Australian Africa Community Engagement Scheme

The road less travelled: Improving maternal and child health outcomes with the nomadic communities of Ethiopia and Kenya

Project Design: Anglicord

Consortium Partners:
Nossal Institute for Global Health (University of Melbourne)
Australian Volunteers International

Date: 30 June 2012

Principal contact: Ms Jo Maher (International Program Manager)

Telephone / Fax: +61 3 9495 6100

Email: jmaher@anglicord.org.au

Anglican Overseas Aid is working in partnership with the Afar Pastoralist Development Association, the Mothers' Union, the Nossal Institute of Global Health and Australian Volunteers International.

Australian Government
AusAID

A Road Less Travelled is delivered as part of the Australia Africa Community Engagement Scheme, an Australian Government, AusAID initiative.

www.aroadlesstravelled.net

Table of Contents

Executive Summary:

This integrated project supports the objectives of the Millennium Development goals four and five to reduce child mortality and improve maternal health. It will do this by targeting key health determinants which impact on the lives of nomadic and marginalized women from communities in Ethiopia and Kenya. Key focus areas will be increasing access to health services, improving conditions of daily living and supporting policy dialogue between stakeholders to achieve sustainable positive outcomes. This project will result in:

- expanded and improved community-based health services and capacity directed at primary health care needs of women and children,
- Increased capacity of women and children to access services and resources that impact on their quality of life and equity[1]
- AusAID, ANGOs and aid stakeholders making investments that are targeted at improving Mother and Child Health for nomadic communities, and
- Raised awareness within the greater Australian community leading to public support to address Mother and Child Health challenges in nomadic communities.

Anglicord together with the Nossal Institute for Global Health (Nossal) and Australian Volunteers International (AVI) will work together with the Afar Pastoralist Development Association (APDA) in Ethiopia, and the Mother's Union of the Anglican Church (MUACK) in Kenya to implement the project. The consortium's members bring complementary strengths in community development, research and evaluation and the placement of technical expertise and will engage with other agencies including national and local government, NGO and academic institutes. The in country partners have a long standing relationship with Anglicord and the project will benefit from lessons learnt from previous joint project work.

A community led approach is at the centre of the AACES design. The community led processes are directed at not only improving the communities' capacity to address their needs but also to influence policy and increased access to services. The range and scope of activities delivered by the project are expected to change and grow over the five years with a peak in the third year. Changes will be supported by evidence gathered from evaluation findings. Evaluations will take place annually.

It is anticipated that the combination of strategies, use of a strengths based methodology, annual evaluation of outputs, and effective partner relationships will lead to sustainable improvement in the health of women and children and a reduction in maternal and infant mortality in the target communities.

Outline of Design:

Organisational strategy of Anglicord and the focus of the AACES project

Anglicord's development strategy is "to support partners that assist specific marginalised communities to take control of their own lives and promote community wellbeing" with a focus on communities that suffer internal systematic discrimination, resulting in reduced rights, marginalisation and poverty". This

[1] *WHO defines (World Health Organisation, 2008. Social determinants of health: Final Report of the Commission on Social Determinants of Health) the social determinants of health (SDH) as the conditions in which people live and which are mostly responsible for the unfair and avoidable differences in health status within and between countries. Among the measures to address these inequities are efforts to improve daily living conditions, such as access to water, nutritious food, education, and livelihoods, as well as initiatives to understand and measure the problem and address inequalities in distribution of power, money and resources. Many of these issues were raised by community members and stakeholders during the design consultations.*

approach is set out in the agency's Strategic Plan which also identifies the health of mothers and children as a priority focus area for project development and Africa as a priority geographic region for program activity. This project specifically targets the health of women and children of nomadic pastoral communities in Afar, Ethiopia and Kenya who are particularly marginalised due to their ethnicity, harsh geographic locality, remoteness and traditional cultural practices.

Alignment with AusAID priorities for investment in Africa

Australian Government priority for development aid to Africa emphasises gender equality in development work and empowerment of women and girls. This project directly addresses institutional and cultural impediments that prevent women and children from accessing proper health services and other basic services needed to improve quality of life, particularly in relation to safe motherhood. This is achieved by building the capacity of the community to attend to primary health needs and by empowering communities to engage with government and service delivery authorities to access basic services and influence policy development. AusAID's three main priority aid investment sectors (Mother and Child Health, Food security and access to clean water) are addressed under this project.

Supporting Millennium Development Goals

This project aligns strongly with health strategies and policies of Kenyan and Ethiopian governments to extend community based health services to hard-to-reach areas thus assisting governments to achieve MDG's 4 and 5 targets. Currently, government health systems do not reach remote communities, particularly those who are nomadic pastoralists. This project has a potential reach to approximately 177,000 people from 7 woredas in Afar, Ethiopia and 27,000 Maasai people from two districts in Kenya in areas that are under serviced.

Consortium Partners

Anglicord, an AusAID-accredited ANGO is the consortium's lead agency offering strategic direction and overall project management. Anglicord has a credible record of partnering with organisations in Africa since 1993 and delivering effective programs. Anglicord currently works in partnership with local agencies in Ethiopia, Kenya, South Africa, Lesotho, Rwanda, Tanzania and Burundi and in Asia, the Pacific and Middle East. Current projects focus on capacity building and mentoring of partners with a priority focus on sustainable futures, HIV and AIDS, health and literacy (particularly MCH), building community resilience and peace and reconciliation.

Nossal's principal role in this project is to work in partnership with local partners and strengthen their capacity to implement the M&E system including (i) by providing technical advice on design of M&E system, (ii) through capacity development of local M&E teams to manage ongoing monitoring and data collection, (iii) By assisting local partners to undertake and write up annual reflection based on routine monitoring system, (iv) to facilitate the establishment of a baseline and perform mid-term and final evaluations, and (v) to contribute annually to an iterative design process. It will also lead operational research activities by working with local partners to prioritise specific knowledge gaps (eg. Interventions able to be delivered in the community that can address high newborn mortality, and make deliveries safer and through expanded community based IMCI). Nossal will engage in institutional partnership with local research institutes to conduct research studies including co-design of research studies, capacity building in research data collection and analysis methods, providing quality oversight and technical input for data collection and analysis processes and by co-authoring of publications and dissemination of research findings.

Australian Volunteers International (AVI) has two important roles in this project, to support the community engagement component of the project and to place technical volunteers with local NGOs for capacity building in MCH and other related community development needs. AVI has been placing and supporting volunteers and partner agencies in Africa for over twenty years. AVI has extensive experience in public relations and marketing on key development issues to raise awareness of and advocate participation in the aid program. AVI and its Returned Volunteers have reached over 6 million listeners

and readers across Australia through various outlets in both metropolitan and rural/regional areas of Australia.

Existing knowledge, experience and relationships of Anglicord and its partners

Anglicord has worked for over a decade in partnership with Afar Pastoralist Development Association (APDA) in Ethiopia and the Mother's Union Anglican Church Kenya (MUACK) to address priorities in health, literacy and HIV and AIDS. Anglicord's program has already led to significant development impacts. For example, in Geeiga in the Afar region of Ethiopia project data suggests that maternal deaths have been reduced to near zero levels from 20-30 per annum, infant mortality has reduced by 30-40%, vaccination rates have increased from 0.25% to over 90% and literacy levels have improved from 3 to 17% through the provision of non-formal education.

Our partners have worked at grassroots level with the target communities for an extended period and employ experienced local staff from within the communities where the project will be implemented. The program coordinators of both African partner agencies are trained midwives who will bring long-term experiences which are locally relevant. The ADPA has much experience and credibility amongst communities, civil society, NGO's and government. MUACK is part of a mainstream church organisation with extensive reach both within communities and government.

Gathering information – in particular about involvement of vulnerable groups and stakeholders

Prior to the project design consultations, APDA and MUACK partners were introduced to the concept of a strength–based approach (SBA) and subsequently facilitated community and stakeholder consultations utilising techniques akin to appreciative enquiry. Consultations with the Maasai communities in Laikipiya and Samburu districts focussed on identifying current access to services and existing community assets. Cultural traditions and gender disparities emerged as important issues in the community. Similar discussions were held with men, women and youth from Yallo, Chifra, Addar, Mille, Assayita, Dubte and Afembo districts (Woredas) in Afar.

Community consultation being held at Yallo, Afar to discuss community priorities

In both countries, stakeholder meetings involved chiefs of communities, women leaders, religious elders, NGO representatives and local government representatives from the Departments of Health, Education, Agriculture, Environment and Public infrastructure. Activities that might contribute or leverage government efforts to improve services to the community were discussed together with modalities for ongoing dialogue and discussions. Other points of discussion included policy impediments to project implementation, the impact of HIV and AIDS and community and government views about service delivery to remote communities. Consultations also focussed on understanding existing mechanisms for decision making and communication as well as attitudes and mechanisms for engagement of people with a disability.

Capacity of Anglicord and partners developed through the design

Design workshops held in Nairobi by AusAID provided the opportunity for shared learning between the project teams in Kenya and Ethiopia, as well as with other AACES NGOs and partners. As a result of the workshops, Anglicord's and our partners' understanding of the challenges and opportunities that exist within nomadic pastoralist communities was enhanced. Our partners' also developed knowledge and experience in utilising a strengths-based approach to problem solving.

While there were a number of similarities between the communities in Kenya and Ethiopia there were also differences including in the availability of external assistance, mostly through NGOs. In Afar, APDA is the main service provider working alongside the government, while in Samburu in particular, a number of other NGO partners are involved in complementary community development initiatives related to livestock and food security. In Samburu and Laikipiya the church plays an influential role including on traditional cultural practices while in Afar Islamic community leaders are the major influence. The structures within both faith-based entities are already providing some opportunities for women to be engaged in community development activities and will be important avenues for increasing the engagement of women in community and family decision making.

Situation Analysis:

Current experience of people including vulnerable groups within the communities

Access to basic health service for nomadic pastoralist communities in Kenya and Ethiopia is severely limited. Target communities described very limited or non-existent health services and a situation where more than 80% of children are currently delivered at home attended by often untrained traditional birth attendants (TBA). Community members and other stakeholders estimated (either from census data or anecdotal evidence) that in some communities as many as 5 out of 50 deliveries in 2010 resulted in a maternal death or significant morbidity. Neonatal mortality rates are also believed to be significant although official records are scant and cultural mores preclude discussion (or recording) of infant deaths. The high maternal mortality contributes to the low life expectancy of Maasai and Afar women - In Kenya, while the average life expectancy for women is about 55 years (2010 est.) amongst Maasai women the average is less than 43 years. The figure in Afar is 47 for women compared to the national average of 60.

Neonatal mortality rates are also believed to be significant although official records are scant and cultural mores preclude discussion (or recording) of infant deaths. The Kenyan Department of Health report 2008/9 records a newborn mortality rate of 31 per 1000 births and under 5 mortality rate of 74 per 1000.

In both targeted regions of Kenya and Ethiopia the number of health facilities with trained staff to treat women during pregnancy and childbirth are few. For example, in the target area in Afar there are only five health centres with a total of 3 health officers and 2 nurses, and APDA staff, serving a population of 177,000. The WHO recommends a ration of 2.2 health workers per 1000 population. Communities described having to walk long distances to reach these limited health facilities. In some Maasai areas of Kenya, people need to travel up to 40 hours by foot to reach a health facility. The service delivery gaps identified in the two pastoral communities are due to community barriers such as remoteness of areas, nomadic nature of the communities, illiteracy in communities, traditional cultural practices associated with childbirth, fear of death and/or instrumental delivery; and institutional barriers such as skilled human resource capacity and their motivation, treatment by male health professionals and their attitude, distribution of services, equipment and supplies and poor referral mechanisms.

During the design consultations communities and stakeholders identified a range of conditions which impacted on their daily lives. Interestingly, there was not widespread recognition of the link between improvements in these conditions and better health; although there was some recognition that changes could impact on the health of livestock. For example, nutrition and food security during pregnancy was not recognised by community members as a priority. Similarly, fetching of water for household use is generally the duty of the women and girls in the family which has a significant time burden. While stakeholders recognised that improved sanitation and hygiene reduces infectious diseases amongst women and children, they also acknowledged that further work is required to build awareness in the community. Communities identified diarrhoea as a major cause of infant mortality and morbidity but the link with poor sanitation was not well understood.

Both women and men in the communities agreed that a lack of education is highest amongst women since girls are not encouraged by the communities to pursue education beyond primary levels. The low literacy rates impact on the women's ability to understand health information about pregnancy and childcare and be aware of antenatal or immunisation services. Opportunities for alternate livelihood opportunities are also diminished for women with low levels of functional literacy.

The impact of HIV/AIDS is far reaching but particularly as it affects women. In Kenya for example women are disproportionally infected at 8.7% compared to men at 5.6% and one out of every ten pregnant women in Kenya (9.6%) are HIV positive (Kenya AIDS Indicator Survey (KAIS), 2007). Reasons given, at community consultations, for the higher rates of infection amongst women reflect their more vulnerable position within a male dominant society. These include their inability to negotiate with partners around safer sex, and the traditional practice of younger women marrying older men who are reluctant to discover their HIV status. According to the KAIS study 83% of Kenyans do not know their HIV status. The practice of polygamy in both Afar and Maasai communities has a significant impact on the spread of HIV and AIDS. However, awareness is poor and community based support mechanisms for people infected with HIV are severely lacking; the vulnerability of women was highlighted during consultations.

For the Maasai and Afar people, traditional and cultural practices and male-centred hierarchical structures govern many; if not all aspects of daily living. Consultations highlighted the decision-making role of men in all matters affecting the community including: decision making about seeking healthcare services, access to educational opportunities and the continuation of harmful practices such as Female Genital Mutilation (FGM).

Strengths and opportunities for change and improvement

Despite many challenges, community members identified a number of strengths which support maternal health. For example, women share the workload with pregnant women and support each other during and after birth. In addition, traditional practices such as massage are used to facilitate childbirth, and the use of iron rich foods for pregnant women, especially when they are sick, is also encouraged in some communities.

Nomadic pastoralist communities have demonstrated enormous resilience and many of their traditional and cultural practices have enabled them to survive despite being systematically pushed from their vast grazing lands and being restricted to pockets of land that have marginal potential for livelihoods.

Both target communities have demonstrated their ability to accept change and to adapt their traditional practices in the light of external influences. The Maasai in Laikipiya for example, explained how the impact of HIV and AIDS in their community changed traditional practice related to polygamy and how an understanding of the negative impact of FGM on women and girls was beginning to influence Traditional Birth attendants (TBAs) who traditionally performed this ritual. Through APDA engagement in Geeiga, Afar men described how, over time they now understood the importance of seeking treatment for women who were experiencing difficulties in labour and provided camel transport, an escort, and high energy food for women on the often long ride to health facilities.

Community members in Afar who have worked with APDA explained that the availability of water and educational opportunities in their community was influencing their traditional nomadic lifestyle with a tendency for women and children to remain in more 'settled' communities while the young men grazed their livestock. These changes also made it possible for some men to be involved in growing crops.

Communities highlighted the role of education (formal and informal) in allowing them to understand the links between cultural practice and negative health (and other) outcomes as well as the need for information to be conveyed through traditional tribal structures. They also emphasised the value of adapting service provision to their nomadic lifestyle, for example in providing functional literacy training to young boys as they tended their goats. They also described other services which while focussed on livestock could be adapted for the benefit of mothers and children, for example mobile vaccination clinics.

Government policy and national health strategies

The design of this project is informed by and compliments government health strategies and policies in Kenya and Ethiopia. The role of the NGOs and the private sector in assisting government to deliver a comprehensive and integrated system of reproductive health care is acknowledged in the national health strategies of the two countries.

In Ethiopia the average maternal mortality ratio (2005-2009) reported by UNICEF is 670. However, these figures do not take into account the much higher deaths amongst remote nomadic communities (5 deaths out of 50 deliveries reported by some communities for 2010). A key strategy under the Health Sector Extension Program (HSEP) is to engage NGOs and private sector to extend reach of government services to pastoral communities. Ethiopia's Health Sector Development Program III (HSDP III) clearly articulates that the new HSEP is introduced in recognition of failure of essential services to reach the people at the grassroots level. As such, it constitutes all the key activities necessary for rapid development, particularly primary health care. In its nationwide implementation HSEP includes 16 packages in four areas that provide primary health in a holistic manner. The four areas are (i) Hygiene and environmental sanitation, (ii) Disease prevention and control, (iii) Family health services and (iv) Health Education and Communication. This project's implementation strategy is clearly aligned to these four areas (see also the sustainability section).

AACES project partners provide a vital conduit to remote communities where government services don't reach and access is hugely challenging. This project and related projects implemented by APDA are complimentary to HSEP by facilitating community-based transport systems to enable physical access for community members to health services and to build on existing local community structures to break down barriers related to language, cultural and acceptability and avoid discrimination evident in mainstream services.

The Kenyan National Health Sector Strategic Plan (NHSSP II) has an ambitious target of reducing Maternal Mortality ratio to 147 per 100,000 births by 2015 – average estimate for the period of 2005-2009 was about 490 (UNICEF).

Kenya's NHSP II plan has targets of 90% of births to be attended by trained staff, however, MoH officials in Maasai areas have concurred that more than 80% of births in remote communities happen in homes unattended by trained staff.

The National Reproductive Health Strategy (NRHS) for Kenya (2009-2015) is committed to improvements in MDG 4 & 5 and emphasises the importance of the Community Strategy "to enhance community access to health care in order to improve productivity and thus reduce poverty, hunger, and child and maternal deaths, as well as to improve education performance across all the stages of the life cycle" (NHSSP II). The Community Strategy has a component of Community-Based Communication which is designed to facilitate behaviour change of individuals at family/household level supported through advocacy, social mobilization and interactive communication. It also states the need to train and equip Community Health Workers and Community Health Extension Workers as service providers in building the community based networks for primary health care, as TBAs are phased out.

This project is aligned closely with this strategy in working with the MoH to achieve better MCH outcomes through a community led holistic approach. Acknowledging the role local NGOs are capable of playing, NHSSP II strategy involves civil society organizations in ensuring that households are well informed about good health behavior and the need to seek professional care in a timely way. In addition, their effective participation to develop and expand public information programs, health promotion messages (healthy life style) and information on the human rights approach to health is also recognized. NHSSP II involves these organizations in ensuring comprehensive support for community ownership of health activities (through health facility committees and District Health Management Boards), as well as the coordination of inter-sector support for community action through District Health Stakeholder Forums.

Government policies in both countries are also influencing the availability of child and maternal health workers, in particular, through policies which discourage the use of traditional birth attendants. Whilst these policies address global concerns about unsafe traditional childbirth practices, their introduction in a setting in which there are no alternate caregivers worsens existing service delivery problems. In other settings, the integration of the role of traditional birth attendants into health systems has been used to increase the proportion of women receiving care from skilled staff.

Objectives:

The goal of this program is to improve maternal and child health outcomes in nomadic communities in Ethiopia and Kenya. To achieve this goal, the result areas under each of the AACES objectives are:

ACCES Objective 1: **Marginalised people have sustainable access to the services they require**

Project result areas:

- Expanded and improved capacity of community-based health services to attend primary health care needs of women and children
- Increased capacity of women and children to access services and resources that impact on their quality of life and equity

ACCES Objective 2: **AusAID policies and programs in Africa are strengthened particularly in their ability to target and serve the needs of marginalised people**

Project result areas:

- AusAID, ANGOs and aid stakeholders making investments that are targeted at improving Mother and Child Health for nomadic communities

AACES Objective 3: **Australian people are more informed about development issues in Africa**

Project result areas:

- Awareness raised through greater Australian community engagement and public support on Mother and Child Health challenges in nomadic communities of Ethiopia and Kenya

Project Strategy:

Theory of change

Both Ethiopia and Kenya have national and sub-national policies and plans which if fully implemented would positively influence maternal and child health outcomes. However, given the isolation and marginalization of the target communities and the lack of resources (both physical and human) there are considerable gaps in government service provision in health and other sectors and few other alternate providers.

Given this lack of services, the AACES project is focused on using SBA to strengthen community self-reliance through harnessing the existing capabilities and structures in the community. Through AACES, communities will better understand the factors impacting on maternal and child health outcomes, and be able to establish community-based initiatives to address current service gaps and improve the living conditions which are responsible for poor health status. However, community self-reliance cannot address all of the communities' health and other needs. Creating greater demand for services and improved conditions will also better enable communities to advocate for increased accountability of service providers to improve the supply and the reach of essential services and programs, and to create vital linkages between communities' own initiatives and government and other external support.

Our strategy is informed by lessons learnt from the ANCP and other programs undertaken with our nominated partners. It is underpinned by a commitment to the Strength Based Approach of Community Development (SBA) to increase ownership and sustainability of outcomes. Applying the SBA empowers community groups to identify priorities, champion changes and advocate for increased access to health

services. SBA allows communities to strengthen confidence by reflecting on past successes, determine realistic goals, identify inherent strengths and resources within their communities and design an action plan to realize their goals. The SBA reiterates that changes in behaviors and practices have to come from within the communities and for the changes to be lasting the communities themselves have to be the change agents. More importantly, it helps community members to realize that they all have inherent capacity, skills or strengths that need to be harnessed to collectively achieve their goals. As communities plan and implement activities, periodic assessments are made to reflect on successes and celebrate achievements.

Recruitment and training of community based staff is a major component of the strategy. Recruited from the local communities they will help populations overcome barriers which currently exist due to cultural, language and isolation factors. They act as local change agents influencing change in healthy behaviors and practices to improve women's and children's health. They further contribute to the communities' capacity to engage community stakeholders, government and other providers in planning and provision of essential health (and other) services.

Community Engagement

The project recognizes that decision making powers in Afar and Maasai communities are held by men. Therefore the entry point for engagement with the communities to address health issues of women and children is through the higher levels of the male-centred hierarchy. Even though the project is targeted towards improvement of health for women and children, without acceptance and ownership of the issues by the traditional leaders, sustainable impacts cannot be achieved.

Community decision making structures amongst Maasai in Samburu is composed entirely of men from different age set groups

The first step is to engage the Community Development Committee (CDC) to ensure an inclusive structure that represents the community broadly. The CDC is an existing programmatic mechanism in Ethiopia which provides a community entry point to engagement, acceptance and ownership of the project. It consists of traditional and religious leaders, representatives of women, youth and persons with disabilities. The CDC plays an important role in ensuring participation and transparency within communities about the situation for different groups within communities and in community decision-making on priorities and strategies for change. To ensure the voice of women is heard at the decision making level, women are represented in the CDC at a leadership level – facilitated by the local NGO. The local NGO being indigenous and consisting of staff from the local community, emphasis made on gender equity will not be seen as imposing culturally outside (foreign) ideology. Dedicated female staff will be employed in the project with roles focused on and to represent women's issues and concerns.

A Stakeholder Committee (SHC) will also be established in each locality consisting of local authorities and government representatives. The interaction and engagement between the CDC and the SHC is facilitated from the onset of the project as a means to promote community empowerment in exchanging community perceptions and knowledge and promoting accountability around the delivery of government

services. The SBA process and the use of these structures will aim to build a basis for introducing the concept of CARE's Community Scorecard Process[2].

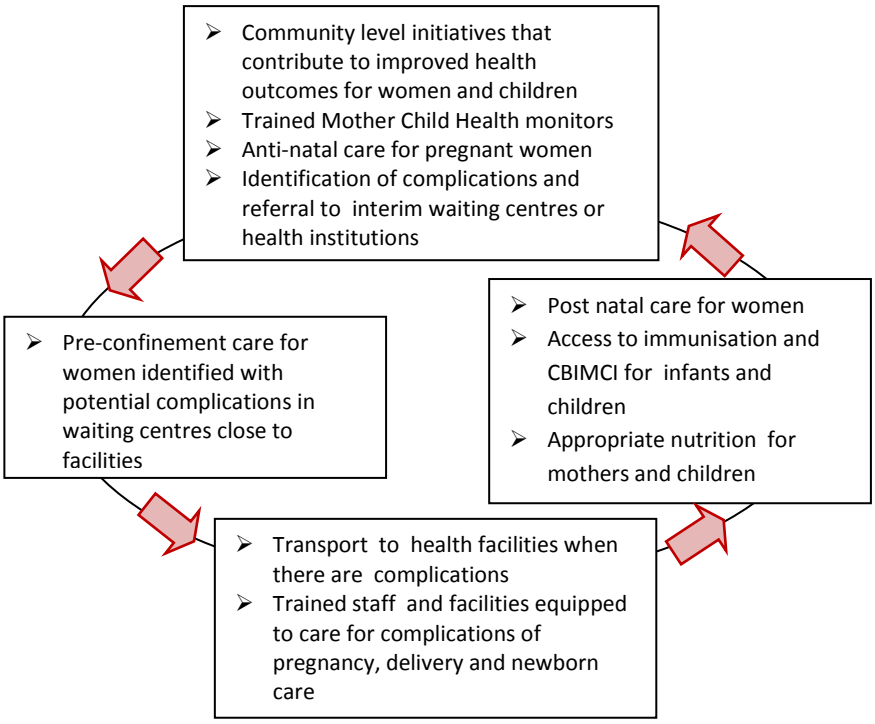
In Kenya, the structures that will be established at the community level will be similar to the CDCs and SHCs established in Afar, Ethiopia.

During the early stages of community engagement, further discussions will be held with: chiefs and community hierarchical bodies; women's and youth groups; TBAs who are currently attending to child births; local government authorities; religious leaders, and persons with disabilities. Through SBA methodologies, communities will determine their own priorities and how they can address key resources issues such as food security, access to water, and literacy, which would improve the quality of life for the pastoralists, particularly addressing the needs of women and children. The SBA approach will lead to a range of community led initiatives addressing priorities such as access to clean water, improved hygiene, better nutrition, reduction in FGM, increased literacy, and reduced stigma and improved life opportunities for PLWHA and persons with disabilities.

Continuum of Care

The project strategy works to create a continuum of care for mothers and children from pre pregnancy to post natal care. Stages in the continuum are outlined in the diagram below.

The project addresses health determinants throughout the continuum of care. Proximal determinants such as literacy, empowerment and income generation, are the foundations upon which interventions targeting specific life stages are strengthened. These include delayed first birth with access to family planning, HIV prevention strategies and monitoring of pregnancy with referral systems for complications. Delivery care is provided through safer deliveries at home, and strengthened referral systems to a newly constructed health facility providing essential obstetric care. In the postnatal period visits on day 1 and 3 provide essential newborn care and counselling about early and exclusive breastfeeding. Nutrition counselling and community based management of common childhood conditions (diarrhoea, pneumonia and malaria) are strengthened. Immunisation coverage and Vitamin A distribution is supported.



Continuum of care model for AACES project

Capacity building at the local level is a key objective of this project. This project includes capacity building of local counterparts, particularly through training for local community members to address basic health needs. Training will be provided at three levels: for grassroots community members; for mid-level professional carers who will be up-skilled to manage

[2] The Community Scorecard approach is a participatory performance monitoring approach developed by CARE in Malawi.

broader health needs and for health professionals providing emergency and hospital-based care for complex cases.

The proposed continuum of care for health to mothers and children looks at building local capacity in communities that are not reached by government services and follow it through to emergency care when needed and finally providing ongoing post-natal care in the communities. The continuum of care approach for the health sector initiatives takes into account the interventions that are required at the community level (for better health including ante-natal care and promoting equity of women and children) right through to referral services for more complicated health needs. Children are also included in the care ensuring adequate and appropriate nutrition and immunisation during their formative years. Between community care and emergency care, women who have been identified with complications will need to be moved to waiting areas, sometimes for many months before the actual delivery of babies. In these waiting areas, mothers and their carers become resident patients and are cared for until delivery. If at any time complications are developed, the mothers can be quickly transported to the emergency hospital being completed in Mille.

A key strategy in achieving a continuum of care is the training of a range of locally based workers. These women's extension workers, HIV and AIDS awareness facilitators and literacy monitors will work directly with community members to address determinants of maternal and child health. The strength of recruiting workers from their respective communities is to be able to provide continued mobile services while the community might be on the move in search of water or pastures for their animals.

Areas identified through community consultation and government policy are literacy, water supply, food security/nutrition, prevention of HIV and AIDS, income generation activities targeting vulnerable women and the reduction of harmful practices. Specific interventions will be determined by each community encouraging them to capitalise on their existing strengths.

The focus of the project is on measures which contribute to changes in community behaviours and practices and improving health worker attitudes towards marginalised communities to encourage the use of health services. Behaviour-change strategies are supplemented by the provision of key interventions such as safe birth kits to reduce risks during childbirth and distribution of ORS to combat high rates of diarrhoea amongst children. Given the influence of gender and power relations in these targeted communities we will support community development processes which allow for greater participation of more marginalised community members (including women) whilst also utilising existing community structures to educate and bring about attitudinal change among leaders, who are mostly male.

The use of local people in community-based roles has been an effective method in past projects undertaken by Anglicord. It is the aim of the project to have many of the community based staff absorbed into government positions at the end of the five years. This has occurred in previous projects (described in the section on Sustainability). There is an acknowledged risk in finding and retaining suitable candidates however this is mitigated by provision of a stipend, training and support from community coordinators, the community development committees and material resources.

Technical support will be used as required throughout the life of the project. This will be provided by volunteers recruited and managed by Australian Volunteers International. Volunteers will be selected for their knowledge and skills in identified areas including, community development, health education and training, institutional strengthening and sustainable livelihoods. The appointment of technical volunteers will be made from the 2nd year based on specific requirements identified by field partners as they begin to implement the project. The advantage of using volunteers is two-fold. They bring appropriate knowledge and skills as well as an interest and commitment to development principles under the support and guidance of an agency with over fifty years' experience in placing volunteers in developing countries.

Work at the grass roots level will be complemented by increased engagement with the wider community and with key duty bearers, namely government, to ensure changes achieved by individuals, families and communities can be sustained through supportive government policies and service delivery.

Community Linkages and Advocacy

The role of NGOs in bridging the gaps between government service delivery and remote (and specifically pastoralist) communities is well acknowledged in national health plans in Ethiopia and Kenya. As such, AACES will support project partners to provide a vital conduit to remote communities where access is a major challenge. Building on APDA's experience, the project linkages with government systems is three-fold.

First, strengthened coordination between NGO and government will extend the reach of health services to remote areas using NGO capacity and community-based workers. The current successful vaccination program delivered by ADPA in Afar and the testing and treatment for Tuberculosis program delivered by the MUACK in Kenya provide models of integration with government and other NGO agencies which will be promoted.

Second, the program will work to strengthen links between communities and existing government or non-government services and programs to gain support to build community resources in a range of areas such as water supply, agriculture etc. APDA currently receives support from Oxfam (GB) to build water harvesting systems in key locations. The AACES project will seek similar links with other NGO's with programs which compliment those of AACES. This will be achieved by monitoring the activities and contributing where possible in planning by other agencies.

Third, the program aims to support communities to better advocate for greater access to the services they are entitled to. This will be facilitated primarily through the function of the locally based committees, (the CDC and SHC) and the introduction of an adaptation of CARE's community scorecard process. Anglicord's local partners have a sound track record of engaging in policy dialogue with local and national government authorities which have brought about positive and sustainable changes in government interventions. In Kenya, ongoing policy discussions with the local health authorities and the Ministry of Education have resulted in change in the government's approach to the provision of services to people living with HIV and AIDS and in the formation of student peer groups in schools. In the Assayita region of Ethiopia, the local government has taken on APDA's highly successful consultative health and literacy capacity building program following close consultation between both parties. Nossal Institute's expertise in M&E and research will provide opportunities for project outcomes to be translated into evidence-based recommendations for inclusion in future policy dialogue between AusAID and other ANGOs.

Nossal will ensure a continual learning approach to design and implementation. Nossal staff will also assist in building the capacity of the partner organisations and stakeholders to develop the evidence base through research. Globally, effective interventions for preventing maternal and newborn deaths are well known. What is not clear is how to scale up coverage of these interventions, particularly in remote and nomadic populations. By combining research with program implementation there is the opportunity to address this gap. In Kenya, the AMREF, a locally established Medical Research and Development organization, is being engaged for capacity building, advocacy and operational research.

In support of objective 2 the project aims to increase policy dialogue between Anglicord and AusAID. Dialogue will be based on evaluation findings, research and lessons learnt through the life of the project as well as the past experience of Anglicord in Africa. It will be facilitated through regional forums, meetings during monitoring visits and presentation of reports.

Knowledge and lessons learnt from this AACES project have the opportunity to inform policy and future investment by AusAID's in the areas of MCH, WASH and food security. Already negotiations are underway with AMREF, a potential partner for AusAID on the MCH program, to build the capacity of local

birth attendants, conduct operational research and undertake advocacy. Other opportunities already identified include food security efforts to introduce drought resistant crops and increase production through introduction of appropriate technologies. Water, sanitation and hygiene related activities have been identified as important areas for Donor investment which will enhance MCH outcomes.

In support of objective 3, the project strategy is to gather stories, evidence and research throughout the life of the project and to work collaboratively with consortium partners, AusAID and other Australian government agencies and NGO's to bring this information to the Australian public. The aim of this strategy is to raise awareness of the Australian public about African development issues which will lead to better informed public debate on aid and development affecting current and future government policy. Each of the consortium members has established channels through which to direct information and stimulate discussion on African development issues.

Features of the project strategy

Expansion of existing programs

Whilst the project involves initiatives in both Kenya and Ethiopia, the scale up of interventions will differ between the two countries. Community priorities are also expected to differ between and within the two targeted sites.

In Afar, the AACES project will expand the existing work in community-based health and literacy in two woredas (Dubte and Assayita) which has been taking place over 8 years and in the prevention of HIV and AIDS in two other woredas (Chifra and Addar) for just over 3 years. More limited interventions focusing on building institutional capacity for maternal health in three other woredas (Afembo, Mille and Yallo) will also be scaled-up.

Activities in the first year of this project will consolidate the achievements in Dubte and Assayita and improve on them. In Chifra and Addar activities will be expanded to target MCH related issues in the communities. In the remaining three woredas, community sensitisation and introductory training for local staff will be the focus in the first year. Progressively over the remaining four years, as activities in the 'older' woredas will be handed over to the local authorities, or owned by the communities themselves, community-led activities will continue to be expanded in the remaining woredas.

New Programs

The model of progressive intervention developed in Afar will be adapted in Kenya amongst the Maasai. In the first year, three locations have been chosen to begin project activities (Ilingwesi - Laikipiya North, Naibor – Laikipiya East, and Suguta Marmar – Samburu) and activities will be expand to 8 locations by the third year subject to progress in these locations. The capacity of the Mothers' Union in Laikipiya (Mt Kenya West Diocese) and Samburu Dioceses will be enhanced to enable them to work as community facilitators and to support capacity development initiatives that can address the maternal and child health needs of the Maasai communities. The health interventions already being implemented by the Good Samaritan Clinic of the Mothers' Union of Mt Kenya West Diocese will be strengthened and expanded. This project compliments the activities in HIV and AIDS prevention implemented through the Mothers' Union in the Kajiado area, also inhabited by Maasai communities.

Major activities:

Objective One: ***Marginalised people have sustainable access to the services they require.***

The project focus, over the five years, will be on supporting improvements to the health system through integrated community development initiatives. The first phase will focus on determining community priorities and identifying service gaps through the baseline surveys, alongside the establishment of the structures and systems which will support implementation and iterative program design. In Ethiopia the project will build on APDA's existing networks and expertise to reach remote communities and address the health needs of women and children.

In all target areas, our partner organisations will facilitate the establishment of community development committees (CDC) and stakeholder committees (SHC) that will provide ongoing support and leadership to achieve project outputs.

In the first year, significant effort will be made to build the capacity of APDA and the MUACK to develop their monitoring and evaluation systems and processes. We will involve community members in the design, collection and analysis steps to develop local skills and capacity in evidence informed programming.

Staff members for the project are appointed from the community to ensure that the reach into the communities can effect behavioural changes. Many are covering significant government service gaps. The roles of community based workers are based on existing models of engagement but the numbers are extended in this project to reach new geographic areas. In Kenya, the project is new and the project has to be initiated with new staff. However, the staff members are chosen ensuring that they have community relevant experience and existing capacity. The project focuses on capacity building to prepare for the handover when government services become available).The roles of each staff member are further detailed in the first year activity plan (annexe 1).

Based on the model used by APDA, community based workers including the health, literacy and women extension workers (WEW) will be selected (one each from each location) and trained. In Afar, Mother and Child Health Monitors (similar to the TBA trained by APDA) will receive training to care for mothers during pregnancy and to provide pre- and post-natal care to women. On average each monitor will be responsible for 20 households. For each district, the appointed health, literacy and women extension coordinators- together with HIV and harmful practices facilitators- will initiate activities that target women and children. WEW employed by APDA and their equivalents in Kenya, together with the Harmful Practices Awareness Teams address practices that affect the health and well being of women, such as female genital mutation. HIV community conversation facilitators address the issues of PLWHA in the community and encourage inclusive practices for them. In a culturally sensitive environment, it is planned to have specific interventions that deal with behavioural and attitudinal changes in both men and women. Recognising that it is a slow and arduous process, it is proposed within the project to capitalise and influence changes through traditional and religious leadership forums. The project is designed to internally examine outputs and outcomes each year and modify interventions and approaches in forthcoming years.

A community health worker in Afar explains the steps to be followed for safe delivery of babies to TBAs in Geeiga

In Kenya, efforts in the first year will focus on strengthening the capacity of MUACK to understand the cultural context of working with the Maasai and develop training modules and translate them in the local language. The training modules will be developed in response to community priorities. Training in areas such as health, literacy, HIV and AIDS, WASH and harmful practices, will particularly focus on what is practically achievable in each community. Community specific practices that may harm the mother and child during pregnancy will be identified and included in training modules for community discussion. Initially it is intended to work in three sites in Kenya and expand gradually to greater number of sites over the 5-year period.

While most activities focus on effecting behavioural changes in the community a limited amount of budget is allocated for targeted interventions in food security and access to water. In two communities (Yallo and Sifra) in Afar, activities will also be developed to enhance the capacity of the community for

income security through facilitating market access to their products in the local markets. Both these locations have existing markets and are points of confluence for extended market access. The income security assists wider community members to sustain fluctuating income generation during the year.

Activities over the five years will also focus on HIV and AIDS awareness and building resilient communities that have the capacity to care for affected people locally. A comprehensive package of information to raise awareness, access to testing and treatment and community care will be delivered as part of the project, particularly targeting women, youth and children. Prevention of Mother to Child transmission (PMTCT) of HIV and AIDS is part of the package delivered through this project. Creating awareness on PMTCT and identifying and promoting alternative nutrition sources instead of breast milk for infants will be an important activity. UNICEF's "Mother-Baby Pack" as a PMTCT preventive option will be explored in Kenya where the pack is available (currently only in two provinces). In Ethiopia, the packs are currently not available and ongoing communications will be maintained with both UNICEF and UNAIDS to explore the introduction of the packs into the project target areas. In both countries, education on additional nutrition for mothers to ensure their health condition is optimised to further PMTCT will be a primary focus. Monitoring of the nutrition status of mothers will be undertaken by the mother and child monitors. Targeted income generation activities will be developed for women who are infected.

In Ethiopia, discussions have been held with CARE to collaborate on two key aspects. Although working in different locations, the issue of traditional harmful practices that impact on women is common. It has been agreed that information will be shared between the two agencies to explore common approaches in curtailing the practices. The other area of collaboration identified is on how best the existing traditional laws in the communities could be used in bringing community changes and adherence to changed behaviour. Both CARE and APDA in Ethiopia will come together early in the project to explore these two areas of collaboration further. The introduction of CARE's "Score Card" into communities as an accountability tool will be assisted by CARE.

In Kenya, five AACES NGOs are working in different geographic locations. Three agencies (Marie Stopes International, World Vision and Anglicord) have MCH as a common focus. Some community practices and challenges to access services are common to the three projects. Shared learning through active liaison with these AACES partners on how each NGO will address these challenges will help develop complementary approaches within Kenya for advocacy on government policies. Early in the project, mechanisms to engage with each other and capture learning will be developed, particularly addressing those issues related to the role of TBAs during childbirth. This is a pertinent issue in other remote African communities as well.

Objective Two: ***AusAID policies and programs in Africa are strengthened particularly in their ability to target and serve the needs of marginalised people***

Drawing on project implementation experience and outcomes, Anglicord and its consortium partners will identify synergies and areas where dialogue about particular issues with other ANGOs and AusAID would be of shared benefit. Such issues may include, for example, access to assisted delivery for nomadic women, health care for illiterate target groups and government services for nomadic populations. Annual national/regional forums could provide opportunities for such dialogue, where NGOs and other stakeholders could explore cooperation on a specific country/thematic situation, share findings and develop platforms for policy dialogue and communication with relevant AusAID sector heads in Africa (Nairobi/Addis Ababa) and in Australia. In addition, through the Africa working forum of ACFID and targeted interactions with the African Diaspora communities, dialogue on policy interventions will also be promoted.

Alongside robust monitoring and evaluation, the project will incorporate operational research to inform evidence-based programming and encourage innovation and new approaches – addressing key knowledge gaps in MCH. Research findings will be documented and shared, and pilot initiatives based on

lessons learnt, will be introduced. While precise operational research questions will be formulated after the baseline assessments have been undertaken, the overarching aim will be to document a replicable model of basic MCH service delivery for nomadic/semi-nomadic communities. Such a model can then be used to influence policy and practice in other communities.

A priority area for engagement which has been identified is the gap between policy and practice in the use of untrained birth attendants for home deliveries in the project areas. Whilst the government discourages the use of traditional birth attendants, the meagre service provision in remote areas means that most women have no alternative access to trained health professionals. This project will provide key information on ways to address this gap. In Kenya, for example, discussion is on-going with the African Medical Research Foundation (AMREF) to undertake a targeted controlled trial in years 2 & 3 to examine the benefits of having trained MCH monitors in the community assisting with child births. Trained MCH monitors are expected to reduce the number of complicated deliveries taking place in the community and over time reduce maternal and child mortality and morbidity. The outcome of this trial will be able to inform policy discussions at local governmental, bi-lateral, multi-lateral and AusAID levels. Similar operational research activities are also planned with the Universities of Semara and Jimma in Ethiopia, in order to bring local perspectives. Development of indigenous research capacity is seen as a key contributor to sustainability.

While advances in MCH remains the overarching aim, the supporting elements of food security, access to water, sanitation and literacy, may also contribute substance for policy dialogue with AusAID and others, in particular where there is current emphasis on investments in the areas of food security and WASH.

Objective Three: ***Australian people are more informed about development issues in Africa***

Over the life of the AACES program, the Consortium will primarily draw on their own established networks to engage with the Australian community. These networks offer access to a range of specific audiences for disseminating information about the Afric program and ways for Australians to engage in it. AngliCORD has expansive church networks; AVI has a strong and active Returned Volunteer and supporter base, and Nossal has significant academic and research linkages. It is envisaged that a range of communication materials, such as in-country status reports, project updates, research findings and evaluation reports will be distributed through the various communication channels employed by the consortium members. These channels include websites, social media, electronic and hard-copy publications and newsletters, press releases and journal articles. In addition, the Consortium's networks will be used to organise and promote specific public events, ranging from workshops to information sessions that will be used to both publicise and add value to the range of activities occurring in Africa. Crucial to the latter, will be a number of events that specifically engage with African Diaspora and draw on their knowledge and expertise.

During the first year of the project a communication plan will be developed to guide all aspects of communication to the Australian public. The focus of the plan will be the dissemination of information about development issues and challenges facing countries in Ethiopia and Kenya and the broader AACES program. AVI expertise will be used to plan, coordinate and lead implementation of the communication plan using innovative methods and materials to generate and hold the interest of the Australian public. A particular focus will be the challenges facing nomadic AFAR and Maasai peoples and African partner perspectives will be used to communicate their particular challenges , existing strengths, resilience and aspirations.

As the project proceeds, the communications and engagement focus will include achievements and emerging outcomes from the AACES program. This may include information taken from field trip reports, monitoring and evaluation reports and AACES NGO partner reports. A major strategy will be to capture stories which highlight positive changes resulting from Australian support to Africa.

The use of Australian volunteers as technical inputs is one way for Australians to engage directly in the Africa Program. Whilst on assignment and upon return, volunteers on the project will be used in a

number of ways to engage with the Australian Community to raise awareness of the development work in Kenya and Ethiopia and the broader Africa Program. Profiling of Australians such as Valerie Browning's work with the APDA can also be used to draw the interest of the Australian community in the work being undertaken through the Africa program.

The consortium envisages that there will be opportunities to work with other AACES partners, including AusAID, to either generate whole of program communication opportunities or collaborate on themed events about issues such as maternal and child health, female empowerment, food security or African development. The communication plan will promote regular liaison with other partners and AusAid to assist this process. For example, as part of the AACES program, CARE Ethiopia is working to understand and capitalise on positive social norms and values that contribute to improved feeding practices and nutrition, reduce conflict within and between tribes/ethnic groups, improve decision making between household members in different groups and facilitate improvements in the area of maternal and child health. Further in Kenya there are similar opportunities for collaboration with World Vision, Plan, Action Aid and Marie Stopes who are also undertaking activities addressing issues of maternal and child health and food security. The Consortium will work closely with these AACES partners to develop a better understanding of the program's impact in these key development areas and its contribution to the broader objectives and initiatives of the Australian aid program in Africa.

Further, through collaboration with other AACES partners it is anticipated that the consortium will be able to contribute to a deeper understanding within the Australian community of cross-cutting issues in development, such as gender and disability. For example, it has been proposed that AACES will become a 'gender learning lab' where, over the five years, information concerning culturally relevant and successful gender programming will be shared between agencies and the broader development sector to enhance understanding and increase development effectiveness. The Consortium will also seek appropriate opportunities and relevant forums to share such deeper understandings of these issues within the broader Australian community.

Monitoring and Evaluation:

SBA approach to M&E

AACES Monitoring, Evaluation and Learning (MEL) is underpinned by the program's strength-based approach. This means MEL should: be integrated into program SBA processes as a means for community reflection and action planning; prioritise participatory processes which engage communities, ensuring that voices and perspectives from different groups (women, youth, persons with disability) are properly captured and; focus on development processes, not only outcomes.

AACES M&E needs to build on and synchronize with current M&E processes in broader APDA and MUACK programs. The review of current APDA monitoring instruments shows that a wide range of socio-economic and health indicators are being collected. However, the approach does not fully cover all the domains of change which are important to the AACES design, and needs to better reflect the SBA. The program partners in both Kenya and Ethiopia are open to introducing more qualitative and less indicator-driven M&E into their programs and we will work with them to make the necessary adjustments and to positively build on existing systems.

Key measures of change and proposed methods

There are five main measures of change in the AACES project:

1. Changes in accessibility to community based health services for mothers and children

The improved health of mother and children in the communities is a key measure in the project. The number of community based workers who are able to deliver primary health services, the number of births that are assisted by trained health workers, the number of children in remote locations who are

able to be reached for immunization, and the cases being referred to health facilities for greater attention are key indicators that will be monitored.

2. Changes in knowledge, attitudes and practices - which result from the range of community-based health and other activities

Community surveys (adapted from the current APDA tool) will measure changes in knowledge, attitudes and practices of targeted community members in response to behaviour change strategies focused on key preventive health and harm reduction practices, and health seeking behaviour. Data will be disaggregated by gender to better understand gender differences in KAP between men and women and possible enablers or barriers to change. The feasibility of disaggregating data by age may also be explored to understand differences between youth and older community members. Purposive sampling will also be employed to collect data from persons with disabilities and people living with HIV and AIDS.

3. Changes in access to essential services (through community initiatives or through external government/ non-government programs)

The design proposes to adapt CARE's Community Scorecard Process[3], a participatory methodology for monitoring community access to essential services. In AACES this would focus on the accountability of service providers, the role of other providers such as NGOs, and the areas that communities can provide for themselves. Dialogue is facilitated through the local CDCs, representing a broad cross section of community interest groups (women, youth, people affected by HIV and AIDS and disability) with the capacity for interface with the SHCs to facilitate community feedback and promote joint decision-making. The data resulting from these processes will provide important monitoring information about changes in community expectations and access to essential services.

4. Changes in participation and transparency in community-based decision-making through the inclusion of perspectives and interests of all groups (including women and other more marginalized groups).

Participatory qualitative methods will be used to assess the inclusion of perspectives and interests of marginalized groups (including women and persons with disability) in local governance and decision making structures. Again, purpose sampling will be used to capture the perspectives of different groups.

5. Changes in AusAID's investment in Maternal and Child Health which reflects the needs of nomadic pastoralist communities in Africa and this change is supported by an informed and empathetic Australian public.

During the first year Nossal will track the impact of the AACES project on the policies and strategic planning of AusAid, ANGO's and aid stakeholders, and impact of the AACES communication plan on public awareness, developed under Objective 3.

Key M&E processes

Evaluation of project outcomes will involve comprehensive collection and analysis of data at baseline, mid-term and end line based on the five key outcome measures discussed above. Stories of change will also be collected and analysed for evaluation.

Annual Learning Forums (ALF) - involving the CDCs, SHC and AACES consortium partners, will provide the opportunity to promote stakeholder learning through bringing together activity and qualitative outcome data in order to plan priorities for the following year's program of activities, incorporating any adjustments necessary to the approach. Prior to the ALF, facilitated discussion will occur with different groups of stakeholders as described above. During the ALF knowledge gaps or ideas for operational research will be explored drawing on the findings from the MEL data. Over time, program learning and

[3] Developed by CARE International in Malawi

operational research will also influence policy and advocacy efforts at a local or national level across the two geographic areas of our program focus and contribute to AACES Objective 2 and 3.

Activity monitoring- will focus on tracking implementation and the activities of implementing staff and community-based workers. Using simple formats and tables, community-based workers will record key data and provide to community coordinators on a regular basis for consolidation in quarterly reports. Relevant data, such as immunisation services provided through APDA, will be provided regularly to the Ministry of Health. The program M/E units will have principal responsibility for processing and analysing progress reports as well as collecting other necessary data from other sources, such as health services data (although it is recognised that these are generally deficient).

The program manager within Anglicord is responsible for the AACES project and is tasked with tracking the expenses incurred in the project against outputs using internal project management tool developed. The office being established in Nairobi will be responsible for quarterly monitoring of expenditure by African partners against agreed outputs. Financial risks are further managed by disbursing funds to partners on a quarterly basis. Annual audits will be conducted on project accounts. Narrative and quarterly financial reports obtained from in-country partners, consortium partners and Anglicord will be presented to the Finance and Risk Committee and the Program Development Committee of Anglicord for approval.

Further detail will be developed in the draft M&E Plan (Annex to be submitted later) and the more detailed M&E Plans developed in year one.

Coordination and management of M&E

Efforts are currently underway to establish dedicated monitoring, evaluation and learning (MEL) units in the partner organizations in both Ethiopia and Kenya and partners are in the process of recruiting new personnel. It is proposed that ongoing coordination and management of M&E will be led by these MEL units.

The Nossal Institute will provide guidance and technical advice to these units in evolving current M&E processes towards a more comprehensive and integrated system that will meet AACES information and learning needs. The Nossal will also provide hands on assistance during key periods of M&E analysis and reporting, such as the ALF, and baseline and program evaluation.

During the first quarter of project implementation, Nossal will work with local project partners to develop the MEL system including orientation on general MEL principles and methodologies and building an M&E Plan. The initial focus will be on the baseline study including refining baseline indicators and developing locally appropriate tools, and training the local team in baseline data collection and analysis.

Capacity development in M&E

An early focus in year one will be on skill-building in SBA and M&E. Our program partners in Ethiopia and Kenya have some existing capabilities in MEL but have identified the need for further training to enable them to move beyond routine data collection and reporting to capturing community learning through participatory data collection and analysis, and utilising data to inform program planning, implementation and advocacy.

Ongoing capacity building of staff in data collection, analysis and interpretation will be supported by the development of appropriate training resources translated into local languages. Participatory development of a MEL plan for each partner organisation will be undertaken along with an SBA implementation manual and 'community friendly' templates for capturing information.

Risk Analysis:

A number of potential risks have been identified in the implementation of this project and the achievement of project objectives. Details about management of these risks are provided in annex 4 "Risk Matrix".

Current Government policies in Ethiopia and Kenya discourage community birth attendants attending to child births and hence training or equipping such attendants is not encouraged. If during the project government policy is strictly enforced making training of TBA not possible, it poses a major risk to the success of the project in reducing maternal and infant mortality in the target areas. Currently government authorities are not actively enforcing this policy as they acknowledge that they are unable to provide an alternative. It is anticipated that the evidence provided from this project's use of women's health monitors will contribute towards further policy discussion on how governments meet the gaps between the reality on the ground and policy ideals.

The capacity of MUACK project team to implement a major project is untested. However, they have worked in the health service sector for a number of years and are led by a trained midwife. The experience gained through APDA will also assist in up-skilling the MUACK team.

Challenges to cultural norms have the potential to lead to unintended outcomes. A focus on gender equity might result on building resistance by males to changes associated with empowering women. The project design should mitigate this risk as it works from a strength based and participatory approach which supports men's hope for strong and prosperous families.

The literacy levels in communities of Afar and Kenya are low and aiming to appoint competent community based staff may be challenging due to a lack of suitable candidates. Further, since people with higher levels of literacy might be able find jobs elsewhere, we may experience high turnover of staff during the project period. As community based staff will be integral to success of the project, it will be important to effectively manage these human resource issues.

Both the Afar and the target areas in Kenya are prone to ongoing droughts. This phenomenon causes communities to constantly migrate in search of water. Constant movement will impact on any training of local community workers and also on community structures established such as community development committees and stakeholder committees. Ongoing functionality of these structures is crucial in planning and implementation of an exit strategy and sustainability.

In both Ethiopia and Kenya the currency exchange rates have been to their disadvantage in the last year or more. With the unstable global financial situation and inflation, the cost of living could have a negative impact on the budgets and in turn impact on the project outputs and outcomes.

Kenya has recently experienced post-elections, political unrest and a feeling of volatility still exists. Although the target areas have experienced less violence than other areas, any future violence could impact on the project. The Samburu area is also extremely vulnerable to inter-ethnic violence and tribal raids which could affect project inputs. In Ethiopia, with the state of war declared with Eritrea, the Afar region faces the brunt of any incursions as it shares the border with Eritrea. A similar situation prevails with Djibouti from where illegal raids are constantly launched across the border from Afar to steal cattle.

Working in a consortium can be a risk if differences between partners cannot be reconciled. Partnership agreements establish a joint understanding of the aim and strategy of the project with clear lines of responsibility for each member articulated. Strategies have been developed to monitor the effectiveness of the consortium and manage disputes.

Sustainability and Exit Strategy:

In both Kenya and Ethiopia the strategy for ensuring sustainability and an exit strategy will be along three approaches. These approaches are tested and are being implementation in Afar, Ethiopia by APDA. Similar strategies will also be applied in Kenya:

1. Strengthened coordination between NGO and government to extend the reach of health services to remote areas using NGO capacity and community-based workers (eg. vaccination programs in remote areas are carried out by APDA with drugs and supplies provided by government and financial support for logistics provided by UNICEF and GAVI)

2. Facilitate links between communities and existing government services or non-government programs (egs. agricultural extension officers providing technical support with veterinary needs, HIV services for VCT and ART, water infrastructure funding provided by Oxfam)
3. Advocate to expand government services to reach its remote populations (egs. greater access to primary care facilities, supply of essential drugs and water supplies through the continuum of care)

During the life of the project, a core number of community members will be trained in each community as health workers and literacy trainers. The capacity of people to work as women extension workers and HIV coordinators will also be built. Trained women extensions workers will contribute to building awareness in communities on the various practices that impact on the health of women and children. These workers will have the ability to continue to conduct activities in the communities beyond the life of this project encouraged by the leadership provided through the community development committees.

Through the establishment and capacity building of community development committees and stakeholder committees it is hoped communities will be in a position to address their development needs and aspirations beyond the life of the project. A community handover plan will be developed from the outset of the project. This process will be established based on successful examples that have already been achieved in parts of Afar, Ethiopia by APDA. The approach in Kenya will be mirrored along the same taken in Afar.

APDA works closely with the Afar National Regional State (ANRS) Government when planning and implementing programs. Conferences and forums organized by APDA together with ANRS have helped to negotiate and mitigate problems hindering or delaying development in Afar Region. Continuing this engagement APDA will train and handover activities region by region progressively to the ANRS. Since APDA commenced teaching programs in nomadic populations, the government has constructed and run schools in several sites ('Adda'ar, Sifra, Uwwa and Awra).As of 2009, the government began piloting mobile education assisted through UNICEF along the same model as that developed by APDA. Similarly, mobile teams adopted by the Bureau of Health and funded by UNICEF have also been modeled by APDA.

APDA is currently working hand in hand with the Bureau of Health on the Expanded Program on Immunization (EPI) coverage - APDA covers remote and 'hard-to–reach' communities and trains health workers to work with the government in government campaigns. Other examples of APDA trained workers who have been subsequently absorbed into the government service sector include almost 50% Afarinya speaking teachers in the government being first trained by APDA and then seconded to the government, and 15 health workers in Adda'ar (2010-11). Examples of services developed by APDA that have been handed over to the government include (i) health and education activities in Konnaba (2009), (ii) Education in Teeru (2009), (iii) Health and Education in Afdeera (2010), and (iv) Teachers in Mille, and Eli Daar. Currently the process of hand over is underway in Assayita the trained health workers and teachers.

Through the continuum of care approach, the project intends to build capacities at all levels between the local communities and health facilities to ensure that health care for women and children is provided to in a holistic manner. The awareness building within communities to access facilities and services is critical to ensure success. Once communities accept and access facilities as a habit it is hoped that health-seeking behaviours will become more prevalent amongst the target communities. The approach taken to enter the community through appropriate traditional and religious leadership structures will help maintain the behavioural and attitudinal changes effected through this project.

AusAID Policy Requirements:

Anglicord is currently compliant with AusAID's policy on child protection. Both partners in Ethiopia and Kenya have developed their own child protection policies as required by category 4 agencies in AusAID's policy direction and have actively instituted the policy across their organisations. Both partners have

translated their policy into the local language and have inducted all staff members prior to getting them to sign the code of conduct. Through the application of the policy, the partner in Kenya has already acted on two cases of child abuse and the perpetrators have been legally prosecuted. In this ACCES project, all project staff and volunteers engaged will be inducted to the child protection policy and will be required to sign the code of conduct. During quarterly monitoring, community coordinators will ensure that child protection obligations are being met.

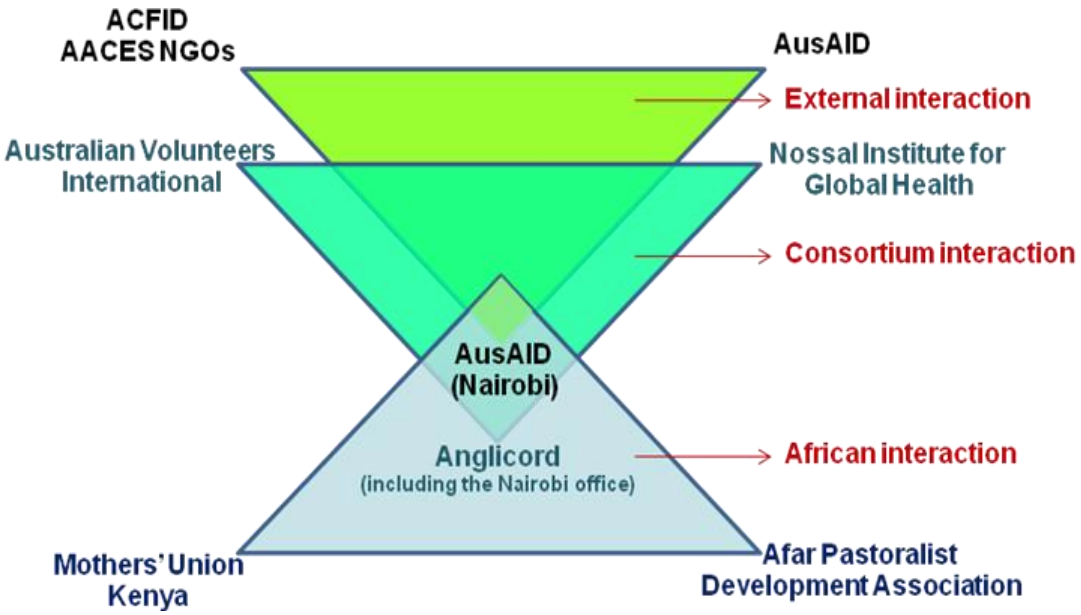
Although addressing environmental issues is not a focus of the project, impact awareness is part of the literacy training that will be provided. Biological wastes generated during the project will be burnt or buried to ensure there is no pollution.

With regards to People with disabilities (PWD), the Maasai and Afar communities perceive that there is no discrimination; but disability inclusive development is poorly understood or addressed. In this project, existing traditional systems and structures will be better utilised to gain more recognition and engagement. Current practices and customary laws that govern the inclusion of PWD will be further researched and strengthened through dialogue and engagement. The representation of PWD in the CDC is a key strategy to give PWD the opportunity to voice their issues at decision making levels. Although this risks tokenism, local NGO representative facilitating the CDC meetings will ensure appropriate participation of PWD. It is also intended that PWD in the communities will be engage using consultation strategies such as self help groups to hear and address MCH issues affecting PWD. Targeted education will be provided to community workers to consciously engage with PWD and ensure their needs are addressed.

Marginalized and vulnerable groups often require capacity development and empowerment to enable their full participation in mainstream development activities. This is especially the case for PWD and people living with HIV and AIDS (PLWHA) who are often hidden within society, stigmatized and viewed by communities as unable to contribute. As part of our commitment to inclusive development, the project will adopt a “twin track” approach, which will promote disability and HIV and AIDS as cross cutting issues within development activities, as well as providing specific activities which will enable PWDs and PLWHA to be active members of their community and the development program.

Anglicord has existing projects in Africa that interacts with community groups to build local resilience to address impacts of HIV and AIDS affecting the community. Both in Kenya and Ethiopia Anglicord’s projects on HIV and AIDS have worked with communities to build capacity in communities to provide a range of support systems, including to extend services for VCT, ART adherence, Home based care, community based care, PMTCT, OVC and opportunistic infections. Recognizing stigma towards PLWHA is high, mainly as a result of ignorance, and that women who are infected are further marginalised in communities, this project targets income generation for these women, although it is not a major component in the project.

Annex 2: Organisational Relationship Model and Chart



Annex 3 Activity plan for the first year

(GANNT chart providing the time line for activities is attached separately – Attachment 1)

Activities
Start up meetings in communities – ***Office set up and staff selection*** In Afar, Ethiopia the operational head quarters of Afar Pastoralist Association (APDA) is well established in Logya. The project management will be coordinated from this office. Staff selection for field activities in all but one district (Woredas) is expected to be completed by the end of July 2011. In Yallo, the staff selection will commence in October 2011. Staff appointments would include health workers, literacy workers, women extension workers, HIV and AIDS conversation facilitators, area coordinators, M&E personnel, admin and finance support staff and a driver. In Kenya a Mothers' Union (MU) project operations office will be established from July 2011 in Nanyuki form where all activities in Laikipiya and Samburu will be managed. A satellite office will be established in Suguta-Marmar in Samburu to coordinate activities in Samburu. A project manager, office support staff and two area coordinators, together with M&E staff will be appointed in July 2011 (already identified and have been working during the design phase). Field activities will commence in three areas (Ilingwesi in Northern Laikipiya, Naibor in Eastern Laikipiya and Suguta-Marmar in Samburu) will commence in July 2011 while the activities in other chosen 5 sites will commence based on the progress of activities in the second half of the first year. Logistical needs of the project and procurement of supplies will be managed from Logya in Afar and from the Nyeri office of MUACK (where the Good Samaritan Clinic is operating), including the purchase and distribution of drugs, delivery kits, vitamin supplements etc to the community health monitors and health workers. ***Establishing Monitoring and Evaluation Teams and capacity building*** In both Ethiopia and Kenya, dedicated M & E teams will be established as part of this project in July 2011. The team in Afar will be situated in the Logya office and will consist of the M&E head of department, a data analysis person and a data entry person. In Kenya the appointed (July 2011) M & E team will be situated at the Nanyuki office and will consist of an M&E officer and a data entry person. All heads of departments and senior project staff of both APDA and MU will be trained by Nossal Institute for Global Health (NIGH) in Aug-Sept 2011 and introduced to the proposed M&E frame work, data and information collection methods and sense making approaches. Special templates for data collection are being developed by NIGH and relevant templates will be introduced to staff obtaining data at different levels. ***Community sensitisation*** As the project commences in July 2011, each of the communities where the project is targeted will be visited by the country project coordinator and relevant senior staff members and the project intentions will be introduced. This sensitisation will be a follow up of the community consultation that was held during the design phase. The community will also be introduced to the strength based approach (SBA) to development activities (the community workshops on SBA will be held later). Community sensitisation will be completed in August for the three communities in Kenya and in July for all communities in Ethiopia. The sensitisation to all remaining communities in Kenya will be completed in February 2012. ***Establishment of Community Development Committees and training*** In each of the communities where the project is targeted, in both Kenya and Ethiopia, a community development committee (CDC) will be established consisting of clan elders, religious leaders, women representatives and youth representatives. The committee will also include a person who will represent people with disabilities (PWD) and people living with HIV and AIDS (PLWHA). This committee will meet on a

quarterly basis and discuss progress on project activities and address community concerns and challenges. The CDC will represent the community on all matters that impact the community and ensure agreed responsibilities between the project implementing organisation, the community members and the local stake holders are followed up. The CDC will be established at the time of community sensitisation and will be trained in their responsibilities and activities. The area coordinator for the district will attend all CDC meetings.

Establishment of Stakeholder Committees

The stakeholder committee (SHC) in each community will be represented by the representatives of the local authorities, including from health, education, women's affairs, youth affairs, water and sanitation, agriculture and public works departments. Local religious leaders will also be a part of the SHC. The SHC will meet twice a year separately and together with the CDC.

It is planned that a tool similar to the "score card" used by CARE international will be introduced to track accountabilities of the LNGO, CDC and SHC. Training will be provided to all committees on the use of the accountability tool and measures and indicators will be mutually agreed at the commencement of activities.

Staff and community training in Strength Based Approach to Community Development –

The strength based approach to community development (SBA) is planned for the project and all staff members, CDC, SHC and community members will be introduced to the approach. Initially, community coordinators of APDA and MU will be trained in SBA (this is planned prior to the commencement of the project in May-June 2010). MU in Kenya is already proficient in using the SBA and the training for APDA staff will be provided by MU. The trained coordinators in turn will train the field staff who will then conduct workshops in the communities. All training workshops are planned in the first quarter for 4 districts in Afar and in the second quarter for 3 districts. In Kenya, training workshops are planned for three communities in August 2011 and for the remaining communities in February 2012.

Base Line Assessments –

A comprehensive baseline assessment (BSL) will be completed prior to the commencement of activities in each of the areas where the project will be implemented. A questionnaire designed in partnership with local implementing agencies and NIGH will be used to survey a representative sample of households in each area.. In Kenya, a household will be considered as a cluster of homes within a *'manyata'* – usually headed by one or two men. Similarly, in Afar a household will be considered as a cluster of homes that moves together in a caravan during nomadic movements – usually headed by a single man. The questionnaire will seek information on the current status of health of women and children, practices followed during child birth, types of food consumed and the status of nutrition, levels of education in the household and their attitudes to education (including that of girls), accessibility to water, religious and traditional practices that could be deemed harmful or which can be utilised to support women and children, social structures in the communities, power dynamics in households, income generation activities and the level of wealth, age of marriage of women and other relevant data to set a base line. A team of ten data gatherers will visit homes as pairs over a set period of time to gather the information. The information will be processed by the M&E team to establish base lines for each community and the information will be shared with the field staff, CDC and SHC. Together with each community, targets for improvement will be agreed during the project period and sustainability measures will also be discussed. Using the SBA, community priorities will be determined and action plans will be agreed between all parties.

BSL will be conducted in Kenya in September 2011 in three communities and in February 2012 for five communities. In Afar, BSL will be completed in three districts prior in the first quarter of the project from July 2011. Of the remaining districts, surveys will be completed in September in Sifra and Adda'ar and in October in Mille and Yallo.

Mother and Child Health Monitors –

Selection

The Mother and Child Health (MCH) monitors will be recruited from each of the communities they represent. They are usually women with a basic level of literacy and command the respect of the community. Quality of these volunteers would be that they are highly motivated and have a sense of community responsibility. In each location approximately 20 monitors will be recruited and each of them will be responsible for a select number of households and will continuously monitor and advice family members of important dates and needs. The selection and appointment of these monitors has to be negotiated with the village elders since the time commitment of the monitors and their work in neighbouring holds has to be agreed by the community. The selection of MCH monitors in Kenya will be done in September 2010 in three communities and in April 2012 for the remaining five communities. In Afar, the selection in Adda'ar, Afembo and Mille will happen in September and in Sifra and Assayita in October 2011. In Geeiga, the selection will be made in January 2012 and for Yallo the selection will happen in May 2012.

Training (including at Mille hospital)

Training of MCH monitors in each district of Afar and in Kenya will be provided a month after selection. Each of the MCH monitors will be trained in a range of approaches to address harmful practices such as FGM. Some culturally and traditionally localised practices that contribute to death, illness or injury at child birth will be identified and the monitors will be trained in preventing these practices in the community. For example in Afar, Ethiopia they will campaign against six practices that are common:

a) Female Genital Mutilation (FGM),

b) 'kayna' - or closing the mother after the birth - literally this is another form of FGM and is done by thorn needles but now more by tying the legs from the knees to the thighs by rope for 7 days,

c) not giving the mother any or very limited water and food in the labour phase as the belief is that the uterus and the bladder are joined during labour ('if you drink, you tip water on the baby's head'),

d) no breast-feeding for up to 72 hours after birth, based on a belief that colostrum is dangerous)

e) Bleeding the mother as much as possible from the umbilical cord immediately after the baby has been delivered. They believe that the blood is 'good and bad' and therefore it should be bled out, and

f) Early washing of the baby and confinement for 7 days in sealed and smoked house..

The Monitors are the local health promoter and facilitate access to health workers and women extension workers by community members to ensure coverage of routine antenatal checks, immunisation and other population based outreach services. In addition they will be provided with a small kit to enable their own practice, which might include some first aid materials, for wound care and dressings. They may distribute birthing kits and assist in the distribution of nutrition supplements such as Iron, Vitamin A.

Activities

They will be responsible for providing ongoing advice to families in basic health and nutrition needs of women and children. For example, pregnant mothers will be reminded of anti-and post-natal clinic dates and the dates for immunisations for infants. They will assist in the ongoing campaign against harmful practices and with deliveries of babies at no cost. As they continue to monitor progress in pregnancies, they will be trained to identify mothers who might be at risk and recommend and refer appropriate care at health facilities. They will also provide promote and provide basic antenatal checking. On average the MCH monitors will visit 120 households per month.

With the use of simple (pictorially assisted) templates, the MCH monitors will record the number of babies delivered in homes and note any complications that may have risen from the births. They will also provide advice about early newborn care and monitor and record the progress of the mother and child. These records will be submitted to the health worker in the area on a monthly basis.

Field staff training –

In Kenya, training for all health and literacy workers will be held in November 2011 (for those from three communities) and in March 2012 (for those from five sites). In Afar, the training for Health workers, Literacy workers and women extension workers will be held between September and November, 2011. In Yallo, only health workers will be trained in the first year in May-June 2012.

The activities of the field staff will continue throughout the year and be monitored on a monthly basis. As most of the target communities are nomadic and since the field workers are selected from these communities, they will be mobile with the communities. In instances where the women and children remain in one place while the men and young boys move with the cattle the tasks will be split between field workers to cater for both circumstances.

Health workers

The health worker training provides capacity development for the worker to take important health messages and build awareness on a daily basis from house to house. They will work interactively with the Community Development Committee.

Areas of responsibility include the following

- Supporting the work of the MCH monitoring
- Providing ANC – according to WHO guidelines, including the assessment of high risk pregnancies
- Provide advice about safe deliveries, including transport readiness, counselling on danger signs in labour and distribution of safe delivery kits for women who choose to deliver at home
- Potentially distribute and counsel on the use of Misoporstol for the prevention of PPH
- Visit and conduct postnatal visits for women on day 1 and 3 post delivery and counsel regarding early exclusive breastfeeding
- Provide community based management of child hood illness (CB-IMCI) including ORS and zinc for diarrhoea, cotrimoxazole for pneumonia

The health workers will also be trained to be constantly alert to any disease outbreaks in the community and learn to treat diarrhoea during rainy seasons and to administer ORS. They will also be trained to provide ongoing awareness on HIV transmission and safe sexual practices, encourage VCT and use of condoms by having them available. The approach to bring awareness will be sensitive to targeting men, women, youth and children differently. The training provided will prepare them to constantly alert the religious leaders, clan elders of harmful practices for community response. They will also be the principal campaigners in the community for hygiene and sanitation – particularly facilitating access to soap and water purifying materials.

Literacy workers

The literacy workers are trained to provide broader non-formal education to all community members. The literacy workers target all age and gender groups in the community to not only teach them basic level education to read and right in the local language but also support the CDC in raising awareness on literacy in the community. The training enables them to assemble students in the evenings for six days in the week to teach basic education up to level 3 of primary school. In addition to this, they also assist the health workers in providing lessons on stopping harmful practices, safe motherhood, hygiene and sanitation etc through the literacy manual developed by APDA (which will be adopted by MU in Kenya for the Maasai community). In the Maasai community of Laikipiya, previously a program named “Sheppard’s Learning” was introduced to increase literacy levels. This contributed to higher number of Maasai youth entering secondary and vocational schools. The Literacy training provided under this project will also aim to equip students for broader learning by continuing to secondary and vocational schools. Together with the CDC the Literacy workers will assist in identifying and selecting community development workers for literacy. Particular emphasis will be made to target female student participation mobilized through CDC and encourage them to participate in daily discussions and awareness-raising. The activities of the literacy

workers will be ongoing throughout the year.

Women Extension Workers

Women extension workers (WEW) are specifically employed by APDA in Afar for targeted activities aimed at women. Although the work carried out by these women are similar to those of the health workers, the focus is on women and address issues particularly pertinent to women. While health workers can be male or female, the WEW are exclusively women. Aside from similar activities that are carried out by the health workers, WEW also monitor and work alongside TBAs in the community. They re-equip the TBAs and take reports on deliveries and assist in their annual training. On a daily basis, they would interact with and work in collaboration with the health workers, literacy workers, TBAs and work in close collaboration with the CDC.

WEW are more literate than other community based workers and are key interlocutors with community decision making structures to ensure the needs of women are adequately addressed. One specific activity conducted exclusively by the WEW is to promote women's group income generation activities through awareness raising, facilitating training opportunities, training to manage funds and to monitor activities.

HIV and AIDS awareness facilitators

Dedicated HIV and AIDS awareness facilitators will be appointed in Afar in Chifra, Addar and Yallo Woredas in the first year. In other areas, where there are facilitators already functioning activities will be targeted amongst high risk groups. In Assayita and in Afembo, targeted activities aimed at providing income generation opportunities for women infected with HIV will be conducted in the third quarter. HIV and AIDS awareness facilitators are responsible for creating awareness in the community on a daily basis. This includes raising awareness in collaboration with health workers, WEW and teachers and CDC. They are the key interlocutors for working with youth groups and ensuring appropriate training is provided. They work closely with youth groups encouraging and motivating them on good and safe behaviours them and link them to woreda officials for further development of local initiatives. The facilitators provide youth and HIV head with monthly report of activities. In Kenya, these activities are carried out by the health worker. They are specifically tasked with building awareness with traditional and religious leaders and alerting them on appropriate community led behaviours and activities to reduce risk of infection. The facilitators in collaboration with local authorities ensure that condoms are made available in market and town areas through supplying distribution boxes.

Harmful Practices awareness coordinator

The harmful practices awareness coordinator is responsible to ensure community members become aware of the impact of existing practices that affect the wellbeing of mothers and children and the inequalities for women that prevail in the communities. The coordinator will train community traditional leadership on Islamic teaching on women's rights, link community- level religious leader with woreda and regional religious leadership and facilitate community workshops for broader awareness creation. They will through interaction with the CDC, women extension workers, health workers, and MCH monitors will regularly monitor changes in behaviours in the community and create opportunities for discussions aimed at stopping the harmful practices.

HIV and AIDS response activities –

Youth group training and activities

In the first year of the project in Kenya, HIV related activities are planned in three sites (Ilingwesi in Northern Laikipiya, Naibor in Eastern Laikipiya and Suguta-Marmar in Samburu). We have identified that youth groups in these areas have previously been active as HIV focus groups and have previously received some training from other NGOs. These youth will be re-grouped and training will be given creating awareness on methods of infection, risk behaviours, high risk groups, safe sexual practices, preventive actions in communities, and targeted approach will be taken to develop specific activities based on the outcomes of the SBA workshops. A concentrated campaign will be carried out to increase awareness of HIV and AIDS and to encourage people for VCT at specific locations. Once groups in these areas have been

activated, other 5 areas in Kenya will be targeted for similar activities in the second half of the year. In Afar, activities will be concentrated along the main transport route, about 800 km in length, that links the sea ports of Assab and Djibouti to the Capital, Addis Ababa cuts across the Afar and carries over a 1000 trucks a day. As prevalence of HIV and AIDS amongst the truck drivers is 50%, targeted campaigns are planned in these areas. The trucks stop along the highway at various villages and towns for rest and refreshment. At the town Mille, where the customs check all commercial vehicles for imposing duties on goods, the trucks remain for extended periods of time, sometimes several days. The commercial trade of the region is dominated by non-Afars coming from the adjacent highlands. Along the truck route, in villages as small as 800 people, it is estimated there are up to 200 highland sex workers. Similarly in Yallo and Chifra, which are both market towns, and in Addar where military camps are present, targeted activities are required to target youth and men who frequent to reduce risks of HIV infection.

In both countries, the establishment of Community Care Teams (CCT), which provide support to people affected by HIV and AIDS, is planned in the first year particularly if there are currently no services available from health care providers and where the incidence of HIV and AIDS is high.

Specific activities that will enable idle youth to be engaged such as in music and cultural activities (as already proven to be effective in Afar, Ethiopia) will be initiated. Specific activities will be identified during the SBA workshop in each area.

IGA start up activities

Limited IGA activities are planned for three sites in Kenya (Ilingwesi, Naibor and Suguta-Marmar) and in two sites in Afar (Chifra and Yallo). Women are generally dis-empowered when it comes to preventing being infected and in the activities planned are targeted at women who are already infected vulnerable. The HIV awareness facilitators, together with the CDC will identify the types of activities and the women who will be trained for specific activities. Through these activities, women will be become able to manage their needs and ensure they have adequate resources to buy nutritious food items that will assist in improving their CD4 counts and have a better chance at survival.

Training and commencement of activities in Afar will be done during February and March of 2012. In Kenya, training is planned in March 2012 and activities will commence in April.

Youth conference in Afar

In Afar, the annual youth conference during which representatives from all parts of Afar gather together to discuss priority issues that impact on them is held in July. The next conference in July 2011 will be supported by the AACES project where some priority activities that can influence behavioural changes reducing chances for HIV infection will be a special session. The conference will support 5 participants (boys and girls) from each of the 32 woredas in Afar. Conference resolutions on prevention of HIV and AIDS will be adopted into action plans in the woredas targeted by the AACES project.

Other activities –

Traditional Harmful Practices workshops

In the first year in Afar, harmful practices workshops in communities are planned in Assayita (September), Afembo (October) and Yallo (December). The Harmful Practices coordinator will work together with the Women extension workers, Health workers and Literacy workers to ensure the messages promoted in the workshops are effectively filtered through to the various sections of the community. During workshops, religious and traditional leaders will also be targeted for promoting and behavioural changes in the communities. In the third quarter, activities targeting the religious leaders will be carried out in Chifra, Addar, Geeiga and Mille. In Kenya, the responsibility to campaign and prevent harmful practices will be the responsibility of the area coordinator together with the health and literacy workers. Workshops are planned for March 2012 for all 8 sites selected.

The focus of the workshops will cover various harmful practices prevalent in the community including prevention of FGM, discouraging teenage marriages, preventing chewing of *Kaat* by youth (*Kaat* is a mild

amphetamine which reduces inhibition when chewed and exposes youth to promiscuity) and other substance abuse.

WASH awareness training and water access activities

In this project, facilitating advocacy by the community to local authorities and stakeholders would be the main strategy by which access to water will be sought. Through the facilitation of discussions during CDC and SHC meetings and by assisting the different partners to advocate for budget allocations, it is envisaged that communities will be able to seek appropriate investments in water infrastructure. As water infrastructure is a high cost, only a limited amount of resources have been allocated within the project. During community discussions, the need to form water management committees will be determined and the management processes will be identified and established. In addition, water harvesting methods appropriate for each community will be identified and where possible limited investments will be made for communal facilities. Through the SBA, communities will be encouraged to come up with their own solutions for investment and managed of water sources. In the first year, 2 locations each in each country will be targeted for establishing water harvesting facilities. These activities are planned for the second half of the year.

Apart from water access activities, general awareness on hygiene in communities is planned for all communities. The appropriate messages will be delivered through health workers and MCH monitors in both Kenya and Ethiopia. In Kenya, hygiene and sanitation training will be offered to staff in February 2012 and awareness activities will be extended to communities during April. In Afar, staff training will be staggered between September and November 2011 and community awareness will be targeted in the second half of the year.

Religious leaders workshops

Religious leaders in Kenya and Ethiopia play a key role in influencing community behaviour and practices. In Afar, 99% of the nomadic people are Islamic. In Kenya, Maasai are influenced by many religions including Christianity, Islam and Animistic beliefs. In afar, APDA has employed scholars on 'Koran' who interact with religious leaders and promote behavioural changes and safe practices that improve conditions for women through religious discourses. Often community practices are dictated by misconceptions and misinterpretations of religious teachings and engagement with leaders help in promoting the good practices. Testing of couples for HIV and AIDS before marriage, discouraging the forced marriages of young girls and practices that deny women a say as to who they marry are some of the changes that have progressed in Afar. Prevention of harmful practices such as FGM are also promoted through the religious leaders. The training workshops targeted are to inform and engage religious leaders and debate the appropriate means for community engagement. In Afar, workshops are planned in Assayita and Afembo in September 2011, in Yallo in December and in the first quarter for Chifra, Addar, Geeiga and Mille. In Kenya, in the first year, field staff will begin the process of engaging the various religious leaders to determine the most appropriate ways of interacting with the Maasai communities and draw a strategy for implementation from the second year onwards.

Market access workshops and activities

This is a targeted activity planned to improve cattle management and market access for the community members. This activity will only be implemented in Chifra, Addar and Yallo where there are current established markets for cattle. The greater income generated from this activity is expected to flow through to families who own the cattle and contribute towards to the well being women and children.

In the first year, it is planned a selected number of Afar men and women will be trained in business management (including in book keeping and cooperative leadership) and create opportunities to establish businesses that sell veterinary drugs locally. A certain number of "scouts" will be trained for early detection of animal diseases and treatment and will be encouraged to move within the community to check animal health. Similarly these scouts will be trained through a ToT program on fodder awareness. With the help of community coordinators, it is planned that marketing opportunities will be developed for each community to improve quality of their cattle and get better prices. These activities are for February 2102 in Yallo and

for March in Chifra and Addar.

M & E workshops –

Inputs in year one will focus on identifying available skills sets and capacity development, creating a detailed M/E framework and tools and formats, as well as work to integrate M/E activity with broader planning, reporting and reflection processes involving teams and communities. Research into existing available and useful data for program M/E will also take place. Towards the end of the first year, an annual learning forum will be bring together staff, and community and government representatives from across the two programs to reflect on the year's activities and make plans for year two. This will also provide an opportunity to assess the relevance and applicability of the MEL framework and make any adjustments as necessary.

Policy dialogue and engagement –

Activities in year one will focus on establishing relationships with AusAID's in-country representatives and developing an understanding of AusAID's policies and programs, as well as those of partner governments, as they pertain to the project. Building a rapport with other AACES NGOs will also be prioritized. By the end of year one, it is expected that the project will have progressed to identify a broad strategy for dialogue with AusAID, identifying at least one theme for policy engagement.

Community engagement –

During the first year, the focus of activities in support of the project's community engagement objective will be on developing a range of project media that can be packaged in different configurations and distributed through different communication channels. The ultimate aim is to establish a profile for, and raise community awareness of, the consortium's project in particular and the AACES program in general. That content would include the key messages for the consortium relative to the project, such as general project description, purpose and approach, local community and partner challenges and aspirations, capturing/collecting images and video footage, etc. As the content is developed it will be used:

- To create project flyers/brochures for general distribution
- Will be packaged and hosted on our respective web-sites
- Will be distributed through agency newsletters, both hard copy and electronic
- Will be introduced to different audiences via existing public engagement activities, e.g. AVI's regular Information Sessions.

As initial project activities are completed in Africa, subsequent content will be developed to reflect on implementation and provide status updates.

Annex 3b: Activity Schedule for Afar, Ethiopia

Activities	Geega in Dubte	Sifra	Adda'ar	Mille	Kutubla in Assaita	Afambo	Yallo
Start Up Activities							
Start up meeting	Jul-11			Jul-11		Jul-11	Jul-11
Setting up Stakeholder Committee	Jul-11	Jul-11	Jul-11	Jul-11	Jul-11	Jul-11	Jul-11
Staff selection	Jul-11	Jul-11	Jul-11	Jul-11	Jul-11	Jul-11	
Setting up of Community Dev Committee	Jul-11	Jul-11	Jul-11	Jul-11	Jul-11	Jul-11	Oct-11
Training of Development Committee	Jul-Sep 2011	Jul-Sep 2011	Jul-Sep 2011	Jul-Sep 2011	Oct-Dec 2011	Oct-Dec 2011	Oct-Dec 2011
Base Line Assessment		Sep-11	Sep-11	Oct-11			Oct-11
SBA training activities							
Staff training	1st week in June -2011						
ToT of Field staff	1st week in July -2011						
Community workshops Initial & Refresher	Jul-Sep 2011	Jul-Sep 2011	Jul-Sep 2011	Jul-Sep 2011	Oct-Dec 2011	Oct-Dec 2011	Oct-Dec 2011
TBA Activities							
TBA selection	Jan-12	Oct-11	Sep-11	Sep-11	Oct-11	Sep-11	May-12
TBA Training	Feb-12	Nov-11	Oct-11	Oct-11	Nov-11	Oct-11	Jun-12
TBA training in Mille hospital				6 every 2 months			
Health workers activities							
HW training (new only)	Sept-Nov 2011	Sept-Nov 2011		Sept-Nov 2011	Sept-Nov 2011	Sept-Nov 2011	
HW training (refresher)	Nov-11		Nov-11		Nov-11	Nov-11	
Women Extension Workers Activities							
New training			Sept-Oct 2011	Sept-Oct 2011	Sept-Oct 2011	Sept-Oct 2011	May-June 2012
Refresher Training	Nov-11				Nov-11	Nov-11	
Literacy Teachers Activities							

New teacher's Training	Sept-Oct 2011	Sept-Oct 2011		Sept-Oct 2011	Sept-Oct 2011	Sept-Oct 2011	Sept-Oct 2011
Refresher Training	May-Jun 2012				May-Jun 2012	May-Jun 2012	
HIV and AIDS Response activities							
Youth group training					Jan-Mar 2012	Jan-Mar 2012	
Traditional Leaders response meetings		Sep-11 & Mar-12	Sep-11 & Mar-12	Sep-11 & Mar-12		Sep-11 & Mar-12	Sep-11 & Mar-12
IGA Training (Sifra & Yallo)		Mar-12					Feb-12
IGA start-up activities for HIV +ve		Mar-12					Feb-12
Youth Conference							Jul-11
Other Activities							
THP awareness workshops (21 sites)					Sep-11	Oct-11	Dec-11
Religious Leader's workshops				Jan-Mar 2012	Sep-11	Oct-11	Dec-11
Est animal drug Vendor in marketplaces		Mar-12	Mar-12				Feb-12
Est Co-operative animal treat scouts		Mar-12	Mar-12				Feb-12
ToT on Marketing and Fodder Awareness	Oct-Nov 2011	Oct-Nov 2011	Oct-Nov 2011	Oct-Nov 2011	Oct-Nov 2011	Oct-Nov 2011	Oct-Nov 2011
Project Management							
Developmenet Committee Meetings	Oc, Ja, Ap, Jl	Oc, Ja, Ap, Jl	Oc, Ja, Ap, Jl	Oc, Ja, Ap, Jl	Oc, Ja, Ap, Jl	Oc, Ja, Ap, Jl	Oc, Ja, Ap, Jl
Stakeholder Committee Meetings 2/yr	Sept & March	Sept & March	Sept & March	Sept & March	Sept & March	Sept & March	Sept & March
Annual M & E workshop	Apr-12	Apr-12	Apr-12	Apr-12	Apr-12	Apr-12	Apr-12

Annexe 3c: Activity Schedule for Kenya

Activities	Laikipiya North Ilingwezi	Laikipiya North Morupusi	Laikipiya North Tiemamut	Laikipiya East Naibor	Laikipiya East Ethi	Samburu Suguta-Marmar	Samburu Kirimon	Samburu Kisima
Training Materials								
SBA & HIV Training manual preparation	April to June -2011							
Identifying and developing manual on THP	April to June -2011							
Develop manuals for WASH	April to June -2011							
Develop manuals for Nutrition	April to June -2011							
ToT of Field staff	April to June -2011							
Community workshops Initial & Refresher	Jul-Sep 2011	Jul-Sep 2011	Jul-Sep 2011	Jul-Sep 2011	Oct-Dec 2011	Oct-Dec 2011		Oct-Dec 2011
Start Up Activities								
Office set-up & Staff selection	Jul-11	Jan-12	Jan-12	Jul-11	Jan-12	Jul-11	Jan-12	Jan-12
Start up meeting-community	Aug-11	Feb-12	Feb-12	Aug-11	Feb-12	Aug-11	Feb-12	Feb-12
Setting up Stakeholder Committee	Aug-11	Feb-12	Feb-12	Aug-11	Feb-12	Aug-11	Feb-12	Feb-12
Setting up of Community Dev Committee	Aug-11	Feb-12	Feb-12	Aug-11	Feb-12	Aug-11	Feb-12	Feb-12
Training of Development Committee	Sep-Oct 2011	Feb-Mar 2011	Feb-Mar 2011	Sep-Oct 2011	Feb-Mar 2011	Sep-Oct 2011	Feb-Mar 2011	Feb-Mar 2011
Base Line Assessment	Sep-11	Feb-12	Feb-12	Sep-11	Feb-12	Sep-11	Feb-12	Feb-12
MCH Monitor Activities								
Monitor selection	Sep-11	Mar-12	Mar-12	Sep-11	Mar-12	Sep-11	Mar-12	Mar-12
Monitor Training & Activity planning	Oct-11	Apr-12	Apr-12	Oct-11	Apr-12	Oct-11	Apr-12	Apr-12
Staff Training								
Training (SBA & HIV)	Aug-11	Feb-12	Feb-12	Aug-11	Feb-12	Aug-11	Feb-12	Feb-12
Training (Health & Literacy)	Nov-11	Mar-12	Mar-12	Nov-11	Mar-12	Nov-11	Mar-12	Mar-12

Training (WASH, THP & Nutrition)	Feb-12	Feb-12	Feb-12	Feb-12	Feb-12	Feb-12	Feb-12	Feb-12
HIV and AIDS Response activities								
Youth group training & activities	Oct-11	Apr-12	Apr-12	Oct-11	Apr-12	Oct-11	Apr-12	Apr-12
Traditional Leaders response meetings	Sep-11 & Mar-12	Mar-12	Mar-12	Sep-11 & Mar-12	Mar-12	Sep-11 & Mar-12	Mar-12	Mar-12
IGA Training	Mar-12			Mar-12		Mar-12		Feb-12
IGA start-up activities for HIV +ve	Apr-12			Apr-12		Apr-12		Feb-12
Other Activities								
THP awareness workshops	Mar-12	Mar-12	Mar-12	Mar-12	Mar-12	Mar-12	Mar-12	Mar-12
WASH awareness	Apr-12	Apr-12	Apr-12	Apr-12	Apr-12	Apr-12	Apr-12	Apr-12
Water Access activities	May-12					May-12		
Project Management								
Development Committee Meetings	Oc, Ja, Ap	April	April	Oc, Ja, Ap	April	Oc, Ja, Ap	April	April
Stakeholder Committee Meetings 2/yr	Sept & March	March	March	Sept & March	March	Sept & March	March	March
Annual M & E workshop	Apr-12	Apr-12	Apr-12	Apr-12	Apr-12	Apr-12	Apr-12	Apr-12

Annexe 4: Risk Matrix

Risk	Potential impact on the project	Likelihood (1-5 where 1= very low 5= very high)	Impact (1-5 where 1= very low 5= very high)	Risk (=likely-hood x impact)	Management strategy (for risks rated 5 and above)	Responsibility	Is the risk assessed through the M&E system (Y/N)
Contextual Risks							
Changes in Government policies. In Kenya • New constitution • Status of TBA's	May require adaptation of design to accommodate government changes	3	3	9	• Regular monitoring and annual evaluation will identify changes needed to comply with changes • Awareness of government policy in training program for women's health monitors • gather evidence of the effectiveness of using mother and child health monitors in the absence of alternative health services to provide to authorities	Anglicord, MUACK, APDA	Yes
Low literacy levels	May impact on ability to recruit workers to deliver community based training.	2	2	4	• Partners have extensive experience working with illiterate staff and have developed a range of teaching resources (visual) and monitoring methods to compensate. • Literacy training is an activity to be provided by the project.	ADPA, MUACK	Yes
Differences of opinion between members of the consortium	May impact the effectiveness of the partnerships and lead to delays in project implementation	3	3	9	• Strong partnership baselines established at design stage through partnership agreements including roles and responsibilities, communication strategy, timelines and dispute resolution.	Anglicord, Nossal, AVI, ADPA, MUACK, AMREF	Yes

					• Use of a partnership tool to measure effectiveness of the partnership to be applied annually.		
Environmental disasters such as drought	May delay training program if communities are moving in search of water May threaten ability of function structures (CDC's, development committees) from operating	3	2	6	• Activities are primarily targeted at women and children as they are more likely to remain stationary when men move with stock. • Use of community workers who will travel with communities • Regular monitoring will identify early any changes to implementation • If properly instituted, community decision making structures can yield an influence even while the communities are on the move.	APDA, MUACK, Anglicord	Yes
Political instability	Inter ethnic violence in Kenya and war between Ethiopia and Eretria has the potential to impact significantly on implementation and scope of project. Influx of refugees and their needs could deflect ADPA's attention from project activities	1	4	4	• Selection of areas for project implementation which have been relatively free of violence recently.	ADPA, MUACK, Anglicord	Yes
Fluctuating currency exchange rates and economic	May increase costs of project inputs	4	1	4	• Conservative exchange rates have been used to absorb currency fluctuations.	ADPA, MUACK, Anglicord	Yes

instability							
Design Risks and assumptions							
Reliance on working at grass roots level with community based workers	May affect ability to recruit, train and maintain enough workers with sufficient ability and time to devote to the project work	3	3	9	Risk minimised by • selection criteria established • Use of workers with prior experience in MCH • Payment • Planned ongoing training, monitoring and support to staff	Community Coordinators in each region, ADPA, MUACK, Anglicord	Yes
Employing a large contingent of staff members at the community level	Staff members left unemployed at end of project	3	3	9	• The number of staff members employed in Kenya are few. As most of their training will be government accredited, absorption to existing systems will be easily facilitated. • In Afar, most staff members are paid a stipend and not a salary. • Salaried staff members are trained and will be absorbed into the pool of staff of the local government as part of the exit strategy. As project progresses, consultation will be maintained between the local implementing agencies, local government and Anglicord to ensure the staff placements within the local government are effective. • Other staff will remain in the community as a community resource for ongoing community support.	APDA, MUACK, Anglicord and local government authorities.	

Reliance on achieving cultural change to underpin behaviour change particularly relating to • Gender equity • Disability rights • PLWHA's	May have unintended outcome such as strengthening resistance to change, back lash to target groups	2	4	8	Risk minimised by • Extensive pre design consultations with representatives of all groups • Training delivered in SBA • Establishment of CDG's with wide community representation to oversee implementation. • Long term relationships established with partners	Project manager, Nossal, Community Coordinators	Yes
Implementation Risks							
Limited capacity of implementing partners particularly in M&E Untested new partners	May limit or delay implementation of activities due to time required to build the capacity of the partner	3	3	9	• Undertake capacity assessment and develop support accordingly building. • Build on the skills of those project staff with prior experience working within both the health sector and Diocese. • Conduct joint meetings of staff from both countries to share and learn. Progressive intervention to allow time for building capacity and lessons learnt	Anglicord, Nossal, AVI, MUACK	Yes
Ability to engage with duty bearers and Inadequate support from local health authorities	May impact on sustainability of project outcomes	2	4	8	Ethiopia: A key strategy of the HESP III (is to engage NGO's and the private sector to extend reach of government services to pastoral communities. This project meets the government strategy. Kenya: this project aligns to the NHSSP 11 community strategy of facilitating behaviour change at family/ household	Anglicord, Nossal, ADPA, MUACK, AVI	Yes

					level supported through advocacy, social mobilisation and interactive communication. Leverage for engaging with government agencies will come by establishing links with other NGO programs and government field workers. Some examples are: • The vaccination program undertaken by UNICEF, GAVI and MOH. • Agricultural extension officers, HIV/Aids programs, water supply – Oxfam • Regular meetings with representatives from all levels of government to consult, inform and learn • Review advocacy and engagement policy through CDC and stakeholder meetings and annual M&E		

Intermediate Outcomes/ Outputs	Measures	Data collection method	Data disaggregation	Who will collect data?	Frequency to collect	Who will analyze data?	Who will report data?	Frequency to report	How will information be utilized
AACES Objective 1 Marginalised people have sustainable access to the services they require									
PROJECT RESULT AREA: Expanded and improved capacity of community-based health services to attend primary health care needs of women and children									
Improved health knowledge, attitudes and practices in communities	Indicative Indicators[i]: Safe birthing, newborn practices Know danger signs pregnancy Early initiation breastfeeding Know danger signs child illness Home treatment diarrhoea Health seeking behaviour for MCH services Safe sex practices Reduction in FGM	KAP Community Survey	Men, women. Purposive sampling of PWD and PLWHA	M&E teams in APDA, MUAK	Year 1 (Baseline) Year 3 (mid-term) Year 5 (Endline)	APDA, MUAK with NI	APDA, MUAK with NI	Year 1 Year 3 Year 5	Evaluation Policy dialogue with AACES stakeholders
Community-based health and literacy services for mothers and children	Indicative Indicators: ANC and PNC visits Assisted delivery, complications and referrals Immunisations CB-IMCI visits Health promotion activities HIV support activities Literacy classes	Activity Monitoring Templates	As per specific groups targeted for activities - women, children, youth	Community Workers report to Community Coordinators [ii]	Monthly	APDA, MUAK	APDA, MUAK	Quarterly	Annual Learning Forums[iii]
PROJECT RESULT AREA: Increased capacity of women and children to access services and resources that impact on their quality of life and equity									
Participation of women and other marginalized groups in community-based decision-making processes	Community perceptions of their capacities, self-confidence and voice in issues that affect their health	Group Discussions	Separate focus groups - PWD, PLWHA, men, women, youth	Community Coordinators	Annual	CDC, APDA, MUAK	APDA, MUAK	Annual	Annual Learning Forums

Intermediate Outcomes/ Outputs	Measures	Data collection method	Data disaggregation	Who will collect data?	Frequency to collect	Who will analyze data?	Who will report data?	Frequency to report	How will information be utilized
Improved community access to essential services (community-based, government, non-government programs)	Community perceptions of access to and quality of services Effective integration of community-based/ government services/ external support	Community Score Card	Separate focus groups - PWD, PLWHA, men, women, youth	Community Coordinators	Annual	CDC, APDA, MUAK	APDA, MUAK	Annual	Annual Learning Forums
OUTPUTS for Objective 1									
Representative Community Development Committees (CDC) have capacity to utilize SBA to plan and monitor community-based activities	Formation of a representative CDC in new communities No. of capacity building activities by implementing partners using a SBA and no. of participants	Project records	Men, women, youth, PWD, PLWHA	APDA, MUAK	Ongoing	APDA, MUAK	APDA, MUAK	Quarterly	Reporting upward (project partners/ donor) and downward (CDC)
Community-based workers equipped and supported to implement activities	No. of training activities for community-based workers No. of volunteers placed in communities to provide technical support No. of essential health supplies distributed through community-based workers	Project records	Men, women	APDA, MUAK	Ongoing	APDA, MUAK	APDA, MUAK	Quarterly	
Evidence-base improved through trialling health strategies and services	Identification and implementation of pilot research initiatives	Project records	na	NI, local research institute	Ongoing	NI, local research institute	NI, local research institute	Annual	

AACES Objective 2 AusAID policies and programs in Africa are strengthened particularly in their ability to target and serve the needs of marginalised people									
PROJECT RESULT AREA: AusAID, ANGOs and aid stakeholders making investments that are targeted at improving mother and child health for nomadic communities									
AusAID and ANGOs strategies for improving MCH for nomadic communities informed by project learning	Increased collaboration/ coordination or funding targeting MCH for nomadic communities in Ethiopia and Kenya	Policy/ program review	na	Project partners	Annual	Project partners	Anglicord	Annual	Program learning - AusAID and AACES NGOs
OUTPUTS for Objective 2									
Project learning and operational research disseminated to inform policy and program development	No. of program and research documents produced and disseminated No. of policy dialogue forums held	Project records	na	Project partners	Annual	Project partners	Anglicord	Annual	Program learning - AusAID and AACES NGOs
AACES Objective 3 Australian people are more informed about development issues in Africa									
PROJECT RESULT AREA: Awareness raised through greater Australian community engagement and public support on mother and child health challenges in nomadic communities of Ethiopia and Kenya									
Increased awareness of Australian public about Australia's contribution to tackling MCH challenges in nomadic communities	No. of target audience participating in or holding communications/ community engagement events Amount of funding or other support contributed to address MCH challenges in nomadic communities	Project records	na	Project partners	Annual	Project partners	Anglicord	Annual	Program learning - AusAID and AACES NGOs
OUTPUTS for Objective 3									
Project learning disseminated to raise awareness amongst target Australian audiences	No. and range of communication documents produced and disseminated to target audiences No. and range of communication events held	Project records	na	Project partners	Annual	Project partners	Anglicord	Annual	Program learning - AusAID and AACES NGOs

Endnotes

[i] Indicative indicators for monitoring of community-based activities and community knowledge, attitudes and behaviours will be finalised during the initial visit in 1st quarter.

[ii] Community Coordinators are NGO staff working with community-based workers.

[iii] Annual Learning Forums will involve Community Development Committees, Stakeholder Committees, local authorities and implementing partners (APDA, MUAK and Australian consortium partners). ALFs are timed to share M&E information amongst project stakeholders to inform consultations on planning for the following year.

The Community Development Committee is a representative community body (including men, women, youth, persons with disability, persons living with HIV and AIDS) that provides an entry point for community engagement, decision-making and ownership for the AACES project.

The Stakeholder Committee, to be established in each locality, consists of local authorities and government representatives. It aims to facilitate knowledge exchange to promote community empowerment and accountability of government and other duty bearers.

List of Acronyms

ANC	Ante-natal Care
ANGO	Australian Non-government Organisation
APDA	Afar Pastoralist Development Association
CDC	Community Development Committee
IMCI	Integrated Management of Childhood Illness
KAP	Knowledge Attitudes and Practices
MCH	Maternal and Child Health
MUAK	Mothers Union Anglican Church Kenya
NI	Nossal Institute for Global Health
PNC	Post-natal Care
PLWHA	Person living with HIV and AIDS
PWD	Persons with disability
SBA	Strengths-based Approach
SHC	Stakeholder Committee