

**INTEGRATED RURAL COMMUNITY
DEVELOPMENT PROJECT**

In

Adami Tulu Jido Kombolcha, Oromiya region, Ethiopia

ENDLINE EVALUATION

ADRA ETHIOPIA

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LIST OF ACCRONYMS

AIDS	Acquired Immuno deficiency Syndrome
ATJK	Adami Tulu Jido Kombolcha
BCG	Baccile calmette Guerin
DPT	Diphtheria Pertussis and Tetanus
EPI	Expanded Program of Immunization
FP	Family Planning
HH	Household
HIV	Human Immuno deficiency Virus
OPV	Oral Polio Vaccine
PMTCT	Prevention of Mother to Child Transmission of HIV
SD	Standard Deviation

EXECUTIVE SUMMARY

This final evaluation covered the project implementation period from February 2006 to December 2008. Its purpose is to determine the extent and direction to which the project goal and objectives were achieved. The study applied both quantitative and qualitative study techniques. The quantitative part involved interview in a total of 360 households selected from 14 kebeles, whereas the qualitative part was conducted through focus group discussion with selected community members.

The study population was comprised of 5.78% children less than 12 months of age, 21.3% between 12 months and 5 years old and 858 between 5 and 18 years old population. The point prevalence of pregnancy in this population was found to be 1.4%, which is about 8.2% of women of child bearing age. The infant mortality rate (deaths under one year) in this population was found to be 47 per 1000 live births per year.

Knowledge of the community about HIV/AIDS has increased to 90.8% and the improvement is observed more on the quality of knowledge on ways of transmission and prevention. About eighty-eight percent of the respondents had the knowledge on how to delay/prevent pregnancy which was only 67.5% three years ago. Awareness about PMTCT and use of condom, increased by 17% and 26.5% respectively compared to the baseline data. Those ever used family planning method increased from 34.2% to 52.9%. Contraceptive prevalence rate among the eligible has increased from 9.2% to 23.9%. About ninety-five percent of the mothers have heard about vaccination programs of which 81.8% had already taken their children to vaccination sites.

Significant majority of the respondents (91.1%) eat three times a day, and nearly all at least twice a day. Seventy percent respondents answered that their children drink milk every day, and among those children who drink milk on daily basis about 55% of them get two or more cups of milk. The two weeks childhood morbidity for diarrhoea/vomiting and cough was found to be 4.4 and 4.5 percent respectively, and the practice of the community in using modern treatment has improved over time. Percentage of women using ORS in treatment of children with diarrhoea increased from 14.7% to 35.3%, while knowledge on causes of diarrhoea increased by 50%. Practice of hand washing after defecation increased from 64.2% to 92%. More (17%) households are getting water supply from pipe and protected well and majority get water from a distance of less than half an hour and their frequency of fetching has increased as the distance gets shorter. There is improved practice of garbage disposal as the percentage practicing burning or burring of trash increased from 16.7% to 70.7%. knowledge of at least two consequences of environmental degradation increased by 32% and similarly knowledge of at least two ways of preventing increased by 21%.

More and more households are using pit latrine compared to the previous practice. Ninety three percent of the respondents in the study population were using fire wood as a means of cooking. The distance to reach to the nearest school has been decreasing with time; and significant majority of parents are sending their children to school. Private farm holdings were the major source of food in the community and more than half of the respondents felt that the food available in the household was adequate for the family. The household food security level has improved significantly. Please see summary table on page iv for detailed comparison of the current findings with that of the baseline data.

Generally, the findings demonstrated that the community development activities implemented by ADRA, over the past three years, have brought a significant changes in the community and it is recommended the project should design a mechanism that ensures sustainability of these achievements in order to realize the long-term impact.

Summary of Key Indicators, End Line Compared To Baseline Results

INDICATOR	BASELINE	TARGET	END LINE
% of women of reproductive age group have knowledge of mother to child HIV/AIDS transmission.	1.4%	50%	18.4%
% of women of reproductive age group know that appropriate and consistent use of condom can prevent HIV/AIDS transmission.	2.2%	60%	28.5%
% women of reproductive age group have knowledge of at least two methods of HIV/AIDS transmission.	66.4%	80%	87%
% of women of reproductive age group have knowledge of at least two ways of HIV/AIDS prevention.	50.2%	70%	75%
% of women of reproductive age group have knowledge of how to delay or prevent pregnancy.	67.5%	90%	87.8%
Contraceptive prevalence rate	9.2%	19.2%	23.9%
% of women use ORS in treatment of their children with diarrhea.	14.7%	50%	35.3%
% of women have knowledge of causes of diarrhea.	43.9%	70%	93%
% of the population practice hand washing after defecation.	64.2%	80%	92%
% of the population practice burning or burring of trash in garbage pit as a method of trash disposal in the household.	16.7%	40%	70.7%
% of the population has knowledge of at least two consequences of environmental degradation.	44.7%	70%	76%
% of the population knows at least two ways of preventing environmental degradation.	49.4%	70%	71%

1. INTRODUCTION

ADRA Ethiopia's Integrated Rural Community Development Project commences in February 2006 and continues through December 2008.

The goal of the project is to improve health status, education and environmental awareness of local villagers in Oromiya region in Ethiopia through construction of water systems, latrines, biogas units, schools, and provision of health promotion activities through community volunteers. Projects activities will be carried out in 14 Kebeles in a remote area of Adami Tulu Jido Kombolcha (ATJK), East Showa Zone, Oromiya Region of Ethiopia.

The project is composed of three complementary components namely; water, basic education, and health promotion and environmental awareness.

The objective of the water s component is to provide potable water to 36,000 people in ATJK through construction of one well and 15 above ground water reservoirs. To achieve the intended impact, a variety of activities are planned. Water committees will be established with the purpose of managing the potable water in cooperation with the village executive committees. One well including a water system (holding tank and pump) will be drilled and above ground water reservoirs with rain water roof catchments systems will be constructed.

Basic education program aims at to have access to basic education for 300 students; age one through 4th grade, through construction of 3 school buildings in 3 separate Kebeles in ATJK district To achieve the intended results of the basic education component, a school building committee will be organized and construction of three schools will be conducted in three Kebeles. Besides, three adult education facilities will be established in the area.

Where as the objective of health promotion and environmental awareness component is to have increased knowledge in basic health and hygiene issues and environmental awareness and have means to practice methods of improving sanitation, hygiene and environmental degradation for 12,000 local villagers. This objective is to be achieved through the following activities: a) Establishment of committees (health promotion committee and environmental committee), b) training of trainers (community based volunteers, local government staff), c) Construction of dry pit latrines, d) and construction of household biogas units.

As an initial step the project has conducted a baseline assessment in April 2006 through a participatory process involving the range of different project stakeholders in a process to clarify programme goals, objectives and measures of performance. Now it is time to measure the difference the project brought about with assessment of strengths and performance, which help to devise appropriate recommendations for the future.

2. OBJECTIVES

2.1 PURPOSE AND SPECIFIC OBJECTIVES OF FINAL EVALUATION

The final evaluation covered the project period from February 2006 to the date of the evaluation (December 2008). The purpose of the final evaluation is to determine the extent and direction to which the project goal and objectives were achieved.

2.2. SPECIFIC OBJECTIVES:

1.1.1. Specific objectives related to general project management:

- To assess general implementation and management of the project in terms of quality, timeliness of inputs and activities, adherence to work-plans, logical framework and budget.
- To assess achievements of the project against the original objectives, outputs and activities as detailed in the project document, including logical framework.
- To assess the appropriateness and relevance of the project's design and implementation strategies to the identified needs in ATJK and in Ethiopia.
- To assess adequacy of management arrangements as well as monitoring and backstopping support given to the project by all parties as established in the project proposal and other unforeseen support
- To assess responsiveness of project management to changes in the environment in which the project operates
- To identify lessons learned to be used in future projects.

1.1.2. Specific objectives related to water component:

- To assess the number of water committees established and their ability to manage the water points.
- To assess the number of above ground water reservoirs constructed and their functionality (including quality)
- To assess the number of rehabilitated boreholes and their functionality (including quality).
- To assess the monitoring/supervision of water committees by project staff

1.1.3. Specific objectives related to health promotion:

- To assess the type of activities conducted by the community based rural health agents (CBRHA) in the villages including sustainability of those activities.
- To assess the effectiveness of CBRHA training
- To assess the monitoring/supervision of the CBRHA by ADRA staff
- To assess the monitoring system for data collection by the CBRHAs.
- To assess the materials used and key health message being taught by the CBRHA.
- To assess the relevance of the health and hygiene training to the socio-political environment.
- To assess the knowledge level of the project beneficiaries

1.1.4. Specific objectives related to environmental awareness:

- To assess the type of activities conducted by the community based rural environmental agents (CBREA) in the villages including sustainability of those activities
- To assess the effectiveness of CBREA training
- To assess the monitoring/supervision of the CBREA by ADRA staff
- To assess the monitoring system for data collection by the CBREAs.
- To assess the materials used and key health message being taught by the CBREA.
- To assess the relevance of the health and hygiene training to the socio-political environment.
- To assess the knowledge level of the project beneficiaries

1.1.5. Specific objectives related to education:

- To assess the number of schools and adult training centers constructed and their functionality
- To assess number of students who have access to basic education
-

1.1.6. Specific objectives related to sustainability

- To assess how the flow of benefits to the beneficiaries and society as a whole are likely to continue after the external aid ends
- To assess stakeholder perceptions and beneficiary participation and ownership in the project interventions
- To assess if the beneficiaries will be able to adapt and ensure continuity of the services after the project ends
- To assess the level of commitment and support from the local authorities and to what extent the project's activities been integrated into local institutional structures

2.1.7.1 Specific objectives related to Gender issues

- To assess the level of gender balance in project committees, beneficiaries and community volunteers
- To assess if the community is aware of the notion that women should participate equally in community decision

3. METHODS AND MATERIALS

The survey was conducted at Adami Tulu Jido Kombolcha district in east Shoa, Oromya region. A total of fourteen kebeles (smallest administrative unit), where the project has been operating, were covered during the survey. The study population primarily comprises of female of reproductive age groups for the quantitative part, as well as both men and women for the qualitative part.

The sample size is calculated in consultation with statistician based on the formula seen below.

$$n = \frac{NZ^2 * 0.25}{[d^2 * (N-1) + (NZ^2 * 0.25)]}$$

Where

- n = sample size required
- N = total population size
- d = precision level (0.5)
- Z = number of standard deviation units of the sampling distribution corresponding to the desired confidence table

Hence the total 360 households were selected for the survey and data collected from all of them.

With respect to sampling technique, households have been selected from all the 14 kebeles of ATJK district. The households from each kebele were selected through proportional sampling technique with reference to the population size. A systematic sampling technique was applied with the calculated sampling interval, in order to identify the selected household. The first household has been selected by spinning a bottle at the center of the kebele and then we followed that direction until a residential house is reached. Then the data collection team moved to that direction to select the next households based on the sampling interval. When the number of households in the selected direction was found to be insufficient, the process was repeated in another direction.

In each selected household, a women in reproductive age group (15 to 49 years of age), which in most cases were the wife in the household, have been interviewed by using a structured questionnaire. In those selected households where the female in reproductive age group was not available, an adult man has been interviewed.

The qualitative information was collected through a focus group discussion conducted with a group of eight to eleven community members who have been selected based on their status in the community and the knowledge they have about the social, cultural and environmental conditions of the area. A discussion guide has been used as a checklist in order to facilitate the focus group discussion.

4. FINDINGS OF QUANTITATIVE COMPONENT

4.1. SOCIO-DEMOGRAPHIC CHARACTERISTIC

The studied population has been comprised of a total of 91.9% females of child bearing age and 9.1% adult males. The socio-demographic characteristics of the study population is summarised in table 1. Sixty nine percent (248) of the respondents were between 15-34 years of age with mean (\pm SD) of 30.4 ± 8.2 years, the median age being 29 years (See histogram).

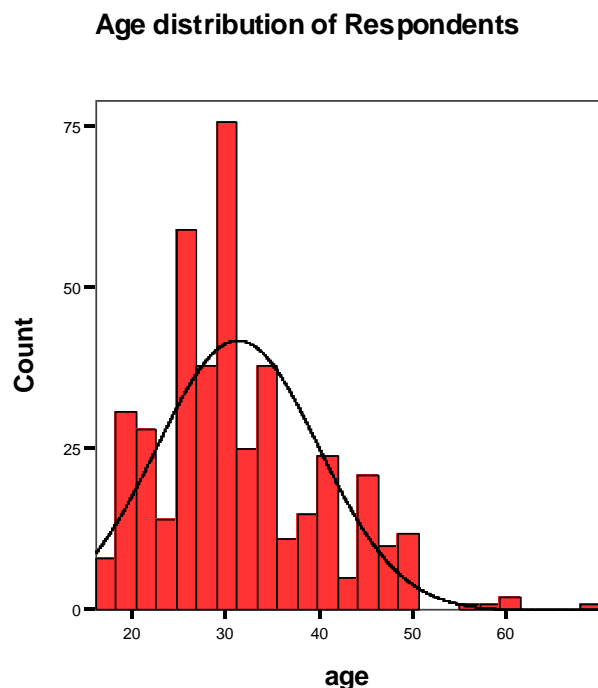


Fig 1. Histogram showing the age distribution of the study population.

Three hundred thirty-five (93.1%) of the respondents were currently married, 93.2% Muslim, 91.3% Oromo and 74.4% Illiterate. The median household income was 279 Birr, and mean household size was 6.2. (Table 1).

Taking the total number of people in the individual household, the summation of the number of people in the study population was 2,221. The study population was comprised of 128 (5.78%) children less than 12 months of age, 472 (21.3%) between 12 months and 5 years old and 858 between 5 and 18 years old population. There were a total of 390 (17.6%) women in child bearing age (15-49) of whom 32 were pregnant during the study period, which gives a point prevalence of pregnancy in this population to be 1.4%, which is about 8.2% of women of child bearing age. The General fertility rate was calculated to be 271 per 1000 women per year. In the preceding 12 months, one hundred six live births and five deaths of less than one year age were reported. The infant mortality rate (deaths under one year) in this population was found to be 47 per 1000 live births per year.

Table-1. Socio-demographic characteristic of the study population, ATJK district, East Shoa Zone, Oromia region, Ethiopia, December 2008

Variable	Category	Frequency n= 360	Percent
Age	15-24 years	65	18
	25-34	176	49
	35-44	83	23
	>=45	36	10
	Mean \pm SD	31.4 \pm 8.6	
Marital Status	Married	337	93.6
	Divorced or separated	5	1.4
	Widowed	18	5
Religion	Orthodox	21	5.8
	Muslim	335	93.1
	Protestant	4	1.1
Ethnicity	Oromo	329	91.3
	Others (Siltie, Mareko, Hadya, Meskan, Hadya..)	31	8.7
Education	Illiterate	268	74.4
	Read & write	27	7.5
	Elementary(1-8)	59	16.4
	Secondary (9-12)	6	1.7
Income per month	< 100 birr	47	13
	100-300 birr	153	42.5
	>300 birr	156	43.4
	None	4	1
	Median income	279 Birr	
Household size	\leq 5	165	45.7
	6-10	180	50
	> 10	15	4.3
	Mean \pm SD	6.2 \pm 2.4	

4.2. KNOWLEDGE AND PRACTICE OF THE STUDY POPULATION TOWARDS BASIC HEALTH ISSUES & NUTRITION

4.2.1 HIV/AIDS

In regard to awareness on HIV/AIDS, 90.8% of the population responded that they had heard of HIV/AIDS. When asked on mode of transmission of HIV/AIDS, unprotected sex was responded by 81.8%, through sharp materials and objects by 68.2%, blood transfusion by 45.2% and mother to child by 18.4% of the study participants. It was only 7% of the respondents who answered “I don’t know” on the mode of transmission of HIV/AIDS. In terms of the number of transmission methods the respondents were aware of; 95% know at least one mode of transmission, 87% mentioned at least two modes where as 81% pointed out at least three methods of transmission.

Table-2. Knowledge and practice of the study population towards HIV/AIDS

Variable	Responses	Frequency	Percent
Awareness on HIV/AIDS	I have heard	327	90.8
	I haven’t heard	33	9.2
Knowledge on Mode of transmission of HIV/AIDS	Unprotected sex	265	81.8
	Mother to Child	60	18.4
	Sharp objects/Materials	221	68.2
	Blood transfusion	146	45.2
	Don’t know	23	7
	Other	10	3.1
Knowledge on prevention methods of HIV/AIDS	Abstain from sexual activity	162	50
	Loyalty to partner	206	63.5
	Use of condom	92	28.5
	Avoiding of sharing sharps	203	62.8
	Don’t know	27	8.2
	Others	3	0.8

Knowledge on prevention methods of HIV/AIDS revealed that loyalty to partner, avoiding sharp materials/objects and abstain from sexual activity were the three most frequent responses answered by the interviewees in that order. Proper and consistent use of condom was responded by only 28.5%. About 8 percent answered that they didn’t know the prevention methods of HIV/AIDS. Stratifying the response by the number of ways of prevention of HIV/AIDS the participants responded, it was revealed that 82% know at least one way of prevention where as 75% and 63% mentioned at least two and three ways of prevention respectively.

4.2.2 Family planning

With respect to family planning, 87.8% of respondents answered that they had the knowledge on how to delay/prevent pregnancy. Pills (75.4%) and Depo-Provera (68%) were the two FP methods mentioned most frequently followed by Norplant (16.6%) and calendar method (11.7%). Out of those who had the knowledge on FP methods, 43.7% had ever used one of the methods and of which 52.9% of the women were currently using modern FP methods making a contraceptive prevalence rate (CPR) of 23.9% of the eligible. Pills (47%) was the method of choice by the current users followed by Depo-Provera 32%.

Table-3. Knowledge and practice of the study population on family planning

Variable	Responses	Frequency	Percent
Knowledge on how to delay/Prevent pregnancy	Know	316	87.8
	Don't know	44	12.2
		N= 316¹	
Knowledge on FP methods	Pills	238	75.4
	Depo-Provera injection	215	68
	IUD	7	2.2
	Norplant	52	16.6
	Surgical	6	2
	Calendar method	37	11.7
	Other	6	1.9
		N=316	
Ever use of FP methods	Ever used	138	43.7
	Never used	178	56.3
		N=138²	
Current users of FP methods	Users	73	52.9
	Non-users	65	47.1
		N=73³	
FP methods used by current users	Pills	34	47
	Depo-Provera injection	23	32
	IUD	1	2
	Norplant	3	4
	Surgical	1	1
	Calendar method	11	15

¹ number who know how to delay/prevent pregnancy

² number who ever used FP methods

³ number who currently use FP method

As shown in figure 2, the major reasons for not using FP methods forwarded were: 'we want to have many children' (62.3%), 'I do not know about family planning' (21.6%), due to cultural and/or religious prohibition (12.3%), and contraceptives are not available (3%).

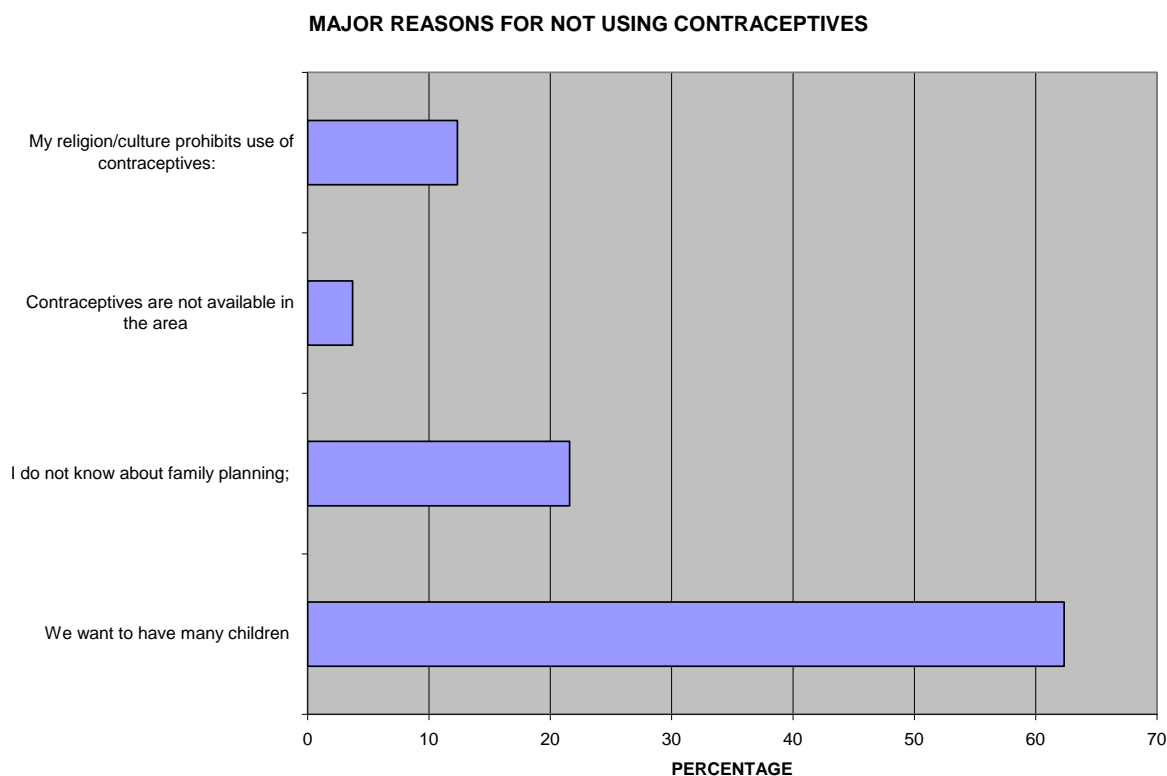


Fig 2; Reasons for not using family planning methods

4.2.3 Vaccination

About ninety-five percent of the mothers have heard about vaccination programs of which 81.8% had already taken their children to vaccination sessions. Vaccination was confirmed by card during the interview (see table 4).

Considering the total number of vaccination per antigen as a denominator, BCG coverage was 70.2%, OPV0 86.8%, DPT3 72.5% and Measles 80.9%. Absence of EPI service and lack of knowledge on the importance of vaccination were mostly mentioned as reasons for not attending vaccination sessions.

4.2.4 Nutrition

Household heads were asked as to how many meals the family eat each day, and significant majority (91.1%) eat three times a day, and nearly all at least twice a day. Almost seventy percent respondents answered that their children drink milk every day, and among those children who drink milk, on daily basis, about 55% of them get two or more cups of milk.

Table-4. Knowledge and practice of the study population on vaccination

Variable	Responses	Frequency	Percent
		N= 360	
Knowledge about EPI	I have heard	342	95.1
	I haven't heard	18	4.9
Vaccination status of children	Vaccinated	294	81.8
	Not vaccinated	66	18.2
		N=162	
Confirmation of Vaccination	BCG by card	114	70.2
	OPV0 by card	141	86.8
	DPT3 by card	117	72.5
	Measles by card	131	80.9
Reasons for not attending EPI	Lack of knowledge on EPI	22	34
	EPI service not available	32	49
	Religion/Culture doesn't allow EPI	4	6
	Other	7	11

Table-5. Knowledge and practice towards nutrition related variables

Variable	Responses	Frequency	Percent
No of meals of the family per day	Once	2	0.5
	Twice	26	7.2
	Three times	228	91.1
Do your children drink milk daily?	Yes	252	69.9
	No	108	29.9
		N=252	
Amount of milk taken by children	One cup daily	114	45
	Two cups daily	81	32
	Three or more cups daily	57	23

4.3. MORBIDITY AND MORTALITY INFORMATION

Fever, cold and eye problems were the first three most frequent childhood illnesses occurred in the study population during the preceding two weeks of the study.

Table-6. Morbidity and Mortality variables of the study population

Variable	Response	Frequency	Percent
Child illnesses in the past 02 weeks	Fever	162	27
	Cold	114	19
	Difficulty in breathing/coughing	43	7
	Diarrhoea/Vomiting	33	5
	Skin Problems	13	2
	Measles	16	3
	Eye Problems	55	9
	Other	13	2
	None	160	55.3
		N=380¹	
Diarrhoea or Vomiting in < 5 during past 2 weeks	Present	17	4.5
	Not present	353	95.5
		N=17²	
Treatment used for diarrhoea	ORS	6	35.3
	Modern Medicine	8	47
	Sugar Salt Solution	2	11.8
	Traditional medicine	1	5.9
What causes diarrhoea	Eating contaminated foods	181	50.4
	Drinking unclean water	153	42.6
	Do not know	0	
	Other	25	7
		N=380	
Cough/difficulty in breathing in < 5 during last 2 weeks	Present	17	4.5
	Not present	363	95.5
		N=17³	
Treatment used for the Cough	Traditional medicine	2	13
	Modern Medicine	5	28
	Nothing	10	58

¹ Total number of under five children in the study population

² Those children who have had diarrhea/vomiting

³ Those children who have had cough

The two weeks childhood morbidity for diarrhoea/vomiting and cough was found to be 4.4 and 4.5 percent respectively. Eighty-two percent of the children with diarrhoea were treated by modern medicines; and was so for 28% of children with cough. Half of the mothers associated diarrhoea with eating contaminated foods, and 43% said it is caused by drinking unclean water.

4.4. WATER, HYGIENE AND ENVIRONMENTAL

4.4.1 Water

Sixty percent of the households get water supply from pipe followed by protected well (17%), unprotected well (11%).(see Figure 3.)

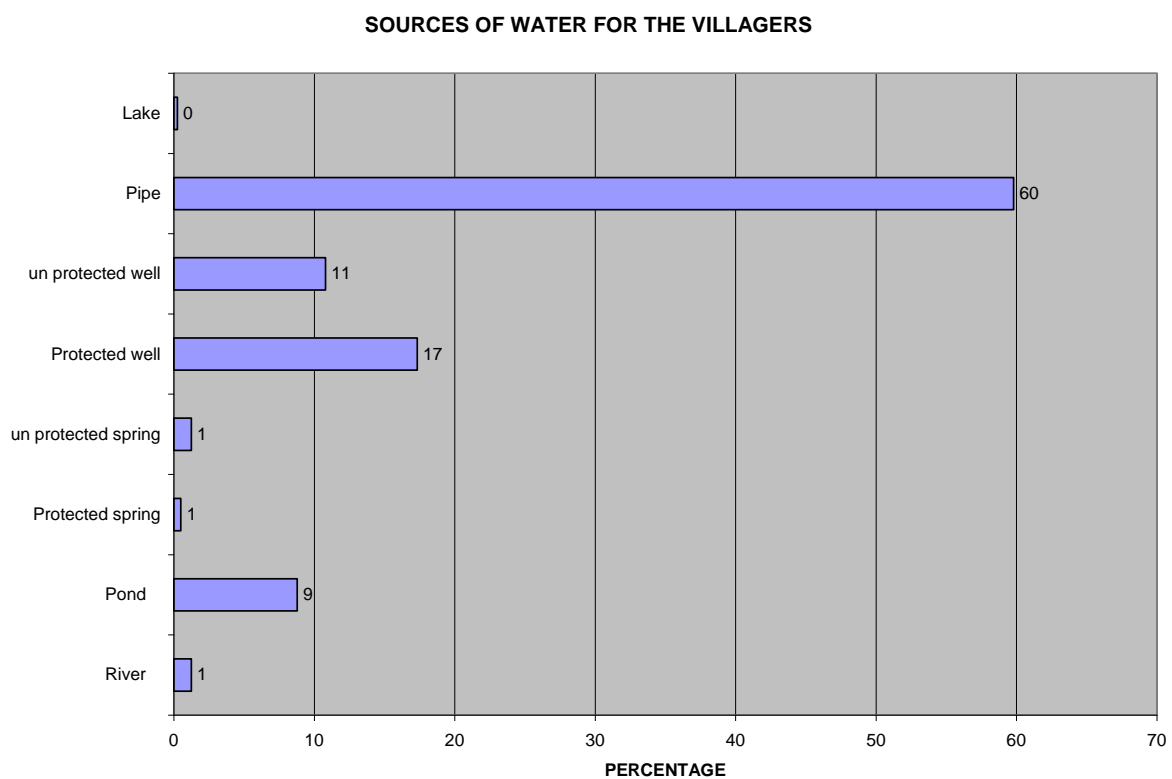


Figure 3. The common sources of water supply in ATJK

Eleven percent of the households walk more than three hours to fetch water whereas 54% get water from a distance of less than half an hour. About 54% of the households fetch water once daily, 38% more than twice daily and the remaining 7.6% every two days or more.

4.4.2 Hygiene

Ninety-six percent of the respondents do not boil water before drinking. About sixty percent of the respondents had ever attended health education session on personal

hygiene topics. Hand washing before handling of food was answered yes by 90.3% of the respondents and 88% of them know the importance of hand washing. Sixty-four percent of the interviewee wash hands always after use of latrine (see Table 7). Up on probing, 82% responded that they knew the importance of hand washing after they use latrine. Sixty nine percent use soap or other detergents for personal or other household cleaning purposes. Ninety-one percent also responded that they had soaps to wash clothes of the family.

Table-7. The situation of Water, Hygiene and Sanitation

Variable	Responses	Frequency	Percent
Distance from the closest water source	Less than half hour	194	54
	One hour	61	17
	Two hours	66	18
	Three hours or more	39	11
Frequency of fetching water	More than twice daily	137	38
	Once daily	196	54.4
	Every two days or more	27	7.6
Is the water available adequate?	Adequate	114	31.7
	Not adequate	244	67.8
	Don't know	2	0.6
Do you boil water for drinking?	Yes	13	4
	No	347	96
Ever attended HE session for hygiene?	Have attended	143	39.7
	Never attended	217	60.3
Wash hands before handling food?	Wash	325	90.3
	Do not wash	35	9.7
Importance of washing hands before handling food	Knows	315	88
	Do not know	45	12
Hand washing after using latrine	Always	231	64
	Most of the times	23	6
	Sometimes	78	22
	Never	28	8
Importance of washing hands after use of latrine	Knows	296	82
	Doesn't know	64	18
Do you use soap or other detergent for personal or household cleaning?	Use soap	247	69
	Do not use soap	113	31
Do you have soap to wash clothes?	Yes	328	91
	No	32	9

4.4.3 Sanitation

The major way of disposing household garbage is through dug a hole and dump it there (45.7%), and about a quarter dispose everywhere on the ground.

It was found out that open field is still the primary way of faeces disposal, as 76.5% of the community practice it, and only 19% use Pit latrine at household, of which 78.6% use traditional pit latrine and 21.4% VIP. Among the 17 households that used communal pit latrines, 52.2%, responded that the latrines were used by less than four households another 53.5% said that more than four households were using the pit latrines.

Availability of open field (41%), lack of money for construction (27%) and not knowing of the importance of latrines (17%) were the three most frequent answers, in their order, given as reasons for not having latrines (see figure 5).

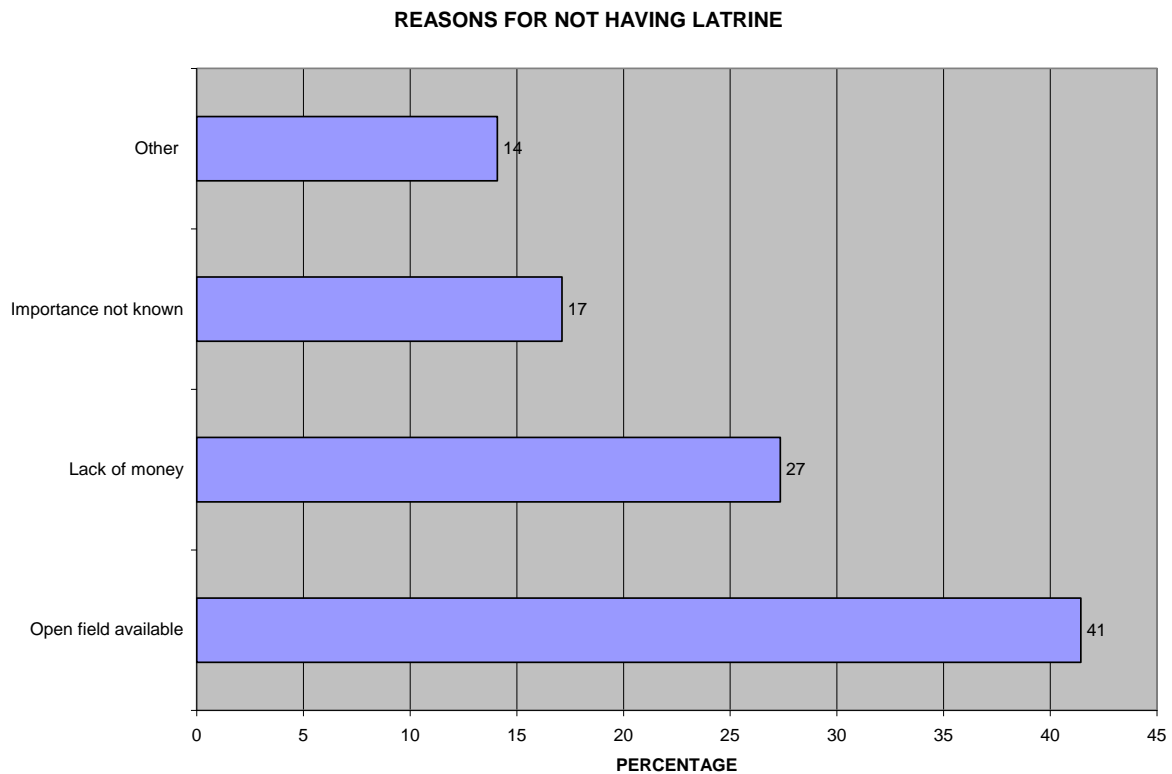


Figure 5: reasons for not having latrine

4.4.4 Environmental protection

Ninety three percent of the respondents in the study population were using fire wood as a means of cooking. Head of households were asked as to what the consequence of cutting trees is. The responses were: erosion (88%), climatic change (73%), drought and famine, (51%), decrease productivity of land and lack of trees for firewood.

In terms of the number of consequences of environmental degradation each respondent know, 81% mentioned at least one, 76% mentioned at least two while

63% indicated three consequences. It was also found that 41% mentioned four consequences of environmental degradation.

Avoiding of cutting (87%) and planting of trees (78.3%) were the two most frequent responses forwarded by the respondents as a means of preventing environmental degradation, while 77.5% responded use of biogas for cooking. Nearly all respondents know at least one way of preventing environmental degradation, and almost two third know at least two ways.

Table-8. The situation of Hygiene, Sanitation and Environment (continued)

Variable	Responses	Frequency	Percent
Place of disposing household rubbish	On the ground everywhere	91	25.3
	Dug a hole and dump it there	165	45.7
	Burning	90	25
	Other	14	4
Primary way of faeces disposal	Pit latrine at household	68	19
	Communal pit latrine	17	4.6
	Open field	275	76.5
Type of latrine available		N=68¹	
	Pit	53	78.6
	VIP	15	21.4
Number of households using shared latrines		N=17²	
	Less than four	9	52.2
	>= 4	7	43.5
	Didn't respond	1	4.3
Distance of latrine from water source	15-50 meters	29	35
	51-150 meters	9	11
	>150 meters	47	55
Source of energy for cooking	Firewood	336	93
	Biogas	5	1.2
	Other	9	2.1
	Didn't respond	10	2.7
Consequences of cutting trees	Erosion	318	88
	Climatic change	163	73
	Drought and famine	183	51
	Decrease productivity of land	32	9
	No trees for firewood	78	21.7
	I don't know	12	3.4
How to prevent environmental degradation?	Avoid cutting trees	312	87
	Use of biogas for cooking	279	77.5
	Plant more trees	282	78.3
	Use of Levi banks for erosion	2	1
	Other	14	4

¹ Those households that have any form of latrines

² Those households that have communal latrine

4.5. EDUCATION

Eighty-two percent of the interviewees answered that the distance to reach to the nearest school is one hour or less. The interviewees were asked that how many of their school age children were attending school, and according to the response, 91.7% have their children in school. Low feeling for need of send children to school and far location of school were mentioned as major reason for not enrolling in school.

Those respondents who reported that their children had dropped out from school were 17.9%. The most frequent reasons for dropout were because children are needed for household labour (39.2%) and low academic performance (31.4%).

Table-9. Variables related to education and school attendance in ATJK

Variable	Responses	Frequency	Percent
Distance to reach to the nearest school	One hour or less	295	82
	Two hours	58	16
	Three hours	5	0.9
	More than four hours	2	1.2
Among your children who are in school age, how many are in school?	None of them	30	8.3
	One child	94	26
	Two children	95	26.5
	Three children	59	16.3
	Four Children	45	12.5
	More than four children	38	10.5
Reasons for non attending school	Children are needed for labour	35	11.8
	School is located far away	94	31.4
	Do not feel the need to send	100	33.3
	Other	70	23.8
Have any of your children dropped from school?	Yes	64	17.9
	No	296	82.1
Reasons for dropout		N=64¹	
	School is located too far	9	13.7
	Low academic performance	20	31.4
	Because of poor health/Nutrition	4	5.9
	Needed for household labour	25	39.2
	Other reasons	6	9.8

¹Those households who reported dropouts

4.6 AGRICULTURE AND SELF SUFFICIENCY

Private farm holdings were the major source of food in the 79% of the respondents, and only 1% of the respondent were fully relying on relief aid. Percentages are more than 100 % because of multiple responses.

More than half of the respondents felt that the food available in the household was adequate for the family. The most common food item eaten in the study population was Maize (92.5%) followed by barely (5.8%). About ninety seven percent of the households get vegetables of different sort in their household, green leafy vegetables (77.5%) and onion (42.8%) being the most commonly eaten.

Household heads were asked for how long the available food reserve can serve and 58.1% said they had enough for 4-6 months and more than a quarter for 1-3 months. Taking the total number of different livestock in the study population, an average number of livestock per household was calculated and graphically represented in figure 5.

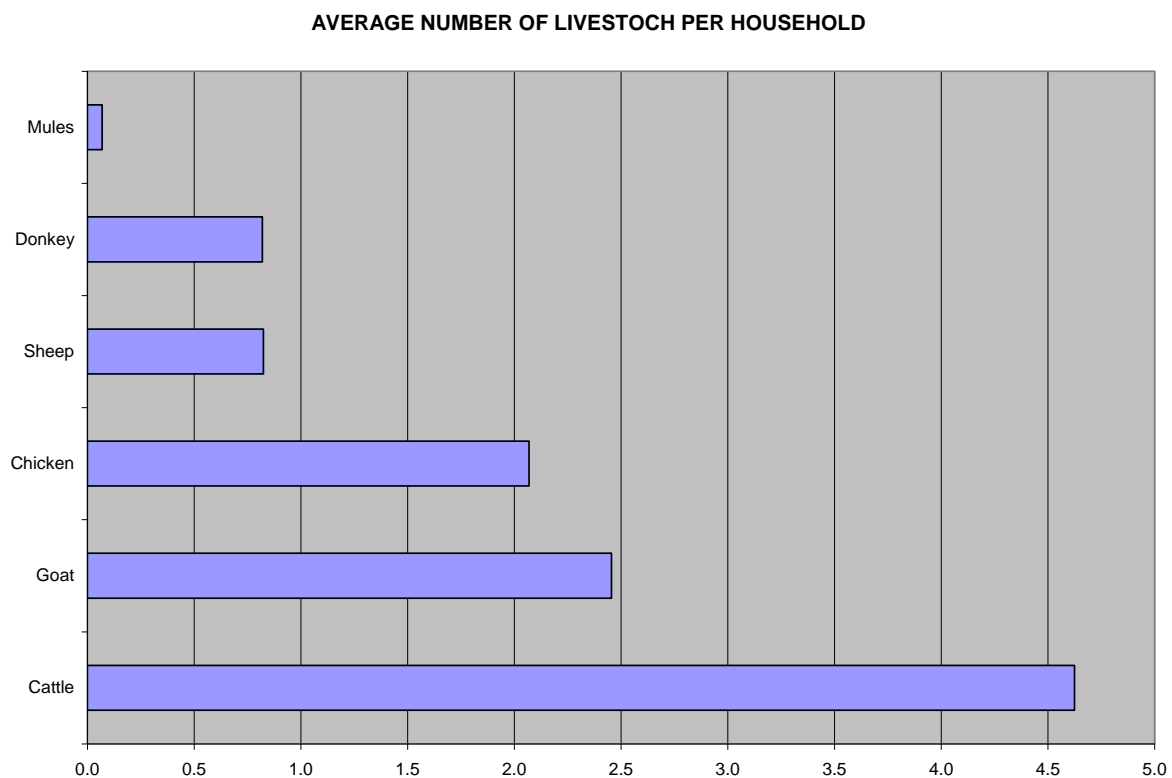


Figure 5; The average number of different livestock per household

On average, every household has at least four cattle, at least two goats and chickens.

Table-10 Variables related to agriculture and self sufficient assessment

Variable	Responses	Frequency	Percent
Source of food of the household	Private farm holdings	285	79
	Market	210	58
	Relief Aid	3	1
Is the food available in the household adequate for the family?	Adequate	209	57.9
	Not adequate	151	41.9
Most commonly eaten item in a HH	Barely	21	5.8
	Maize	333	92.5
	Teff	6	1.7
vegetables eaten in the HH	Carrot	11	3.1
	Green leafy vegetables	199	55.3
	Onion	118	32.8
	None at all	27	7.5
	Tomato	5	1.4
How long the available food can serve?	No reserve	11	3
	One week	26	7.1
	Two to three weeks	19	5.3
	1-3 month	95	26.4
	4-6 month	209	58.1
Have you suffered from poverty in the last six months?	Yes	220	61.1
	No	140	38.9
Did you receive food aid in the last six months?	Received	74	33.6
	Not received	146	66.4
How many times did you receive food aid in the last six months?		N=74	
	Once	29	39
	Twice	16	21
	Three or more	29	39

About sixty-one percent of the households responded that they had suffered from poverty in the last six months. During which time 51 % of them sold their live stock as a coping mechanism, where as 18% borrowed from friends, 14% got relief from NGOs (see figure 6). About thirty-four percent of the households in the study population received food aid relief during the last six months out of which 39% got once, and 60% received more than once.

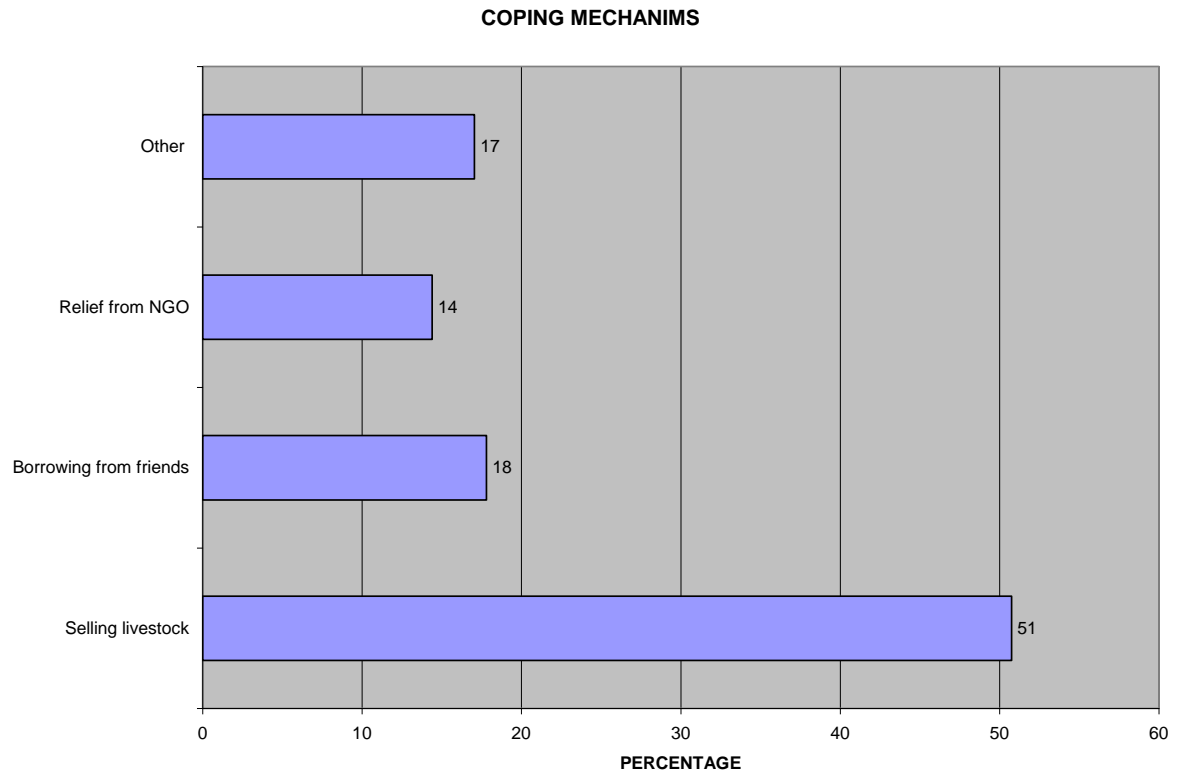


Figure 6: Coping mechanism used by households to survive poverty

5. FINDINGS OF QUALITATIVE COMPONENT

Health

According to the focus group discussion with the community members in Adamitulu Jido kombolcha, common health problems in the area are Malaria, Diarrhea, and fever and eye disease. When they commented on the challenges or difficult situations in the community in relation to access to health service, it came out that they had lots of challenge previously, however after ADRA trained the CBRHAs this problem has been decreasing. They said this is because, CBRHAS have been teaching them how to take care of themselves, how to prevent disease and what to do when disease occurs. A middle aged mother said *'Among the preventing ways, they thought us about keeping ourselves clean, how to prepare pit latrine, draining surface water, etc'*. It was reported that the CBRHAs have been doing their activities through home to home visit.

When focus group discussion participants were requested about Health care seeking behaviors of the community members, they indicated that there is a big change in this regard in the recent years. A man in late forties said, *'no one remained at home when he/she feels sick or when there is fever, headache or diarrhoea. It has become culture to go to a health center when ill.'* All respondents echoed that in the last three years there has been big improvement in community's behaviors in seeking health care. A female respondent said, *'Before three years, we used to use traditional medicine to apply on eye diseases, however after we received health education by ADRA trained CBRHAs, we are aware and we seek health service as soon as we feel sick.'*

The respondents also mentioned that the CBRHAs were teaching them to use family planning methods based on their choice such as oral pills, injections, norplant, and condom. As a woman said, *'Regarding family planning, we are using Norplan that serves preventing pregnancy for 5 years. Apart from this we have obtained oral contraceptive pills and injections.'* It was said that every mother is aware of importance of vaccination because they have been told by CBRHAs, and they said, whenever there is a vaccination program be it in immunization campaign or outreach at kebele level, the community brings all children for vaccination.

Regarding personal and environmental hygiene, they said they now know the advantage of hand washing before handling food. A female respondent said, *'We are told that if one does not wash hand before handling food, it can cause diarrhea and ameba. We wash our hands after latrine because it can cause intestinal disease. We have been thought about importance of pit latrine and the consequences of defecating everywhere in open field.'* They added that they are informed on importance of cleaning their environment, *'we know that if we clean our environment, we can prevent malaria, diarrhea, and other diseases.'* They know If they use pit latrine and keep personal and environmental hygiene, their children will be protected from intestinal diseases.

ADRA has built pit latrine for some members of the community and it has trained them how to use it together with purpose of hand washing after latrine. Moreover, it was mentioned that some people have prepared pit latrine by themselves based on the education they were given. Generally all respondents agreed that in the past three years they have known how to prevent diseases.

Education

Attitude of the community in sending children to school is changing, according to the respondents, nowadays; every parent is sending their children to school, because everyone knows about advantages of sending children to school. As one man said, *'In the past three years attitude of parents in sending children to school has improved very well. When children reach 5 years and above, all parents are sending them to school. There is a fundamental change of attitude in sending their children to school.'*

The respondents mentioned several advantages of sending children to school;

'Education is foundation for development. If a person is educated, he can help himself to become a great man, and he can also govern the society.'

'If a person is educated he will be changed and he can change the life standard of the community.'

'Uneducated man will be burden to the community; he will be thief, drunkard, become engaged in non-productive harmful practices that pose danger to the community. So learning has lots of advantages to the people.'

'They gain knowledge and develop'

'If children are educated they can be respected and work in governmental organizations'

'Because there is no enough land to plough for the community at this time, the only way to escape this land scarcity is to educate children and prepare them for other work opportunities'

'If children get education, they can change their communities, families and the country. They know how to keep themselves clean and healthy, and how to prevent diseases. They can get everything by being educated.'

'They can serve their families when they return from school. Even they are teaching us what they learned in school such as importance of hand washing, keeping environment clean, so we are really happy to send our children to school.'

'Before ADRA constructed this school, our children had been traveling very long distance to town which take two to two and half ours, but now thanks for ADRA they can reach school in maximum of half an hour.'

The survey team visited two schools to assess the quality of education. The first school is named Wallin Bulle and it teaches students of grades 1-4. In current academic year, there are 327 students of which 45.8% (157) were girls and 54.2% (170) boys. It is the only school in the kebele and established 3 years ago. The previous year they had 20 drop outs, including 8 males and 12 females. The main reasons were distance and lack of water in their village which takes 2-3 hours to fetch water from the nearest source. The school is staffed by four teachers, 3 employed by government and one of them paid by the public. The first grade has 97 students, second grade 66 students, grade three has 110 and fourth grade has 54 students in class.

According to discussion with the headmaster, after ADRA established school roof water catchments, it helped to increase school attendance and encouraged morale of teachers. He said “ *We very much appreciate role of ADRA and that is why we requested for ADRA logo to be written on the water tanker*”

The other school is Edo kontola which started service in 2007/8. In current academic year, it has 278 students including 45.3% (126) males and 54.7% (152) females. It has three grades; first grade has 73 students, grade two has 90 students and grade three has 115 students in class. It has four teachers i.e. 3 government employees and one paid by public. The previous year, they had 30 dropouts, including 16 males and 14 females. The major reason by then was lack of awareness among parents which the headmaster believes it has improved with time.

Water and sanitation

It was known that the community gets water from different sources. In some villages, animals and human beings use water from the same source. As the respondents mentioned, In Gido kebele there is one deep well near the village and both animals and people are using this water source. In other villages, for instance in Edo kontola, human beings and animals are using different water sources; humans are using water from deep well and animals are taken to the lake.

Regarding attitude of the community in using pit latrines, they said that the community has been trained by ADRA volunteers about the advantages of using pit latrine for the last three years. Some households have started to construct pit latrine by using their own resources and already started using pit latrine. In addition ADRA has been providing VIP latrines for the community and the community members expressed their happiness about it, and sincerely appeal for its continuation. A male respondent said, *‘In the past we were using open field defecation, and we had suffered from diarrhea by drinking contaminated water by human feces. But after ADRA started this project, we had received training from CBRHAs and started to prepare pit for latrine, and also some households received pit latrine from ADRA. We know the advantages of excavating pit latrine and we are using it.’* Another respondent added that *‘We sincerely request ADRA to continue to distribute pit latrine for all communities.’*

Migration in search of food, water or work

According to the respondents, migration in search water was common practice previously, but for the last one year, they said the community been relieved from migration, thanks for the water tanks and deep wells constructed by ADRA and some other humanitarian organizations. But occasionally when electric power is cut off, the community fall in to water crisis and is obliged to travel far places to get water. As one female respondent said, *'In the past two years migration in search of water has significantly reduced except in situations of power cut and pipe malfunction.'* Some participants said, there is no migration in search of food, water or work at this time but migration in search of land for farming is happening. It was mentioned that in some part of the district that didn't receive support from ADRA there is still migration in search of water.

Environmental protection

The respondents were requested to discuss if deforestation is commonly practiced in the area, if so, what are the reasons and their knowledge on impacts of deforestation. According to the response, nowadays the community has increased awareness about consequences of deforestation and do not cut trees; rather people are more involved in reforestation. They said the government and ADRA have been distributing seedlings and people have received training from ADRA on advantages of planting trees and everyone is practicing taking care of endogenous trees and planting more trees. Generally there is a great improvement in knowledge and practice in the community after they received training by CBREAs and other community volunteers.

A male FDG participants said, *'previously before ADRA came in to our village, deforestation was happening in the community, but at this time the community received training from ADRA volunteers and governmental development agents about consequences of deforestation, and no more deforestation.'*

The respondents said, nowadays everything has improved because of reforestation, *'the climate is changing we got more rain fall, and we stopped deforestation for production of charcoal'* said a female respondent.

The community members were asked to mention impacts of deforestation, the responses were as follows;

'It exposes soil for erosion, washes off the surface of earth and make it dry and less fertile'

'It will reduce rain fall, creates bad weather condition.'

'The environment becomes dusty as there is no tree to reduce the wind'

'There will be no shade to protect human beings and animals from strong sun light'

'It will create shortage of water, where human beings and animals will not have water for all purposes'

'The environment will be desert and it will lead to hunger'

'If there are no trees the fertile part of the land will be taken off by wind and no good production of seeds'

'I believe if there is no forest all living things will not be able to survive on earth.'

'If there is deforestation, there is no rain fall, the climate and sunlight becomes so strong'

'If there is forest, it can pull cloud and causes rain. It keeps the land cold'

In summary they said, they learnt many about deforestation in the past three years. According to the respondents, in order to get adequate rain fall and prevent hunger, everyone should stop deforestation and takes care of indigenous trees and plant more trees. They also mentioned that ADRA has supported them by providing energy saving stove which helped to reduce deforestation

General opinion about ADRA

The participants of focus group discussion were requested to express their general opinion about what ADRA has been doing over the past three years;

'ADRA provided us with pit latrine, water tanker, school, and family planning, education about personal and environmental hygiene'

'Our community came to know about family planning because of ADRA'

'We have got school and our children started education and they fill gap of knowledge in education among the community. Our children are educating we parents about personal hygiene, sanitation, family planning and other important things.'

'Regarding energy saving stove, we sincerely believe ADRA gave us the best thing we ever saw in our life'

'Before ADRA gave us this option, the fire from wood had burnt our cloth, parents and children were heavily exposed to smoke which expose them for eye diseases and other health problems. Nowadays, after we started using the energy saving stoves such problems have gone.'

'This is the best choice for rural women, previously we suffered a lot from eye diseases caused by smoke of fire woods, and it burnt clothes and children. But by using this technology, no need to collect fire wood on daily basis, instead we can use animal dung or other dry things around us, so no eye disease no fire hazard'

'By using pit latrine we have prevented diarrhea, typhoid, and intestinal parasites by washing hands after defecation.'

'We know how to space birth by using family planning. Before ADRA trained us, every woman was giving birth year after year like 3 children in 3 years, but nowadays we do not have such problem because we can use any family planning method based on our choice. This happened because of ADRA.'

'We have received education about harmful traditional practices like female genital mutilation, uvulectomy, skin burning.'

'We thank ADRA for what it did for us and we like if it continues helping us for many years.'

6. DISCUSSION AND RECCOMENDATIONS

6.1 DISCUSSION

The findings demonstrated that knowledge of the community about HIV/AIDS has increased to 90.8% compared to the baseline data of 90.3%. Although the increment with overall knowledge seems minimal, the difference is huge in terms of details how the disease is transmitted. For instance, unprotected sex was mentioned by 81.8% of the respondents which was only 71.9% at time of baseline. Another evidence for improved quality of knowledge is the fact that 95% of the respondents know at least one mode of transmission.

Similarly knowledge about ways of transmission has increased during the project implementation period, as the percentage of community members that didn't know the prevention methods of HIV/AIDS which was 18% reduced to 8%. Awareness about PMTCT and use of condom, increased by 17% and 26.5% respectively compared to the baseline data.

With respect to family planning, more percentage of the population is aware of the choices compared to the baseline. About eighty-eight percent of the respondents had the knowledge on how to delay/prevent pregnancy which was only 67.5% three years ago. Those ever used family planning method increased from 34.2% to 52.9%. Contraceptive prevalence rate among the eligible gas increased from 9.2% to 23.9%, which is remarkable.

Regarding vaccination about ninety-five percent of the mothers have heard about vaccination programs of which 81.8% had already taken their children to vaccination sessions. The figure was lower in all respects three years ago, both in terms of general knowledge and practice.

Significant majority of the respondents (91.1%) eat three times a day, and nearly all at least twice a day, while at time of baseline survey the proportion of families that eat three times a day was Sixty-five percent. Almost seventy percent respondents answered that their children drink milk every day, and among those children who drink milk, on daily basis, about 55% of them get two or more cups of milk while the figure three years ago demonstrated that of those children who drink milk on daily basis, only about 38.8% of them get two or more cups of milk.

The two weeks childhood morbidity for diarrhoea/vomiting and cough was found to be 4.4 and 4.5 percent respectively, which were 9.8 and 9.1 percent. A general observation is that the practice of the community in using modern treatment has improved over time. As the finding demonstrated, percentage of women using ORS in treatment of children with diarrhoea increased from 14.7% to 35.3%, while knowledge on causes of diarrhoea increased by 50%.

More households are getting water supply from pipe and protected well (17%), which is much higher than the situation observed at time of the base line in 2006. Previously many households used to walk more than three hours to fetch water, whereas currently the percentage has reduced from twenty-eight percent to eleven.

Majority of households get water from a distance of less than half an hour and their frequency of fetching has increased as the distance gets shorter.

Knowledge on hand washing before handling of food has improved better than that the previous time, and similarly Practice of hand washing after defecation increased from 64.2% to 92%.

The major way of disposing household garbage is through dug a hole and dumping it there (45.7%), and about a quarter dispose everywhere on the ground. This is an improved practice compared to what was happening three years ago as it was reported by then that 82% of the households dispose everywhere on the ground. The percentage practicing burning or burring of trash increased from 16.7% to 70.7%. knowledge of at least two consequences of environmental degradation increased by 32% and similarly knowledge of at least two ways of preventing increased by 21%.

The number of households that use pit latrine has increased and proportionally the percentage that use open field as the primary way of faeces disposal has reduced. This is an evidence for improved sanitation practice of the community.

Ninety three percent of the respondents in the study population were using fire wood as a means of cooking, which was relatively better as every body used to fully rely on it previously. This shows that some people have started using alternative source of energy like biogas. In terms of the number of consequences of environmental degradation more and more villagers have become aware of the various multidimensional consequences, which is an important development to protect the environment.

The distance to reach to the nearest school has been decreasing with time, and most parents are sending their children to school.

Private farm holdings were the major source of food in the community which is much more than the situation in 2006. Unlike the previous time, none of the respondent was fully relying on relief aid. About half of the respondents felt that the food available in the household was adequate for the family while ninety percent of interviewees during baseline survey felt it was not adequate.

The household food security level has improved as more families are having food reserve for longer duration. The average number of cattle in every household has increased by one, and similar increment has been noted in the average number of goats and chicken. About sixty-one percent of the households responded that they had suffered from poverty in the last six months, which was reported by Eighty percent at time of baseline.

The qualitative data demonstrated that the community has gained ample knowledge regarding health such as on family planning, vaccination, personal and environmental hygiene. Attitude and practice on education has shown marked

progress, and there is a fundamental change of attitude in sending their children to school, and school enrolment has increased. Migration in search of food, water or work has reduced significantly. It was made clear that nowadays the community has increased awareness about consequences of deforestation and do not cut trees; rather people are more involved in reforestation.

6.2 CONCLUSIONS AND RECOMMENDATIONS

The findings demonstrated that the community development activities implemented by ADRA, over the past three years, have brought about a lot of significant changes in Adami-tulu jido kombolcha district. All parameters from health to environmental protection are indicative of the beneficial impact of the project. Public awareness about health issues especially on prevention of communicable diseases and timely seeking of care has shown a marked improvement. Utilization of primary health care services like family planning and vaccination has become almost a popular culture. The education on hygiene be it personal and environmental sanitation has influenced the public sense of cleanliness and practice to impressive degree.

Attitude towards sending children to school has dramatic progress to extent the community perceive that 'children to school and adults to work.' It has been remarkable to hear from the community the way they express their appreciation of value of education.

There are evidences that the public has already taken the lead in conserving the environment so much so that they associate the presence of trees to survival of human beings and all living things, their slogan being 'no trees no life'. They are confirming their commitment not only by avoiding cutting trees and planting more but also by shifting their practice to use alternate sources of energy for cooking.

Poverty has been deep-rooted problems in the community and very difficult to see changes in short period of time. However, the findings demonstrated that even such seemingly unbeatable challenge is showing defeat gradually. More households are depending on their private farm holdings to feed their family, and the food security period has increasing over time.

As a general remark, given the short duration of the project, the changes obtained so far are impressive and cost effective. Most importantly the project activities have been driven by the need of the community, through active participation of the beneficiaries. At this stage, the question is, 'is it really timely for the project to come to its end?' There are number of issues to consider answering this question, first of all community developmental efforts of this kind require a longer period of time to see the overall impact in the community. Second the remarkable achievements obtained so far are still in process of upward trend and they require close follow-up to maintain their progress. Third, further extension of the project's duration requires

minimal resource compared to the first time, as all the major project investments have already happened at the beginning and what is needed more is only running costs. The community has been well sensitized and already reached a stage where they appreciate the need and importance of striving for change and as time goes on the public will rely more and more on its own resources and gradually less dependent on the external support.

Therefore for these and other reasons, it is strongly recommended that the project extend its assistance to the community at Adami tulu Jido kombolcga district for few more years. There is a need to conduct critical analysis which helps to scrutinize the strengths, weaknesses, opportunity and threats, and based on the identified gaps, to build on successful interventions in order to design more effective and efficient strategies. The project has laid its foundation of success on its remarkable community empowerment approach which will remain to be the ultimate guarantee of alleviating poverty and realizing a prosperous and productive society.

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ANNEX I SCOPE OF WORK



TERMS of REFERENCE

For the Final Evaluation of the project:

Integrated Rural Community Development Project (IRCDP), Adami Tulu Jido Kombolcha (ATJK) District of the Oromiya Regional State of Ethiopia

Implemented by: **ADVENTIST DEVELOPMENT & RELIEF AGENCY ADRA Ethiopia**

2. BACKGROUND

2.1. Information on the NGO

Adventist Development and Relief Agency (ADRA) is an International NGO working in 125 countries across the world. ADRA is a non profit NGO with a motto of changing the world one life a time. ADRA works in emergency relief and development works in a given needy community at grassroots level irrespective of age, sex, religion, ethnicity, color or race.

2.2. Information on the NGO's activities in the country of the operation

ADRA Ethiopia has been implementing several development and emergency projects in Ethiopia since 1982. ADRA Ethiopia works in 4 major regions of Ethiopia. Our areas of work covers, Health and Nutrition, Water and Sanitation, Education, Emergency response, Integrated Rural community Development Projects, Environmental Protection Projects and Prevention of Harmful Traditional Practices. Our major donors include; ADRA Norway & Norad, ADRA Germany & GFM, ADRA Switzerland, ADRA Sweden & SMC, USAID and several Private donors.

2.3. Information on the Integrated Rural Community Development Project

ADRA Ethiopia's Integrated Rural Community Development Project commenced February 2006 and continues through December 2008, funded by Norad and ADRA Norway.

The goal of the project is to improve health, education, and environmental awareness of local villagers in Oromiya region in Ethiopia through construction of water systems, latrines, bio-gas units, energy saving stoves, schools, and provision of health promotion activities through community volunteers. Projects activities have been carried out in 15 Kebeles in a remote area of Adami Tulu Jido Kombolcha (ATJK), East Showa Zone, Oromiya Region of Ethiopia.

The project is composed of three components: Water, basic education, health promotion and environmental awareness:

a) Water: The objective of this component is to provide potable water to 36,000 people in ATJK through construction of one well and 15 above ground water reservoirs.

To achieve the intended impact, water committees have been established with the purpose of managing the potable water in cooperation with the village executive committees. One existing well in Anano Shisho including a water system (holding tank and pump) will be drilled and 15 above ground water reservoirs with rainwater roof catchments systems will be constructed.

b) Basic education: The objective of this component is for 600 students; 1st grade though 4th grade, to have access to basic education through construction of 3 school buildings in 3 separate Kebeles in ATJK.

To achieve the intended results, school building committees have been organized and constructions of three schools have been done. Also, three adult education facilities have been established to provide adult education and training to local villagers.

c) Health promotion and environmental awareness: The objective of this component is for 12,000 local villagers to have increased knowledge in basic health and hygiene issues and environmental awareness and have means to practice methods of improving sanitation, hygiene and environmental degradation.

This objective is to be achieved through the following activities: a) Establishment of committees (health promotion committee and environmental committee), b) training of trainers (community based volunteers, local government staff), c) Construction of dry pit latrines, d) construction of household bio-gas units e) health and environmental education activities in the communities f) construction of energy saving stoves.

3. PURPOSE AND SPESIFIC OBJECTIVES OF FINAL EVALUATION

The final evaluation will cover the project period from February 2006 to the date of the evaluation (December 2008). The purpose of the final evaluation is to determine the extent and direction to which the project goal and objectives were achieved. This will be done through a participatory process that will involve a diverse range of different project stakeholders. The evaluation will provide recommendation as to how to continue with development projects in the area as well.

Specific objectives:

3.1.1. Specific objectives related to general project management:

- To assess general implementation and management of the project in terms of quality, timeliness of inputs and activities, adherence to work-plans, logical framework and budget.
- To assess achievements of the project against the original objectives, outputs and activities as detailed in the project document, including logical framework.
- To assess the appropriateness and relevance of the project's design and implementation strategies to the identified needs in ATJK and in Ethiopia.
- To assess adequacy of management arrangements as well as monitoring and backstopping support given to the project by all parties as established in the project proposal and other unforeseen support
- To assess responsiveness of project management to changes in the environment in which the project operates
- To identify lessons learned to be used in future projects.

3.1.2. Specific objectives related to water component:

- To assess the number of water committees established and their ability to manage the water points.
- To assess the number of above ground water reservoirs constructed and

- their functionality (including quality)
 - To assess the number of rehabilitated boreholes and their functionality (including quality).
 - To assess the monitoring/supervision of water committees by project staff
- 3.1.3. Specific objectives related to health promotion:
 - To assess the type of activities conducted by the community based rural health agents (CBRHA) in the villages including sustainability of those activities.
 - To assess the effectiveness of CBRHA training
 - To assess the monitoring/supervision of the CBRHA by ADRA staff
 - To assess the monitoring system for data collection by the CBRHAs.
 - To assess the materials used and key health message being taught by the CBRHA.
 - To assess the relevance of the health and hygiene training to the socio-political environment.
 - To assess the knowledge level of the project beneficiaries
- 3.1.4. Specific objectives related to environmental awareness:
 - To assess the type of activities conducted by the community based rural environmental agents (CBREA) in the villages including sustainability of those activities
 - To assess the effectiveness of CBREA training
 - To assess the monitoring/supervision of the CBREA by ADRA staff
 - To assess the monitoring system for data collection by the CBREAs.
 - To assess the materials used and key health message being taught by the CBREA.
 - To assess the relevance of the health and hygiene training to the socio-political environment.
 - To assess the knowledge level of the project beneficiaries
- 3.1.5. Specific objectives related to education:
 - To assess the number of schools and adult training centers constructed and their functionality
 - To assess number of students who have access to basic education
 -
- 3.1.6. Specific objectives related to sustainability
 - To assess how the flow of benefits to the beneficiaries and society as a whole are likely to continue after the external aid ends
 - To assess stakeholder perceptions and beneficiary participation and ownership in the project interventions
 - To assess if the beneficiaries will be able to adapt and ensure continuity of the services after the project ends
 - To assess the level of commitment and support from the local authorities and to what extent the project's activities been integrated into local institutional structures
- 2.1.7.2 Specific objectives related to Gender issues
 - To assess the level of gender balance in project committees, beneficiaries and community volunteers
 - To assess if the community is aware of the notion that women should participate equally in community decision

4. EVALUATION METHODOLOGY

The final evaluation will consist of a quantitative survey (KAP) and information from methodologies of more qualitative and participatory in character, involving the principle stakeholders in the project, will be added. The stakeholders will include:

- General project beneficiaries; men and women (direct recipients of the interventions).
- Water committee members
- What other committees?
- Community volunteers (CBRHA and CBREA)
- ADRA Ethiopia staff members
- Local authorities – Sector offices for health, education and environment

4.1. The evaluation may include the following methodology:

4.1.1. Review of existing information and secondary data:

This will include review of project proposal (including log frame, detailed implementation plan, and budget), baseline survey report, mid-term evaluation report, quarterly reports, and project agreements. These documents will be provided prior to the evaluation to allow team members to become familiar with the project.

4.1.2. Quantitative KAP survey

The baseline survey will be repeated to be able to measure the impact of the project activities. The same questionnaire and methodology will be used and data analysis will include comparison to baseline data set.

4.1.3. Focus Group discussions:

This methodology may be used when extracting information from for example water committees committee's, CBRHA, CBREA, local authorities and direct beneficiaries.

4.1.4. In-depth, individual interviews (semi-structured):

This may be used with ADRA staff, local authorities etc.

4.1.5. Direct observation:

During the visits to the villages the evaluation team will see the project activities and outputs delivered by the project.

4.1.6. Most Significant Change Stories:

This method will be used to supplement focus group discussions, and as a tool in in-depth interviews. It has the potential to reveal unintended outcome of the project as well as suggest impact.

4.1.7. Informal meeting:

During the implementation of the evaluation informal meetings between the evaluation team and the different stakeholders may take place. Observations and impressions from these encounters will influence the overall impression of the project by the evaluation team.

4.2. Sampling procedures:

A sample of all the target villages will be selected randomly. The consultant will decide on the appropriate sample size based on the scope of the evaluation and the methodologies selected. The consultant will conduct the random sampling.

4.3. Limitations/assumptions

There are several limitations/assumptions to the implementation of the final evaluation:

- It is possible that in January we may see some rain. We assume that this does not affect the survey
- Government officials provide necessary support for the survey

- The consultation fee does not escalate as is seen with prices of several services here in Ethiopia

5. EVALUATION TEAM LEVEL OF EFFORT AND COMPOSITION

5.1. External Consultant, Team leader:

Competencies include project management experience in integrated rural community projects (including water, education, health and environment). He/she have extensive experience in implementation of quantitative and qualitative evaluations including design of qualitative/quantitative evaluation tools, sampling, training of enumerators/supevisors, data collection, data analysis (SPSS or EpiInfo) and report writing. He/she will have experience from Ethiopia.

He/she is responsible for the overall implementation (team leader) of the final evaluation including review of project documents, development of evaluation tools as needed, training of enumerators/supervisors, data collection, data analysis and report writing including recommendations and lessons learned.

5.2. Enumerators

12 Enumerators will be hired to participate in the data collection for the KAP survey. Competencies include, under best scenario, good understanding of the English language and Affan oromo (Local language). It also requires good knowledge of the lay out of ATJK, with good capacity to move around in the ATJK terrain. The pther option is to prepare the questionnaire in the local language so that we can get people with good knowledge of the area.

5.3. Supervisors

We need five to six supervisors and we can get as much from ADRA Shashemene and ADRA Ethiopia programs department. Also we shall use some staff with good capacity from government offices.

5.4. Assistant for focus group discussions

The consultant will be hired from Addis Ababa with experience in both qualitative and quantitative services. His CV will be shared with ADRA Norway before hand. Assistance, if so required on the local language will be provided by project staff.

Since this is an external evaluation, we cannot use project staff for this. Hire an external or use someone for Addis office

5.5. Data entry staff, Hewan Ayalew

She is ADRA Ethiopia's IT specialist and will enter data during the survey.

5.6. Gezu Legesse, Project Manager

Competencies include a BA in Economics and Business Administration with 7 years experience in NGOs (5 of them in ADRA) as Monitoring and Evaluation Officer, Project Officer and Project Manager. Has been involved in several population based surveys as Supervisor and data entry personnel and had proved himself competent..

He will be responsible to assist the evaluation team in every aspect of the survey process. He takes charge of logistics and administrative arrangement as well as facilitating the implementation of the survey, with technical assistance from Programs Director

5.7. Mesfin Hailemariam, Programs Director ADRA Ethiopia

A Medical Doctor with 16 years of experience in public health and community development as well as child serviva projects. Had been working in different capacities in ADRA Ethiopia for the past five years as Field Doctor, Project Officer, Project Director and Programs Coordinator. Has lead and directed several population based surveys for ADRA and has coordinated and conducted all ADRA Ethiopia's Nutrition Surveys in Somali region. Presently working in ADRA Ethiopia HQ.

He will be responsible for closely monitoring the survey process including hiring of consultant, schedule of activities, development of ToRs, and ensuring timetable is adhered to.

6. FINAL EVALUATION SCHEDULE OF ACTIVITIES

Task	Time table	Responsible
Develop detailed budget for evaluation to be submitted to ADRA Norway	By October 20, 2008	ADRA Ethiopia
Identify and hire of consultant(s)	By November 15, 2008?	ADRA Ethiopia
Identify and hire enumerators and supervisors	A day before training starts	ADRA Ethiopia
Review project proposal and other relevant documents	December with the consultant	Consultant and ADRA Ethiopia
Review baseline KAP questionnaire and add a few questions if needed	December with the consultant	Consultant in consultation with ADRA Ethiopia
Develop qualitative evaluation tools	December with the consultant	Consultant in consultation with ADRA Ethiopia
Conduct sampling of the target population	During the training	Consultant
Conduct training of Enumerators and supervisors	2 days	Consultant
Conduct training of data entry person	A week before the training of data collectors for 2 days	Consultant
Conduct the KAP survey (data collection)	5 days	Consultant
Conduct data collection for the qualitative evaluation	3 days	Consultant
Data analysis and report writing		Consultant
Submit draft evaluation report to ADRA Ethiopia	10 calendar days after consultant returned from the field	Consultant
Submit draft evaluation report to ADRA Norway	10 calendar days after consultant returned from the field	ADRA Ethiopia
ADRA review draft report	5 days	ADRA Ethiopia and ADRA Norway
Submit Final evaluation report to ADRA	10 calendar days after comments have been received from ADRA	

7. BUDGET

8. REPORTING REQUIREMENTS

The first draft report, in accordance with the format given below, shall be submitted by electronic transmission (Word 97.0 format or a more recent version) within 10 calendar days after the consultant's return from the field. The draft will be sent to the partners (ADRA Norway, ADRA Ethiopia and Government line departments) and they will have 5 working days to make their comments. A final report should be given to the donor office after 10 calendar days after the comments from the partner being evaluated.

8.1. Report format:

The final report should include the following sections:

- Cover page
- Table of content
- Executive summary
- Body of the report which will include:
 - Introduction
 - Purpose and specific objectives for the final evaluation
 - Methodology employed
 - Findings
 - Analysis/discussions
 - Conclusions and Recommendations

Supporting data should be included in appendices. The appendices should include, among other pertinent technical or supporting documentation:

- The evaluation teams Terms of Reference
- Data collection instruments
- A list of places visited
- A list of documents reviewed
- A list of persons interviewed (FGDs)
- Most Significant Change Stories

ANNEX II REVIEW TEAM'S COMPOSITION AND QUALIFICATION

Name	Qualification	Responsibility
Ezra Shimeles	MD,MPH	Consultant principal Investigator
Mesfin Hailemariam	MD, Pediatrician	Survey coordinator
Zerihun		Country director
Hazel Smart		Project officer
Legesse Hirpa	HO	Survey coordinator
Gezu Legese	Sociologist (BA)	Supervisor
Hana Dembi	Accountant	Supervisor
Lencha Tekle	nurse	Interviewer
Omar Abdulahi	Sanitarian (Bsc)	Interviewer
Roba Ditta	Diploma	Interviewer
Samuel Megersa	Diploma	Interviewer
Beri Oljira	Nurse	Interviewer
Hamda Bati	Nurse	Interviewer
Kemaye Girma	Diploma	Interviewer
Ruvia Ferejo	Nurse	Interviewer
Tigist Ayalew	Nurse	Interviewer
Adugna Abebe	Nurse	Interviewer
Shimeles Defak	Nurse	Interviewer
Ayele Zenebe	Nurse	Interviewer
Abdella Uluso	Nurse	Interviewer
Abdi Adem	Nurse	Interviewer
Feysa Edeti	Nurse	Interviewer
Mesfin Guta	Nurse	Interviewer
Mekdes Tekleselasse	Sanitarian	Interviewer
Alemayehu Mamo	Nurse	Interviewer
Susi Tadesse	Nurse	Interviewer
Abyio Barra		Guide translator
Nega Bara		Guide translator
Feyso Negeso		Guide translator

ANNEX III DATA COLLECTION INSTRUMENT

QUESTIONNAIRE FOR BASELINE SURVEY ON HEALTH, EDUCATION AND ENVIRONMENTAL SANITATION IN ATJK DISTRICT

ADRA ETHIOPIA

INSTRUCTIONS:

1. Ask the following questions the head of the household. In case he/she is not present ask the questions the marital partner of the head of the household. In polygamous family it is only the wife who lives in the selected house who should be asked.
2. Please mark X in the box in front of the answer
3. In questions where multiple answers are possible, put X in all boxes in front of each answer

Peasant association: _____

House number: _____

Name of interviewer: _____

Name of supervisor: _____

Date of interview: _____

I. SOCIO-DEMOGRAPHIC DATA

1. How old are you? _____

2. Respondent's sex: Male Female

3. Ethnicity

- a. Oromo
 b. Amhara
 c. Other (specify) _____

4. Religion

- a. Muslim
 b. Orthodox
 c. Protestant
 d. Other (specify) _____

5. Are you married?

- a. Married
 b. Divorced
 c. Widow
 d. Never married
 e. Other (specify) _____

6. Educational status

- a. Illiterate

- b. Read and write
- c. Elementary school (1 – 8th grade)
- d. Secondary school (9th – 12th grade)
- e. College or more

7. What is your main occupation?

- a. Farmer
- b. Government employee
- c. Community worker (health extension agent, agricultural development agent)
- d. Other (specify) _____

8. How much is the household's income per month? (*try to assist in providing best possible estimate*)

9. Number of people who live in the house in the following category:

Total number of people in the household: _____

Children less than 12 months of age: _____

Children 12 months to 5 years old: _____

Children 6 – 18 years old: _____

Women of child bearing age (15-49 years): _____

Currently pregnant women: _____

II. HEALTH

10. Have you ever heard about HIV/AIDS? (*if the answer is b go to Q.12*)

- a. I have heard
- b. I haven't heard

11. If you have heard about HIV/AIDS, do you know how HIV is transmitted? (*There can be more than one answer*)

- a. Unprotected sex
- b. Mother to child (during pregnancy, delivery or breastfeeding)
- c. Contaminated sharp objects like blade
- d. Contaminated injection
- e. Blood transfusion
- f. Other (specify) _____
- g. Don't know

12. What are the ways of prevention of HIV/AIDS? (*There can be more than one answer*)

- a. Abstain from sexual activity
- b. Be loyal to partner (does this mean – have sexual relation with one partner that is HIV negative)
- c. Proper and consistent use of condom
- d. Prevention of Mother to child to Transmission how?
- e. Avoid use/sharing of unclean sharps, syringe and needles
- f. Others(specify) _____
- g. Don't know

13. Have you hear about family planning methods? (*if the answer is b go to Q. 18*)

- a. I have heard
- b. I haven't heard

14. What type of family planning methods do you know? (*There can be more than one answer*)

- a. Pills
- b. Depo provera injection
- c. IUD
- d. Norplant
- e. Surgical
- f. Calendar method
- g. Other (specify)_____

15. Have you/your partner ever used family planning methods? (*if the answer is b go to Q.18*)

- a. Yes
- b. No

16. Are you/your partner currently using any family planning methods? (*if the answer is b go to Q. 18*)

- a. Yes
- b. No

17. Which kind of contraceptive are you/your partner using?

- a. Pills
- b. Depo-Provera injection
- c. IUD
- d. Norplant
- e. Surgical
- f. Calendar method
- g. Other (specify)_____

18. If you/your partner are not using family planning methods, what are the reasons?

- a. We want to have many children
- b. I do not know about family planning
- c. Contraceptives are not available in the area
- d. My religion/culture prohibits use of contraceptives
- e. Other (specify) _____

19. Have you heard about vaccination programs? (*if the answer is b go to Q. 22*)

- a. I have heard
- b. I haven't heard

20. Are your children vaccinated?

- a. Yes
- b. No

21. Check immunization card for children less than one year of age and mark if they have been vaccinated for each of the following vaccines. *(If there are more than one child in the household, use the back page)*

Vaccine	Yes	No
BCG		
OPV-0		
OPV-1		
OPV-2		
OPV-3		
DPT-1		
DPT-2		
DPT-3		
MEASLES		

22. If your children are not vaccinated, what are the reasons?

- a. I do not know about importance of vaccination
- b. Vaccination service not available
- c. My religion/culture prohibits use of contraceptives
- d. Other (specify) _____

23. How many meals does your family eat each day?

- a. 1 meal
- b. 2 meals
- c. 3 meals
- d. Other _____

24. Do your children drink milk daily?

- a. Yes
- b. No

25. If yes, in what amount do they drink?

- a. One cup daily
- b. Two cups daily
- c. Three or more cups

III. MORBIDITY AND MORALITY INFORMATION

26. What health problems/illnesses have your children suffered from most frequently in the past month? *Check all that apply*

- a. Fever
- b. Cold
- c. Difficulty in breathing and cough
- d. Diarrhoea/vomiting
- e. Skin problem
- f. Measles
- g. Eye problems
- h. Injury
- i. Other _____
- j. None

27. Is there any child in the household who is under five years of age who had diarrhea and/or vomiting in the last two weeks?
- a. Yes
 - b. No

NB. Diarrhea is 3 or more loose, watery, or bloody stool in 24 hours period.

28. If so how many children do have diarrhea and/or vomiting during the past two weeks?
Write number _____

29. What treatment did you use?

- a. ORS
- b. Western medicine (Tablets, syrup) (type _____)
- c. Sugar salt solution
- d. Traditional medicine (type _____)
- e. Stopped feeding
- f. Increased feeding
- g. Other _____
- h. Nothing

30. What causes diarrhea?

- a. Eating spoiled/dirty foods
- b. Drinking unclean water
- c. Do not know
- d. Other _____

31. Have your children had cough or difficult breathing during the past two weeks? (*if the answer is b go to Q. 32*)

- a. Yes
- b. No

32. If yes, what treatment was given

- a. Traditional medicine (type _____)
- b. Western medicine (type _____)
- c. Nothing
- d. Other

33. Number of live births during the past 12 months in the household?

34. Number of deaths for those under one year of age during the past 12 months

IV. WATER, HYGIENE, SANITATION AND ENVIRONMENT

Water

35. What is your most common source of water supply?

- a. River

- b. Pond
- c. Protected spring
- d. Unprotected spring
- e. Protected well
- f. Unprotected well
- g. Pipe
- h. lake
- i. Other (specify) _____

36. How long (walk) does it take to fetch water from the closest water source?

- a. Less than half hour
- b. One hour
- c. Two hours
- d. Three hours or more (specify) _____

37. How often do you fetch water for the household?

- a. More than Twice daily
- b. Once daily
- c. Every two days or more

38. Is the water available in your area adequate for home use and cleaning?

- a. Yes
- b. No
- c. Do not know

39. Do you usually boil water for drinking?

- a. Yes
- b. No
- c. Do not know

Hygiene

40. Have you ever attended a health education session on personal hygiene?

- a. Yes
- b. No

41. Do you always wash your hands before handling food?

- a. Yes
- b. No

42. Please explain why it is important to wash your hands before handling food? (*Probe*)

- a. Knows
- b. Doesn't know

43. Do you wash your hands after you went to the latrine?

- a. Always

- b. Most of the times
- c. Sometimes
- d. Never

44. Please explain why it is important to wash your hands after going to the latrine? (*Probe*)

- a. Knows
- b. Doesn't know

45. When you wash your hands do you use soap?

- a. Yes
- b. No

46. Do you have soap for washing clothes?

- a. Yes
- b. No

47. Where does your household dispose of the rubbish?

- a. Behind the shelter/hut
- b. On the ground everywhere
- c. Dug a hole and dump the rubbish there
- d. Burning
- e. Other _____

Latrines

48. What is the primary way this household disposes of feces?

- a. Pit latrine at household
- b. Communal pit latrine
- c. Open field
- d. Other _____

49. If you have a latrine, what type of latrine is it?

- a. Pit
- b. VIP
- c. Other (specify) _____

50. If you use a shared latrine, how many households are using it?

Write the stated number of households who use the latrine _____

51. If no latrine, what is the main reason?

- a. Lack of space
- b. Lack of money
- c. Open field available
- d. Importance not known
- e. Other (specify) _____

52. How far is the latrine from your water source? (*check for the correct estimate by observation*). Write the stated average distance in meters _____

Environment

53. What do you use for cooking?

- a. Firewood

- b. Biogas
- c. Other (specify) _____

54. What do you think are the consequences of cutting trees/deforestation? (*Multiple answer possible*)

- a. Erosion
- b. Climate change
- c. Drought and Famine
- d. Decrease productivity of the land
- e. No trees for firewood?
- f. I don't know

55. How do you think you can prevent environmental degradation? (*Multiple answer possible*)

- a. Avoid cutting trees
- b. Use of biogas for cooking
- c. Plant more trees
- d. Use of Levi banks for erosion
- e. Other _____

V. EDUCATION

56. How long (walk) does it take to reach the nearest elementary school in your area?

- a. One hour or less
- b. Two hours
- c. Three hours
- d. Four hours
- e. More than four hours (specify) _____

57. Among your children in school age (5-18 years of age), how many are in school?

Write the stated number _____

58. If your children do not go to school, what are the reasons?

- a. School not available in the area
- b. School is located far away
- c. I don't feel the need to send my children to school
- d. Other (specify) _____

59. Have any of your children dropped out from school?

- a. Yes
- b. No

60. If there were dropout from school, what were the reasons?

- a. School is located too far
- b. Low academic performance
- c. It is waste of time
- d. Because of poor health/nutrition conditions
- e. Fear of lack of safety for girls
- f. Other (specify) _____

VI. AGRICULTURE AND SELF SUFFICIENCY ASSESSMENT

61. What is the source of food for the household?

- a. Private farm holdings
- b. Market
- c. Relief aid
-

d. Other _____

62. Is the food available in the household adequate for the family?

- a. Yes
 b. No

63. What is the most commonly eaten food in the household?

- a. Barely
 b. Maize
 c. Teff
 d. Sorghum
 e. Other _____

64. What type of vegetables do you eat?

- a. Carrot
 b. Green leafy vegetables
 c. Onion
 d. Other _____

65. How long does the available food can serve (security period in months)? _____

66. Type and number of livestock in the house hold

Type
Number

67. Have you suffered from poverty in the last six months?

- a. Yes
 b. No

68. What coping mechanisms did you use to survive from poverty?

- a. Selling livestock
 b. Borrowing from friends
 c. Relief from NGO
 d. Other _____

69. Did you receive food aid in the last six months?

- a. Yes
 b. No

70. If yes, how many times? _____

II. **FOCUS GROUP DISCUSSION GUIDE**

(With 8-12 group of adult men and group of women community members)

BASIC APPROACH

1. Greet the participants in a locally acceptable manner
2. Introduce yourself as a facilitator and the recorder
3. Let the participants introduce themselves, the way they like
4. Explain the purpose of the FGD, the kind of information needed and how the information will be used
5. Ask permission to use a tape recorder, let people hear their own Voice before the session starts
6. Allow some informal discussion before the actual session
7. Thank everybody and start the session

Guide for Focus Group Discussion of community members

- I. Common health problems in the area
- II. Challenges or difficult situations in the community in relation to access to health service
- III. Health care seeking behaviors of the community members
- IV. Attitude of the community in sending children to school
- V. Advantages of sending children to school and their disadvantages, if any?
- VI. If human beings and animals are using different water sources
- VII. Attitude of the community in using pit latrines
- VIII. Is there migration in search of food, water or work
- IX. Is deforestation commonly practiced in the area? If so, what are the reasons? Discuss on the knowledge on impacts of deforestation?

III. Information to be collected from existing schools

Access

- Total number of children in school age who are enrolled
- School to population ratio

Equity

- The proportion of male to female among students in basic education

Efficiency

- Number of students who dropped out from school in one year
- Number of students who successfully completed their academic year

Quality

- Teacher to student ratio
- Class room to student ratio
- Average number of students per class room

ANNEX IV LIST OF PLACES VISITED AND INDICATORS BY KEBELE

INDICATORS	PERCENTAGE BY KEBELE														
	Edo Gojela	Chitu Geto	Nagal egne	Elan Ababu	Korme Bujure	Gerbi Widana	Naka	Alaka Gulanta	Denbi Adanso	Walim Bulla	Adansho Barnota	Adansho Gogesa	Bara Hobicho	Rejji	Leliso Danbi
% of women of reproductive age group having knowledge of mother to child HIV transmission	22.7	12.2	37.5	41.2	10.3	14.3	9.0	14.3	9.0	30.5	9.0	16.7	15.6	24.0	16.0
% of women of reproductive age group know that appropriate and consistent use of condom can prevent HIV transmission	29.5	39.0	40.0	31.0	20.5	39.00	9.0	16.6	35.0	34.0	31.0	25.0	47.0	16.00	21.0
% of women of reproductive age group have knowledge of at least two ways of HIV transmission	86.0	85.0	91.0	95.0	89.0	84.0	85.0	81.0	83.0	85.7	91.0	84.0	90.0	84.0	87.0
% of women of reproductive age group have knowledge of at least two ways of HIV prevention.	72.0	78.0	80.0	71.0	71.0	64.0	85.0	55.0	79.0	70.0	80.0	85.0	81.0	83.0	71.0

% of women of reproductive age group have knowledge of how to delay or prevent pregnancy	86.4	80.5	67.0	87.0	84.6	77.8	100.0	87.5	90.9	100.0	81.8	100.0	85.0	100.0	95.0
Contraceptive prevalence rate	27.1	16.0	21.1	31.0	21.7	18.4	29.8	27.2	17.5	30.2	18.0	12.9	31.5	29.8	27.0
% of women who use ORS in treatment of their children with diarrhoea	51.0	45.0	40.0	35.0	21.0	29.0	25.0	29.0	47.0	35.2	35.0	NA	48.0	33.0	28.0
% of women have knowledge of causes of diarrhoea	98.0	89.0	91.0	90.0	95.0	87.0	94.0	90.0	95.0	97.0	92.5	96.0	97.0	86.0	87.0
% of population practicing hand washing after defecation	88.6	92.9	89.7	100.0	91.0	85.1	100.0	91.3	91.9	87.5	93.0	98.1	86.0	99.1	100.0
% of population practicing burning or burring of trash in garbage pit as a method of trash disposal in the household	75.0	71.0	67.0	85.0	70.5	64.2	71.2	58.6	53.9	82.7	84.0	77.0	69.0	61.0	73.0
% of population has knowledge of at least two consequences of environmental degradation	81.0	87.8	67.0	75.0	85.0	74.0	66.7	73.0	66.3	77.2	73.0	82.0	77.6	77.3	75.0
% of population has knowledge of at least two ways of preventing environmental	70.0	70.6	76.0	78.0	76.9	72.0	64.0	58.0	50.0	81.0	72.0	75.3	75.0	77.3	74.7

degradation