years of age). In polygamous family it is only the wife in reproductive age group (15-49 years) who lives in the selected house who should be asked.
2. Please circle in the number next to the selected option
3. For open ended questions, please write down the response using the respondent words and a clear handwriting
4. In questions where multiple answers are possible, circle all the identified options

Start time:_____ **End time:** _____
Kebele:_____ **Date** _____

Interviewer Name:_____ **Signature:**_____

Supervisor Name:_____ **Signature:**_____

HOUSEHOLD LISTING FORM

FIRST, PLEASE TELL ME THE NAME OF EACH PERSON WHO USUALLY LIVES HERE, STARTING WITH THE HEAD OF THE HH.

(Use survey definition of HH member). List the first name in line 01. List adult HH members first, then list children. Then ask: ARE THERE ANY OTHERS WHO LIVE HERE, EVEN IF THEY ARE NOT AT HOME NOW? (THESE MAY INCLUDE CHILDREN IN SCHOOL OR AT WORK*). If yes, complete listing. Then, ask and record answers to questions as described in Instructions for Interviewers.*

Add a continuation sheet if there is not enough room on this page. Tick here if continuation sheet used ☐

Line no.	**101.** *Name* *Kindly tell me what are the names of the members of the HH (first names are sufficient)* **Make a list of all names before asking other questions**	**102.** *What relationship is (name) to the head of HH* 1 HEAD 2 SPOUSE 3 CHILD≥5 YEARS (GREATER THAN 5 YEARS) 4 CHILD<5 YEARS (LESS THAN 5 YEARS) 5 RELATIVE 6 OTHERS	**103.** IS (*name*) MALE OR FEMALE? 1 MALE 2 FEMALE	**104.** HOW OLD IS (*name*)? (INDICATE WHETHER AGE IN YEARS OR MONTHS) 99=DK*	**105.** ***For persons age 15 or over*** WHAT IS THE MARITAL STATUS OF (*name*)? 1= MARRIED , 2= WIDOWED , 3= DIVORCED, 4= SEPARATED, 5= NEVER MARRIED	**106.** **WHAT IS THE HIGHEST LEVEL OF SCHOOL (name) ATTAINED? (FOR HOUSEHOLD MEMBERS OVER 7 YEARS)** 1= NEVER BEEN TO SCHOOL 2= GRADE 1 – 4 3=GRADE 5 – 8 4=GRADE 9 – 10 5= GRADE 11 – 12 6= COLLEGE OR HIGHER 7= ADULT LITERACY CLASSES
LINE	NAME		M F		M W D S N	
01		1 2 3 4 5 6	1 2		1 2 3 4 5	1 2 3 4 5 6 7
02		1 2 3 4 5 6	1 2		1 2 3 4 5	1 2 3 4 5 6 7
03		1 2 3 4 5 6	1 2		1 2 3 4 5	1 2 3 4 5 6 7
04		1 2 3 4 5 6	1 2		1 2 3 4 5	1 2 3 4 5 6 7
05		1 2 3 4 5 6	1 2		1 2 3 4 5	1 2 3 4 5 6 7
06		1 2 3 4 5 6	1 2		1 2 3 4 5	1 2 3 4 5 6 7
07		1 2 3 4 5 6	1 2		1 2 3 4 5	1 2 3 4 5 6 7
08		1 2 3 4 5 6	1 2		1 2 3 4 5	1 2 3 4 5 6 7
09		1 2 3 4 5 6	1 2		1 2 3 4 5	1 2 3 4 5 6 7
10		1 2 3 4 5 6	1 2		1 2 3 4 5	1 2 3 4 5 6 7

EDUCATION		ED
*This module is to be administered to all women with children of age 7 – **18 years***		
ED1. HOW MANY OF YOUR CHILDREN BETWEEN 7 – 18 YEARS ARE IN SCHOOL?	_____	
ED2. ARE THERE ANY OF YOUR CHILDREN BETWEEN 7 – 18 YEARS WHO ARE NOT IN SCHOOL?	Yes ..... 1 No..... 2	1⇨ED3 2⇨ED4
ED3. WHAT ARE THE REASONS MAKING THEM NOT ATTEND SCHOOL? *MULTIPLE ANSWERS POSSIBLE*	DISTANCE FROM SCHOOLS……A NO SCHOOLS IN THE AREA……B DOMESTIC DUTIES……C MARRIAGE……D FAMINE/ LACK OF FOOD……E LACK OF MONEY……F ILLNESS……G LOOKING AFTER LIVESTOCK……H PARENTS NOT INTERESTED – NO NEED……I PASSAGE RIGHTS (EG FEMALE GENITAL MUTILATION AND BOY'S CIRCUMCISION)…… ..J PREGNANCY……K Other (specify)_____	
ED4. DO YOU HAVE ANY CHILD WHO HAS DROPPED FROM SCHOOL?	Yes ..... 1 No..... 2	1⇨ED5 2⇨ED6
ED5. IF THERE ARE ANY DROPOUTS FROM SCHOOL, WHAT ARE THE REASONS?	PASSAGE RIGHTS (EGFGM AND BOY'S CIRCUMCISION)……A POOR ACADEMIC PERFORMANCE……B IT'S A WASTE OF TIME……C POOR HEALTH……D LACK OF FEES……E LACK OF SAFETY FOR GIRL……F TO GET MARRIED……G PREGNANCY……H Other (specify)_____	
ED6. HOW LONG DOES IT TAKE TO REACH THE NEAREST **ELEMENTARY** SCHOOL? (PROVIDE DISTANCE IN TIME AND KILOMETERS) ***1 HOUR = 4 KILOMETRES***	Less than half hour ..... 1 One hour ..... 2 Two hours ..... 3 Three hours..... 4 Four hours or more (specify)..... 5 Approximate Distance:_____KMs	
ED7. DO YOU HAVE A CHILD IN A **PREPARATORY**SCHOOL?	Yes ..... 1 No..... 2	1⇨ED8 2⇨next module
ED8. IF YES IN WHICH PREPARATORY SCHOOL IS YOUR CHILD?		

WATER AND SANITATION				WS
WS1. WHAT IS THE **MAIN** SOURCE OF DRINKING WATER FOR MEMBERS OF YOUR	**SEASON**	**WET**	**DRY**	
	Public tap / standpipe	1	1	

HOUSEHOLDDURING THE WET AND DRY SEASONS?	Borehole 2 2 Protected well 3 3 Unprotected well 4 4 Rainwater collection 5 5 River/stream 6 6 Dam/lake 7 7 Pond 8 8	
WS2. WHAT IS THE **MAIN** SOURCE OF WATER USED BY YOUR HOUSEHOLD FOR OTHER PURPOSES SUCH AS COOKING AND WASHING CLOTHES DURING THE WET AND DRY SEASONS? OTHER (*SPECIFY*) _____	SEASON / WET / DRY Public tap / standpipe 1 1 Borehole 2 2 Protected well 3 3 Unprotected well 4 4 Rainwater collection 5 5 River/stream 6 6 Dam/lake 7 7 Pond 8 8	
WS3. HOW OFTEN DO YOU FETCH WATER FOR THE HOUSEHOLD USE DURING THE WET AND DRY SEASON?	SEASON / WET / DRY Once Daily 1 1 More than twice daily 2 2 Every two days or more 3 3 Others: _____	
WS4. HOW DO YOU GET THE WATER TO YOUR HOUSEHOLD?	Carry on back ..... 1 Animal Cart ..... 2 Other (*specify*)_____	1⇨WS5 2⇨WS6
WS5. IF ON BACK, HOW LONG DOES IT TAKE TO GO THERE, GET WATER, AND COME BACK INCLUDING WAITING / QUEUING? *PLEASE PROBE FOR TIME*	SEASON / WET / DRY Less than half hour 1 1 One hour 2 2 Two hours 3 3 Three hours or more **(specify)**	
WS6. IF ON ANIMAL CART, HOW LONG DOES IT TAKE TO GO THERE, GET WATER, AND COME BACK INCLUDING WAITING / QUEUING? *PLEASE PROBE FOR TIME*	SEASON / WET / DRY Less than half hour 1 1 One hour 2 2 Two hours 3 3 Three hours or more (**specify**)	
WS7. HOW MUCH WATER **PER DAY** DOES YOUR HOUSEHOLD USE NOW (EXCLUDING FOR ANIMALS)? (ASK THE QUESTION IN THE NUMBER OF 20 LITERJERICAN)	Jerican = _____	
WS8. WHO USUALLY GOES TO THIS SOURCE TO COLLECT THE WATER FOR YOUR HOUSEHOLD? PROBE:	Adult woman (age 15+ years) ..... 1 Adult man (age 15+ years) ..... 2 Female child (under 15) ..... 3 Male child (under 15) 4	

IS THIS PERSON UNDER AGE 15? WHAT SEX?	Don't Know 8	
WS9. DO YOU DO ANYTHING TO THE WATER TO MAKE IT SAFER TO DRINK?	Yes ..... 1 No ..... 2 DK 8	1⇨WS10 2⇨WS11 8⇨WS11
WS10. WHAT DO YOU USUALLY DO TO MAKE THE WATER SAFER TO DRINK? *Probe:* ANYTHING ELSE? *Multiple responses are possible. Record all items mentioned.*	Boil ..... A Water Guard / Aqua Tabs/BishanGari ..... B Strain it through a cloth ..... C Use water filter (sand filter.) ..... D Solar disinfection ..... E Let it stand and settle ..... F DK ..... G Other (*specify*) _____ X	
WS11. WHAT KIND OF TOILET FACILITY DO MEMBERS OF YOUR HOUSEHOLD USUALLY USE? *If necessary, ask permission to observe the facility. What did you observe:* _____	Ventilated Improved Pit latrine (VIP) ..... 1 Pit latrine with slab ..... 2 Pit latrine without slab ..... 3 Open pit ..... 4 No facility, Bush, Field ..... 5 Other (*specify*) _____ 96	1⇨WS12 2⇨WS13 3⇨WS13 4⇨WS13 5⇨WS15 96⇨WS13
WS12. IF VIP LATRINE WHO CONSTRUCTED IT FOR YOU?	_____	
WS13. DO YOU SHARE THE TOILET FACILITY WITH OTHERS WHO ARE NOT MEMBERS OF YOUR HOUSEHOLD?	Yes ..... 1 No 2	1⇨WS14 2⇨WS15
WS14. HOW MANY HOUSEHOLDS IN TOTAL USE THIS TOILET FACILITY, INCLUDING YOUR OWN HOUSEHOLD?	Number of households (if less than 10)..___ Ten or more households ..... 10 DK 98	
WS15. WHAT HAPPENS WITH THE STOOLS OF YOUNG CHILDREN (0 – 5) YEARS) WHEN THEY DO NOT USE THE LATRINE OR TOILET FACILITY?	Children always use toilet or latrine ..... 1 Thrown into toilet or latrine ..... 2 Thrown outside the yard ..... 3 Buried in the yard ..... 4 Left on the ground ..... 5 Other (specify) ..... 6 No young children in household 7	

HAND WASHING HABITS		**HW**
HW1. HAVE YOU EVER ATTENDED A HEALTH EDUCATION SESSION/TRAINING ON PERSONAL HYGIENE?	Yes ..... 1 No ..... 2 DK 98	
HW2. DO MEMBERS OF YOUR HOUSEHOLD WASH THEIR HANDS?	Yes 1	

	No .....2 DK..... 98	
HW3. DO YOU THINK IT'S IMPORTANT FOR PEOPLE TO WASH THEIR HANDS?	Yes.....1 No .....2 DK..... 98	1⇨HW4 2⇨next module
HW4. WHY SHOULD PEOPLE WASH THEIR HANDS? *PROBE FOR DIFFERENT REASONS*		
HW5. WHEN DO YOU NORMALLY WASH YOUR HANDS? *MULTIPLE ANSWERS POSSIBLE*	Before Eating ..... A After Eating ..... B Before cooking..... C Before feeding the child ..... D After the toilet..... E After child defecating ..... F Before holding the child .....G	
HW6. DO YOU HAVE ANY SOAP OR DETERGENT (***or other locally used cleansing agent***) IN YOUR HOUSEHOLD FOR WASHING HANDS?	Yes.....1 No 2	1⇨HW7 2⇨next module
HW7. WHAT DO YOU USE TO WASH YOUR HANDS? MULTIPLE RESPONSES ARE POSSIBLE	Bar soap ..... A Detergent (Powder / Liquid / Paste) ..... B Ash / Mud / Sand ..... C Other (specify) ..... Y	
HW8. HAND WASHING FACILITY OBSERVED	Yes.....1 No 2	

HOUSEHOLD CHARACTERISTICS		HC
HC1. WHAT IS THE **MAIN** INCOME GENERATION ACTIVITY/OCCUPATION FOR THE HOUSEHOLD? *ONLY ONE OPTION*	Petty trading ..... 01 Farming ..... 02 Government Worker ..... 03 Safety Net ..... 04 Daily Labourer ..... 05 Relatives ..... 06 Other (*specify*) _____ 96	
HC2. WHAT TYPE OF FUEL DOES YOUR HOUSEHOLD **MAINLY** USE FOR COOKING? *ONLY ONE OPTION*	Biogas ..... 01 Kerosene ..... 02 Charcoal ..... 03 Wood ..... 04 Straw / Shrubs / Grass ..... 05 Animal dung ..... 06 Other (*specify*) _____ 96	
HC3. DOES YOUR HOUSEHOLD HAVE:	Yes No	
[A] ELECTRICITY?	Electricity 1 2	
[B] A RADIO?	Radio 1 2	
[C] A TELEVISION?	Television 1 2	
[D] MOBILE TELEPHONE?	Mobile telephone 1 2	
HC4. HAVE YOU HEARD ABOUT ENERGY SAVING STOVES?	Yes ..... 1 No 2	1⇨HC5 2⇨next module
HC5. DO YOU HAVE ENERGY SAVING STOVE IN YOUR HOUSEHOLD? PLEASE OBSERVE	Yes ..... 1 No 2	1⇨HC6 1⇨HC7
OBSERVED EXISTENCE OF ENERGY SAVING STOVE	Yes ..... 1 No 2	
HC6. WHERE DID YOU GET THE ENERGY SAVING STOVE FROM		
HC7. WHAT ARE THE BENEFITS OF USING THE ENERGY SAVING STOVE?		
HC8. MATERIAL OF DWELLING HOUSE? OBSERVE AND RECORD	Mud with Grass ..... 01 Mud with Iron sheets ..... 02 Other (*specify*) _____ 96	

ENVIRONMENTAL AWARENESS		EA
EA1.Have you ever attended any environmental awareness seminar, training, meeting, etc?	Yes……..……...1 No…….2 DK.....8	
EA2.Are you involved in any activity to conserve the environment?	Yes……..……...1 No…….2 DK 8	Go to EA3 Go to EA4 Go to EA4
EA3. If yes please tell me any environmental activities you are or have been involved in.		
EA4. Do you think it is important to conserve the environment?	Yes……..……...1 No…….2 DK / Not sure / Depends.....8	Go to EA5 Go to EA6 Go to EA6
EA5. If yes in EA4 above why is it important to conserve environment?		
EA6. Please tell me ways in which people can conserve and protect the environment?		
EA7. In your opinion what are the harmful environmental practices that destroy the environment?	Deforestation…..……...A Burning……B Overgrazing.....……...C DK / Not sure / .....D Others (Specify)_____	
EA8. Are you involved in any of the following Tree Planting.…..……...A Decomposting..……B Cleaning surroundings...……...C Burning rubbish.……...D DK / Not sure / Depends.....E	Tree Planting.…..……...A Decomposting..……B Cleaning surroundings...……...C Burning rubbish.……...D DK / Not sure / Depends.....E	1⇨EA9
EA9. In the last 3 years how many trees have you planted as an individual?		
EA10. Of the trees you have individually planted, how many have survived and are now growing?		

MATERNAL AND NEWBORN HEALTH		MN
This module is to be administered to all women with a live birth in the 3 years preceding date of interview. Use the child's name in the following questions, where indicated.		
MN1. HAVE YOU HAD A LIVE BIRTH IN THE LAST 3 YEARS	Yes .....1 No 2	1⇨MN2 2⇨Next Module
MN2. WHEN WAS YOUR LAST DELIVERY?	Year And Month_____	
MN3. WHEN WAS YOUR SECOND LAST DELIVERY?	Year And Month_____ No second delivery.....1	
MN4. DID YOU SEE ANYONE FOR ANTENATAL CARE DURING YOUR LAST PREGNANCY?	Yes .....1 No 2	1⇨MN5 2⇨MN7
MN5. WHERE DID YOU GET INFORMATION ON ANTE NATAL CARE FROM	Community Health Volunteers.....1 Health Extension Workers.....2 Trained Traditional Birth Attendants.....3 Friends/Neighbours/Relatives.....4 Others:_____	
MN6. WHERE DID YOU VISIT FOR ANTENATAL CARE	Health Post.....1 Health Centre.....2 Hospital.....3 Private Clinic.....4 Others:_____	
MN7. WHERE DID YOU GIVE BIRTH TO YOUR LAST CHILD (NAME)? PROBE TO IDENTIFY THE TYPE OF SOURCE.	Home .....1 Govt. hospital/post/clinic.....2 Private hospital/clinic .....3 Other (*specify*)_____	
MN8. WHO ASSISTED WITH THE DELIVERY OF YOUR LAST CHILD (NAME)? PROBE: ANYONE ELSE? PROBE FOR THE TYPE OF PERSON ASSISTING AND CIRCLE ALL ANSWERS GIVEN.	Doctor ..... A Nurse/ Midwife ..... B Health Extension Workers.....C Trained Traditional Birth Attendants ..... D Relative/Friend ..... E No one.....F Other (*specify*) _____	
MN9. HAVE YOU EVER HEARD ABOUT VACCINATION PROGRAMS?	Yes……...1 No……2 DK 8	
MN10. ARE YOUR CHILDREN VACCINATED?	Yes……...1 No……2 DK 8	

CHILD HEALTH
This section is to be asked to mothers who have a child less than 5 years of age **CH**

CA1. DO YOU HAVE A CHILD WHO IS BELOW 5 YEARS?	Yes ..... 1 No 2	1⇨CA2 2⇨Next Module
CA2. IN THE LAST TWO WEEKS, HAS (*name*) HAD DIARRHOEA?	Yes ..... 1 No ..... 2 DK 8	1⇨CA3 2⇨CA4 8⇨CA4
CA3. DURING THE EPISODE OF DIARRHOEA, WAS (*name*) GIVEN TO DRINK ANY OF THE FOLLOWING: *Read each item aloud and record response before proceeding to the next item.* [A] A PRE-PACKAGED ORS FLUID FOR DIARRHOEA? [B] HOME BASED ORS OTHERS	Y N DK Pre-packaged ORS fluid ..... 1 2 8 Home Based ORS ..... 1 2 8 OTHERS	
CA4. WHAT DO YOU THINK CAUSES OF DIARRHOEA	Eating spoiled/dirty food ..... A Drinking unclean water ..... B Personal Hygiene ..... C DK ..... D Others _____	
CA5. AT ANY TIME IN THE LAST **TWO WEEKS**, HAS (*name*) HAD AN ILLNESS WITH A COUGH?	Yes ..... 1 No ..... 2 DK 8	2⇨Next Module 8⇨Next Module
CA6. DID YOU SEEK ANY ADVICE OR TREATMENT FOR THE ILLNESS FROM ANY SOURCE?	Yes ..... 1 No ..... 2 DK 8	2⇨Next Module 8⇨Next Module
CA7. FROM WHERE DID YOU SEEK ADVICE OR TREATMENT? *Probe:* ANYWHERE ELSE?	Health Centre ..... A Health Post ..... B Private Hospital/ Clinic ..... C Private Pharmacy ..... D Shop ..... E Traditional practitioner ..... F Other (*specify*) _____	

CONTRACEPTION – WOMEN 15-49 YEARS *Ask Q.1 for all women age 15-49 and then follow the skip instruction carefully. Questions in this section are to be asked only to women who are currently married or in union.*		**CP**
CP1. ARE YOU CURRENTLY MARRIED?	Yes .....1 No, widowed, divorced, separated .....2 No, never married.....3	1⇨CP2 2⇨NEXT MODULE 3⇨NEXT MODULE
CP2. HAVE YOU EVER HEARD OF FAMILY PLANNING?	Yes .....1 No 2	1⇨CP3 2⇨CP4
CP3. WHERE DID YOU HEAR FROM ABOUT FAMILY PLANNING?	Community Health Volunteers.....1 Health Extension Workers.....2 Trained Traditional Birth Attendants.....3 Friends/Neighbours/Relatives.....4 Others:_____	
CP4. HAVE YOU / YOUR PARTNER EVER USED ANY FAMILY PLANNING METHODS?	Yes .....1 No 2	1⇨CP5 2⇨CP7
CP5. ARE YOU CURRENTLY DOING SOMETHING OR USING ANY METHOD TO DELAY OR AVOID GETTING PREGNANT?	Yes .....1 No 2	
CP6. WHAT ARE YOU DOING TO DELAY OR AVOID A PREGNANCY? *Do not prompt.* *If more than one method is mentioned, circle each one.*	Female sterilization ..... A Male sterilization..... B IUD ..... C Injection ..... D Norplant ..... E Pill.....F Male condom ..... G Lactational amenorrhoea method (LAM)..... K Calendar (Safe/unsafe Days).....L Withdrawal.....M Other (*specify*) _____ X	
CP7. IF YOU / YOUR PARTNER ARE NOT USING FAMILY PLANNING METHODS, WHAT ARE THE REASONS?	We want to have many children……A I do not know about family planning…….B Contraceptives are not available in the area……C My religion/culture prohibits use of contraceptives……D Contraceptives have side effects…….E Other (specify):_____	

HIV/AIDS		HA
This module is to be administered to the Woman Head of the household		
HA1. NOW I WOULD LIKE TO TALK WITH YOU ABOUT SOMETHING ELSE. HAVE YOU EVER HEARD OF AN ILLNESS CALLED AIDS?	Yes ..... 1 No 2	1⇨HA2 2⇨End
HA2. WHERE DID YOU HEAR IT FROM?	Peer/Friends…….....…...1 Radio/Television.....…….2 Mosque/Church.....…….....……...3 Community Health Volunteers.....4 Community Meetings.....5 Health Post/Centre.....6 School.....7 Others.....	
HA3. CAN YOU NAME AT LEAST **THREE (3) WAYS** HIV/AIDS IS TRANSMITTED?	Exposure to infected blood ……..A Mother to child – during pregnancy…….B Mother to child – during birth / delivery…..C Mother to child – through breastfeeding….D Any type of sex……..……E Unprotected sex with an HIV positive person……F Sharingcontaminated sharp objects like needles / other sharps……..G Mosquito bites……H Witchcraft/curse……...……I Sinning.....J Other _____ Don't know / no answer……30	
HA4. CAN PEOPLE REDUCE THEIR CHANCE OF GETTING THE AIDS VIRUS BY HAVING JUST ONE UNINFECTED SEX PARTNER WHO HAS NO OTHER SEX PARTNERS?	Yes ..... 1 No ..... 2 DK 8	
HA5. CAN PEOPLE GET THE AIDS VIRUS BECAUSE OF WITCHCRAFT OR OTHER SUPERNATURAL MEANS?	Yes ..... 1 No ..... 2 DK 8	
HA6. CAN PEOPLE REDUCE THEIR CHANCE OF GETTING THE AIDS VIRUS BY USING A CONDOM PROPERLY EVERY TIME THEY HAVE SEX?	Yes ..... 1 No ..... 2 DK 8	
HA7. CAN PEOPLE GET THE AIDS VIRUS FROM MOSQUITO BITES?	Yes ..... 1 No ..... 2 DK 8	
HA8. CAN PEOPLE PREVENT THEMSELVES FROM GETTING THE AIDS VIRUS BY ABSTAINING FROM SEX?	Yes ..... 1 No ..... 2 DK 8	
HA9. CAN PEOPLE GET THE AIDS VIRUS BY SHARING	Yes 1	

FOOD WITH A PERSON WHO HAS THE AIDS VIRUS?	No ..... 2 DK 8	
HA10. CAN PEOPLE GET THE AIDS VIRUS BY SKIN CONTACT EG SHAKING HANDS WITH A PERSON WHO HAS THE AIDS VIRUS?	Yes ..... 1 No ..... 2 DK 8	
HA11. IS IT POSSIBLE FOR A HEALTHY-LOOKING PERSON TO HAVE THE AIDS VIRUS?	Yes ..... 1 No ..... 2 DK 8	
HA12. CAN THE VIRUS THAT CAUSES AIDS BE TRANSMITTED FROM A MOTHER TO HER BABY: [A] DURING PREGNANCY? [B] DURING DELIVERY? [C] BY BREASTFEEDING?	Yes No DK During pregnancy ..... 1 2 8 During delivery ..... 1 2 8 By breastfeeding 1 2 8	
HA13. IN YOUR OPINION, IF A TEACHER HAS THE AIDS VIRUS BUT IS NOT SICK, SHOULD HE/SHE BE ALLOWED TO CONTINUE TEACHING CHILDREN IN SCHOOL?	Yes ..... 1 No ..... 2 DK/Not sure/Depends 8	
HA14. WOULD YOU BUY FRESH VEGETABLES FROM A SHOPKEEPER OR VENDOR IF YOU KNEW THAT THIS PERSON HAD THE AIDS VIRUS?	Yes ..... 1 No ..... 2 DK/Not sure/Depends 8	
HA15. IF A MEMBER OF YOUR FAMILY GOT INFECTED WITH THE AIDS VIRUS, WOULD YOU WANT IT TO REMAIN A SECRET?	Yes ..... 1 No ..... 2 DK/Not sure/Depends 8	
HA16. I DON'T WANT TO KNOW THE RESULTS, BUT HAVE YOU EVER BEEN TESTED TO SEE IF YOU HAVE THE AIDS VIRUS?	Yes ..... 1 No 2	 2⇨HA19
HA17. WHEN WAS THE MOST RECENT TIME YOU WERE TESTED?	Less than 12 months ago ..... 1 12-23 months ago ..... 2 2 or more years ago 3	
HA18. I DON'T WANT TO KNOW THE RESULTS, BUT DID YOU GET THE RESULTS OF THE TEST?	Yes ..... 1 No ..... 2 DK 8	1⇨ End 2⇨ End 8⇨ End
HA19. DO YOU KNOW OF A PLACE WHERE PEOPLE CAN GO TO GET TESTED FOR THE AIDS VIRUS?	Yes ..... 1 No 2	

Thank You for Your Participation