REACHING THE MARGINALISED

SOUTH OMO *Pastoralist Health Development Project*

H. Unlim Big Loto EPaRDA

AUGUST 2010

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***SOUTH OMO** Pastoralist Health Development Project*

Highlights on Best Practices and Lessons

Edited by
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PREFACE:

Like in most developing nations, in Ethiopia there is a large discrepancy between access to healthcare and the overwhelming demand for the service.

This reality is compounded when it comes to communities that are marginalized; in this case the pastoralist communities. But these challenges also offer opportunities if support coupled with creative local leaders can fight back and rebuild communities.

This publication is about the Pastoralist Health Development Project that was implemented by Ethiopian Pastoralist Research and Development Association (EPaRDA) now renamed Enhancing Pastoralist Research and Development Alternatives (EPaRDA) and supported by Health Unlimited with financial support from The Big Lottery Fund (UK). It was designed to tackle some of the health problems in Hamer and Bena Tsemay woredas of the South Omo Zone. The project has been implemented over the last five years and introduced various innovative approaches that can serve as a good model for other areas too. The vast community engagement and ownership of interventions has shown how a little support can create the critical mass needed for remarkable change.

The success stories outlined in this publication summarize best practices and lessons of the South Omo Pastoralist Health Development Project (SO-PHDP). It outlines what the communities in Hamer and Bena-Tsemay woredas did with the project's support and what they have achieved by starting their own journey down the path of asset-based development, particularly with regards to community health.

This publication is hoped to provide helpful lessons and best practices for local community leaders, leaders of local associations and institutions, government officials, and NGOs and all development actors that wish to provide effective support to communities in need.

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ACRONYMS

MOH .....Ministry of Health

EPaRDA .....Ethiopian Pastoralist Research and Development Alternative

GOVERNMENT .....Government of Ehtiopia

HIS .....Health Insurance Scheme

BH .....Birthing Huts

TBA .....Traditional Birth Attendant

RDF .....Revolving Drug Fund

PHC .....Pastoralist Health Committees

WHC .....Wored Health Committess

FGM .....Female Genital Mutilation

EPI .....Expanded Program of Immunization

TTBA .....Trained Traditional Birth Attendants

PART ONE

BACKGROUND AND INTRODUCTION

SOUTH OMO PASTORALIST HEALTH DEVELOPMENT PROJECT (PHDP) PROFILE

The South Omo Pastoralist Health Development Project was started in April 2005 by Health Unlimited in partnership with a local non-governmental organization (NGO), the Ethiopian Pastoralist Research and Development Association (EPaRDA). The five year (2005-10) project attempted to address the basic health needs of the pastoralist communities of the Hamer and Bena Tsemay woredas in South Omo Zone, Southern Nation Nationalities and Peoples Regional State (SNNPRS) with funding sourced from The Big Lottery Fund (UK). The long term objective of this project was to improve the health of pastoralist communities in the target areas, particularly women and children. The short term and

specific objective of the project was to enable increased utilization of sustainable, integrated health services of improved quality. Part of the aim was for the delivery of these services to be increasingly influenced by the communities themselves.

THE PROJECT HAD THREE MAJOR OUTCOMES:

- Bringing about positive behavioral change with regards to health practices among beneficiaries, particularly heightening awareness of harmful traditional practices
- Improve Expanded Program of Immunization (EPI) coverage among children under-5 years old; improve EPI coverage among children under 5 years of age;
- Enhance reproductive health of women of childbearing age.

In addition, there were five crosscutting outcomes for the project. These were: capacity building; influencing opinion; networking and collaboration; gender and diversity; and participation. The project aimed at benefiting a total of more than 80,000 direct and indirect beneficiaries residing in the two target woredas. The direct beneficiaries consist of 40,000 children under the age of 15 and 20,000 women of childbearing age; also 40 health service providers; 55 traditional birth attendants; 50 community health attendants; 200 youth club members; 20 woreda and zonal health staff; eight EPaRDA staff; 265 health committee members. 20,000 pastoralist men in the two target woredas were considered as indirect beneficiaries even though this project was designed to target women and children.

STRATEGIES OF THE PROJECT

- Giving emphasis towards community ownership of the initiative
- Providing services to the communities
- Building the capacity of government staff, traditional birth attendants, youth club members, and health committee members in order for them to contribute to a significant and sustainable gains in the pastoralist health services.
- Emphasize prevention and awareness-creating approaches, although some capacity building of curative services was also included.
- Seeking to bring key stakeholders (local government, EPaRDA and communities) together into an effective implementation partnership.

SOCIO-ECONOMIC PROFILE OF THE PROJECT AREA

There are six ethnic groups in the target area. Based on the socio-economic survey conducted in September 2002[1], the Bena are primarily engaged in apiculture and farming. The Hamer, are cattle breeders and earn cash through the sale of milk and tourism. The Tsemay practice rain-fed farming and livestock rearing. The Arbore have close relations with the Tsemay. The Karo produce sorghum and find it difficult to keep cattle as they reside in tsetse-infested areas. The Braile




are a small group of only 82 households who are predominantly hunters and practice a small amount of apiculture. Overall the communities are predominantly poor and considered as critically food insecure. Women form 49.9% of the population, 50.5% are under 15 and 4.8% are under one.

Table 1: Beneficiaries covered by the project

WOREDA	MALE	FEMALE	TOTAL	MAIN ETHNIC GROUP
Hamer	21,129	21,235	42,364	Hamer, Karo, Arbore
Bena-Tsemay	20,000	19,729	39,729	Bena, Tsemay, Braile
Total	41,129	40,964	82,093	
South Omo Zone Total	230,788	227,303	458,091	

Source: Demographic and Socio-economic Profile-SNNPR, Jan. 2001. SNNPRS Plan and Economy Bureau, Awassa

Pastoralist communities were chosen as target groups because they suffer the most in lacking access to health services in the country. Although the health status of Ethiopia is poor, pastoralists experience particular problems that cannot be easily addressed unless there is an effective partnership between communities, NGOs and the Government. This includes the lack of participation of pastoralists in decision-making. SNNPR was the region chosen, after extensive consultation by Health Unlimited with numerous government and non-government stakeholders, because other pastoralist areas had relatively more development interventions. South Omo Zone was chosen after further consultation with the government at regional level.

The two woredas were then pre-selected by EPaRDA as it was already working on other interventions there, and were looking to incorporate a human health component into their existing program. Priority was given to women because of the inadequate facilities for safe delivery, abortion, lack of family planning, Female Genital Mutilation (FGM), heavy workloads, and violence towards women; children's vulnerability to disease; and to those living in the most remote areas of the woredas with least access to preventive and curative health services. Community health agents, such as traditional birth attendants, community health associations, youth club leaders, and health committee members were chosen by the communities, based on merit.

1. Socio Economy of pastoral communities in Bena Tsemay and Hamer woreda 2002; EPaRDA

PART TWO:

SO-PHDP ACTIVITIES, ACHIEVEMENTS AND SUCCESS STORIES

- Health Insurance Scheme
- Birthing Huts
- Birth Attendants
- Mobile Outreach Camp Service
- Immunization Campaign
- Revolving Drug Fund
- Health Information and Education
- Community Mobilization
- Capacity Building
- Research, Knowledge Transfer & Networking

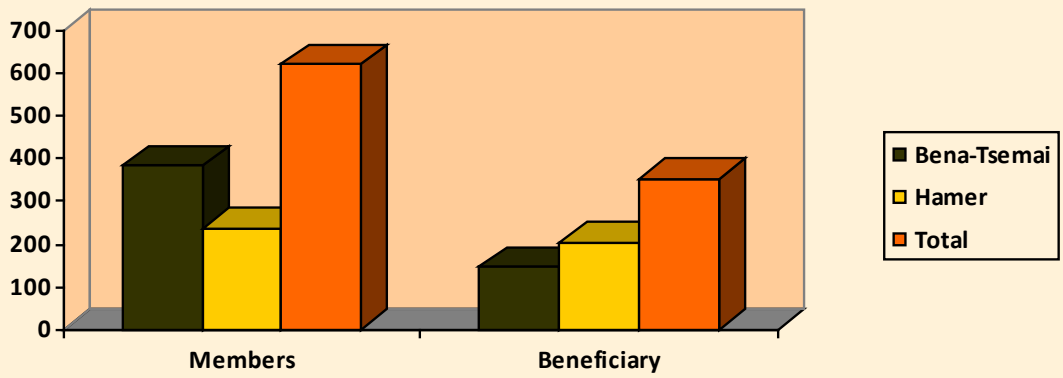
HEALTH INSURANCE SCHEMES

The high level of poverty is one of the causes that lead to limited access to health services in pastoralist communities. Very often pastoralists cannot afford the cost of transportation to health centers, fees required for medicines and modern health services. Therefore communities are forced to resort to traditional healers and witchcraft. Usually pastoralist communities have no access to cash - even for health emergencies. The pastoralists, who have a predominantly non-cash economy, frequently have to sell livestock to pay for medical treatment, which causes setbacks, as well as harms livelihoods.

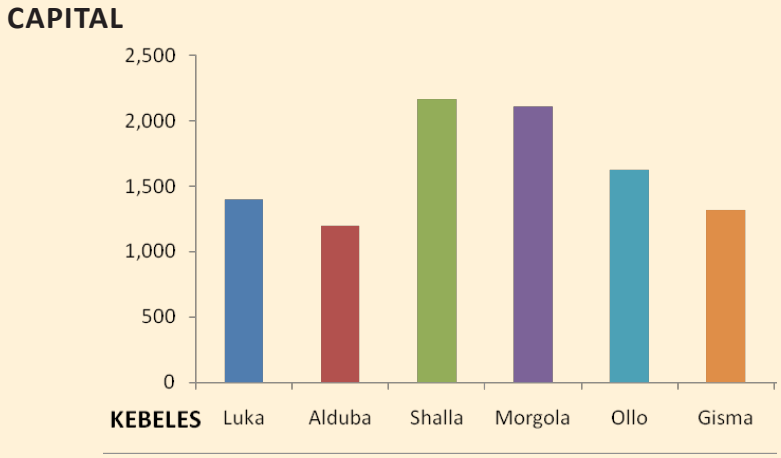
Due to the widespread poverty in the area health insurance schemes were seen as a way to ensure that even those community members with very limited incomes were able to receive medical treatment when they required it. These schemes, which have grown in popularity, operate with members paying money into a fund and receiving a payout when they require it for medical treatment.

In order to address the problem, EPaRDA introduced health insurance schemes in different kebeles of the two target woredas. After extensive consultation with community elders, 11 health insurance scheme groups were established to provide medical treatment, purchase medicine and provide transportation, as even people with minor curable diseases live with pain for a long time due to the problem. The total number of members of the schemes reached 619 with a total capital of 44,865 Ethiopian birr. The communities selected their leaders, formed by-laws and made them functional. Among the 11 health insurance schemes, six are in Bena–Tsemay, while the rest are located in Hamer Woreda. In terms of the impact in improving health access to the pastoralist community, 352 members of the community have benefited from the schemes. Out of that total, 148, around 42%, are female. Because of the widespread poverty in the area, the schemes were seen as a way to ensure that even those community members with very small incomes were able to receive medical treatment when they required it.

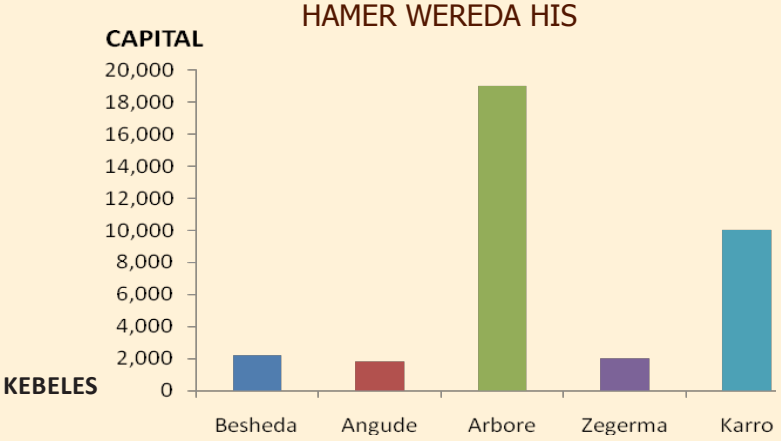
STATUS OF THE HEALTH INSURANCE SCHEME (HIS)



BENA TSEMAY WEREDA HIS



HAMER WEREDA HIS



The setting up of community groups for the pilot health insurance schemes was one of the most challenging tasks of the project because of the awareness level of the target communities and as the concept is new to the government health sector offices, the community and project staff. Once intensive communication and awareness creation was conducted with the communities through the project staff, the health committees and youth club members, followed by the community, formed the groups themselves with the help of project staff.

Various activities were undertaken to help promote and develop the health insurance schemes. To ensure the performance and sustainability of the health insurance schemes, 45 health professionals and cooperative staff were trained to support the schemes. Efforts were also made to facilitate experience sharing during the conference on microfinance that was held from 23-28 March 2008 in Assosa. This had the objectives of experience-sharing and forging partnerships with local and international stakeholders.

A GOLDEN CHANCE TO BRING MY SIGHT BACK

Yaye Gilo is an elderly woman of 70. She explains the medical treatment she obtained using EPaRDA's health insurance scheme loan.

"I took a loan from the Health Insurance Schemes and was able to get treatment for a persistent eye problem. While visiting the hospital, I could not walk without the help of people. Before the surgery, my eye was covered with darkness. I could not see without the help of another person. But today, I can see, I can distinguish whether your skin color is white or not. Losing one's sight is very bad, but now I am very happy. Previously, I was very worried, but since I got the loan I am very happy.

"I used to eat and excrete without moving from one place, but now I am able to go out and excrete. Because of this I am happy and I want to thank EPaRDA for that. You would have felt very sad if you had seen me when I could not see.

"I want EPaRDA to continue with its support for people who suffer similar eye problems".

Birthing Huts

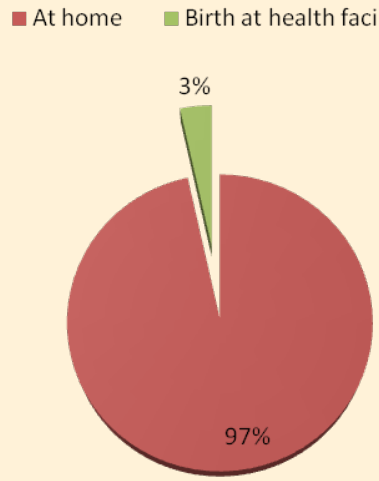
Health problems associated with child birth had been a persistent problem in the project area due to lack of medical facilities and harmful traditional practices. In the target communities, women even gave birth alone and outside in some of the cases. Health facilities are often located far away and cost money, making them inaccessible for the vast majority of people.

Women normally deliver their babies within their communities with the support of traditional birth attendants. Very few are trained and some of the procedures they undertake are hazardous to mothers and newborns. Although there are few positive traditional practices for childbirth such as mobility during labor and delivery positions, others undoubtedly put the mother and baby at risk. These include unclean cord cutting, application of drugs on the umbilicus and others. There is little or no data on maternal morbidity and mortality related to childbirth among the pastoralists. The traditional birth attendants have limited capacity to respond to complications.

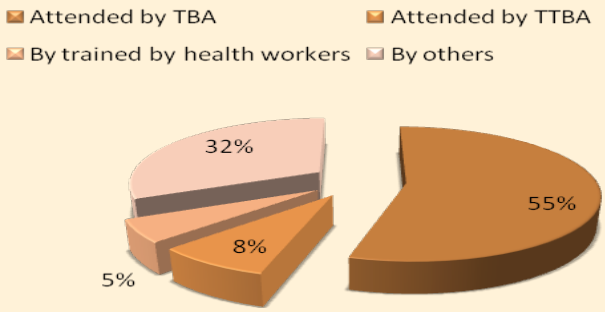
LOCATIONS OF CONSTRUCTED BIRTHING HUTS:

- Hamer Woreda -Arbore Health Center, Turmi Health Center, Dimeka Health Center and Karo Health Post
- Bena-Tsemay Woreda -Alduba Health Center, Key Afar Health Center and Luka Health Post
- Jinka Town -Jinka Zonal Hospital

DELIVERY BY LOCATION



BIRTH BY ATTENDANTS



This situation led EPaRDA to prioritize the construction of birthing huts in the project as well as training and providing equipment for traditional birth attendants.

The layout and design of birthing huts are intentional and take into consideration the unique lifestyles and cultural contexts of the pastoralist communities. Following extensive consultations with communities and the Government health sector office regarding the design of the huts and plan for the scheme, it was agreed the designs should be similar with the types of huts constructed locally. Experience-sharing visits to Gisma Missionary Clinic's maternal wards were organized for community representatives and women.

A major challenge in this intervention was securing permission from the Government health sector office who wanted standard cement and brick constructions rather than traditional huts. However, after explaining the purpose of the huts an agreement was reached. The huts received relatively quick acceptance by the communities than the structures built from cement.

By the end of the project, eight birthing huts were built, equipped and complemented by the training of traditional birth attendants to provide service to the community members. Since then, 319 women have benefited from the services of the birthing huts.

Alongside the construction of the birthing huts, extensive awareness-creation sessions about the importance of birthing huts and the role of health workers in supervising them were provided to 92 health workers from 48 kebeles at the annual zonal performance review meeting.
Most importantly, during implementation, great emphasis was given to raise the communities' awareness of birthing hut in public events and around the mobile outreach camps services that this project provides. In raising awareness of the purpose and importance of birthing huts, woreda health office staff, traditional birth attendants, community health associations and community elders played a crucial role.

SAVING MOTHERS AND CHILDREN

Tekekel Angaro is from Dimeka Kebele. This is her experience of changes to maternal health services.
"I used to visit the health attendant at the birthing hut before I gave birth to my first child to get access to pre-natal healthcare. However, I did not give birth to the child on time. The midwife at the birthing hut helped me get further medical attention and give birth to the child at Key Afer Hospital.
"I was given medical treatment when I was pregnant with my second child in the birthing hut as well. I delivered the child with the medical care of the people here.
"Before the building of this hut, our mothers could die while giving birth in the very remote rural area we live. But after the building of this birthing hut and the provision of training to the health attendants we have benefited a lot.
"Besides, we used to have to spend a lot of money and travel long distance in order to get medical attention in Jinka or Key Afer but the intervention of EPaRDA was a good solution for this."

BIRTH ATTENDANTS

To enhance the reproductive health status of women of child-bearing age, multi-faceted capacity building activities were undertaken with a focus on traditional birth attendants. A total of 55 (52 female and three male) traditional birth attendants have been trained. In total, training took 30-50 days with both theoretical and practical sessions. Training facilitators were from the government health sector office and the training was based on the Traditional Birth Attendants training manual of the government health sector office with an emphasis on project intervention. Other major areas were health education communication skills and HIV/AIDS prevention. Follow up and supervisory support sessions were provided to the attendants, project staff and government health sector office counterparts, and all Traditional Birth Attendants were supplied with safe delivery kits at least three times during the project period.

No	Beneficiaries	How do they benefited	Number of Beneficiaries		
			Male	Female	Total
1	Trained traditional birth attendants (TTBAs)	Training of new TBAs	3	52	55
		Supportive supervision for TBAs(periodically)	14	301	315
		Supplied with safe delivery kits	7	141	148
		Trained as PHC members, Participated in birthing huts experience sharing visit.	---	5	5
		TBA trained as health promoter		22	22
		TBAs trained on the use of birthing hut	3	66	69
		TBAs trained on health education	5	62	67
		Refresher training	4	126	130
Total			36	775	811

RECEIVING TRAINING FOR BETTER SERVICE

Gilo Wole is from Zeleketa kebele in Hamer Woreda. She expressed her satisfaction at being transformed from a traditional birth attendant into a semi-modern well-equipped birth attendant who has helped the successful delivery of many children thanks to the training and support provided by EPaRDA.

"I was provided training as a birth attendant. I also took sessions in personal hygiene and sanitation.

"After the course, I was able to train people to clear their surroundings, take care of their personal hygiene and sanitation, and dig a toilet.

"Besides, I was able to assist in child delivery and provide healthcare in relation to births with equipment provided by EPaRDA.

"In the past, a lot of mothers and children used to die during birth. But now, the rate has declined.

I provided child delivery health care service to six mothers in the first round and five in the second. I recently also provided child delivery health care service to four mothers.

"Since there are a lot of attendants in the area, it would be valuable to provide them with training and support".

MOBILE OUTREACH SERVICE

An inadequate and inappropriate health service delivery system is one of the main challenges for pastoralist health development. Only about half the population lives within the government target of being a maximum of a two hour walk from a health facility, and, even if they get there, the service and quality of care is poor. There is a serious lack of drugs, medical equipment and staff. In addition, the cost of treatment is prohibitive for pastoralists unless they first sell livestock, which would delay treatment. Facilities are also frequently not culturally familiar. Prior to the project intervention, there are no regular ongoing outreach programs on immunization, maternal child health services and health education because of limited mobility of heath teams, shortage of trained health staff, vaccines, etc. Though the polio eradication campaign has managed to reach remote populations according to government reports, the use of indigenous medicine often means that patients are delayed in arriving at health facilities.

Taking into consideration the mobile lifestyles and unique health development challenges of the communities, the Pastoral Health Development Project introduced mobile outreach camps service that move with the communities. Within the project, a mobile outreach camp service is a center that is used to provide outreach services in various integrated EPaRDA projects for the pastoralists at grassroots level. EPaRDA has introduced a mobile outreach service in 2002 as part of its Southern Ethiopia Pastoralist Project in the Hamer and Bena-Tsemay woredas in agreement with administrators. The camp shifts from one kebele of the woreda every three months.

Services delivered at camps include provision of Information, Education and Communication/ Behavioral Change Communication/ (IEC/BCC) on HIV/AIDS, family planning and communicable diseases, a mobile clinical service, and a training center.

The mobile outreach camp service was designed to become a base for a mobile health team of the health co-coordinator, health officer and nurse/midwife who were assigned to areas of the two woredas according to a schedule agreed with the woreda health committees and pastoral health committees. Besides, support staff, such as one cook, two guards and a driver, were included in the team. In general, one mobile outreach camp comprises an average of about seven to nine team members at a time.

The mobile health teams are working in each location with the birth attendants, community health attendants and the woreda health office staff. Health development is carefully coordinated with woreda health office outreach work and services focusing on promotion and prevention, which include:

- Maternal and children's health services. E.g. EPI, ante-natal care, diarrhea management
- Health education carried out with TABs, PCHAs, and youth club members

As part of the integrated team in the camps, the health team organized and hosted community-based services such as outreach immunization and family planning activities in and around the mobile outreach camp sites during the project period by coordinating activities with the respective woreda health offices. Health education on different topics was also given for several pastoralists by using TV and cassettes at the camp.

Essential drugs are purchased during the project period to strengthen the mobile outreach camp service. As a result, a total of 1,108 pastoralists benefited from curative clinic service in camps. For instance, during the last quarter of the project, camp officers provided curative clinic treatment in Karo Dus and Shaba kebeles for 411 pastoralists; 235 of whom were females. Many children benefited from this service due to the provision of pediatric suspensions and syrups.

Beneficiaries and type of diseases in the project last quarter

S.No	Prevalent diseases	Male	Female	Total
1	AFI	37	68	105
2	IP	27	53	80
3	URTI	21	44	65
4	Gastritis	9	27	65
5	UTI	9	21	30
6	GE	4	23	27
7	Arthritis	7	18	25
8	Skin infections	12	11	23
9	Accidental injuries	17	3	20
	Total	143	268	411

Immunization Campaign

In the project area, children and mothers are affected by some diseases due to a lack of immunization. The two main reasons for the low immunization coverage are limited facilities as well as the negative attitude of the community due to a low level of awareness.

The baseline survey undertaken at the outset of the Pastoral Health Development Project revealed important facts regarding immunization in the area. For example, out of the 376 children, only 42.2% have vaccination cards. For boys it is 45.7%, while for girls it is 39.7%. Details on types of vaccination show BCG was given to 7.9%, DPT to 31.1%, polio to 34.9% and measles to 24.0%. Besides, 35.6% of women reported the use of complete immunization of children. On the other hand, the profile of the mother when they gave birth to their last child shows that only 17.7 % of 367 mothers were vaccinated against TT.

The survey showed there are negative attitudes towards immunization. Beliefs include that children can be deformed and growth retarded if vaccinated and women may become sterile. In response to the low immunization coverage, EPaRDA has undertaken various activities to improve coverage in the area within the framework of the Pastoral Health Development Project.
The major activities undertaken were:

- The purchase and supply of 10 motorcycles to the health offices and posts in Hamer and Bena-Tsemay woredas for EPI purposes. Users of motorbikes were provided with training in management and maintenance of motorcycles which seemed to enhance the effectiveness and sustainability of the health services provided.
- Owing to the interrelated nature of the health challenges of the population, technical and vehicle support was provided for the meningitis, tetanus and polio campaigns undertaken. This had the effect of enhancing the awareness and interest of the community regarding immunization.

- As mentioned in reference to the human health component, immunization also has been included among the services provided by mobile outreach camps services.
- Training and education related to the importance of immunization was provided to the community through mobile outreach camps, traditional birth attendants, youth club members, and health committees in their local areas.

In line with and as a result of the multifaceted activities undertaken to improve coverage, EPaRDA immunized and vaccinated 21,252 individuals. This shows a remarkable improvement in coverage in the area compared to the beginning of the project. It is believed to have improved the health of the community even if concrete evidence is not available on how much. In detail, 11,471 children (5,632 male and 5,837 female) under one were provided with BCG, Pental 1,2,3 and measles vaccinations during the five years. 9,293 women of child bearing age were provided with TT1, TT 2, TT 3, TT 4, and TT 5 vaccinations. As a component of this service, growth monitoring service was provided to 488 children of less than three years.

Immunization service provided by EPaRDA

Beneficiary Categories	Type of Immunization	Male	Female	Total
Children under one	BCG	1394	1433	2827
	Penta1	1018	1157	2175
	Penta2	871	807	1678
	Penta3	1243	1354	2599
	Measles	1106	1086	2192
Total no. of children		5632	5837	11471
Children under three years of age	Growth monitoring	188	300	488
Women of child bearing age (15-49)	TT1	0	2775	2775
	TT2	0	2031	2031
	TT3	0	1673	1673
	TT4	0	1420	1420
	TT5	0	1394	1394
Total Immunization Service		5820	15430	21252

Revolving Drug Fund (RDF)

One of the health challenges of pastoralist communities is the availability and affordability of much-needed drugs. Under the Pastoral Health Development Project, EPaRDA created a Revolving Drug Fund system to provide crucial pharmaceuticals. The intention was to provide a fund in order to boost the availability of drugs in remote areas. Challenges faced were a low level of awareness of the community and other stakeholders as to the meaning and

utilization of the Revolving Drug Fund system.

Intensive awareness-raising efforts at community and health facility level, and training of government health staff on revolving drug fund systems for managing the scheme were jointly created with the government health sector office based on its prior experience of handling a similar process at Jinka Hospital. Accordingly, the revolving drug fund scheme was established in two health centers in the two woredas and provided drugs and medical

equipment. In general, 146,000 birr worth of drugs for Turmi Health Center and 120,000 birr of drugs for Key-Afer Health Center were provided. EPaRDA also assisted the woreda health office in setting-up a monitoring system.

To ensure effective utilization of the revolving drug fund, training was offered to service providers and the community. In addition, an experience-sharing visit was made by Key-Afer Health Center pharmacists to Turmi Health Center. Various activities to raise awareness of the fund in communities were implemented through mobile outreach camps, traditional birth attendants, youth club members, and health committees in their local areas.

In terms of implementation, both health centers separated the prescription of revolving drug fund drugs from budget drugs' prescription. In the last quarter the project implementation period, 480 individuals (295 female) benefited.

BETTER ACCESS TO MEDICINES

Guyane Tadesse is the head of Turmi health center pharmacy and she has been working there for four years. She compares the status of the pharmacy before and after the RDF programme.

She states: "Before the RDF programme by EPaRDA many clients were referred to other health facilities to get essential drugs which were not available in health centers. After RDF programme was started essential drugs, laboratory reagents and medical equipment were purchased. Then the health center dispensary system was improved satisfactorily.

"So far 14,500 patients especially from pastoralist associations have benefited from the programme and 85,000 birr has been deposited in the health centers within 8 months.

"The main reason for the success of our dispensary doesn't indicate our strength alone but it is the realization of EPaRDA's continued endless support from purchasing essential drugs up to technical supportive supervision".

Health Information and Education

Lack of awareness of causes of disease and how to prevent them, compounded by harmful traditional practices, contributes to the health challenges of the target communities. In particular, the low awareness of major diseases puts the population in the project area at risk. Some of the traditional practices that accelerate the spread of HIV/AIDS are married men having multiple sexual partners; the practice of circumcision of many men and women during mutual ceremonies using the same cutting tools; widows before remarrying are allowed to have multiple sexual partners; and scarification.

The baseline survey undertaken in the area provided tangible evidence as to the actual existence of the above challenges.

Here are some of the findings:

- 24% of the adult men know how to use condom correctly
- 16.3% discuss openly the negative effect of FGM
- 20.5% discuss openly the negative effect of abortion 61.4% of the mothers circumcised their female children
- 23.8% identified two or more ways of DD transmission
- 20.1% identified two or more ways of malaria transmission
- 23% identified two or more ways of malaria prevention
- 4.9% identified two or more ways of RTI transmission
- 11.4% reported sickness in the family in the last two weeks. Among them 17.6% had visited a health facility.
- 39.5% of the household have bed nets (ITNs)in the project area. Of these, 36.7% of households reported the regular use of the nets(ITNs)
- Among children under 5 who reported as sick from diarrhea in the last two weeks, 25.2% got ORT
- 25.2% of the women and 52.6% of all the female respondents wash under the waist

The figures clearly show the importance of raising awareness of the community in the two project areas. The Pastoral Health Development Project has set out a lot of activities that seem to bear fruit with respect to tackling the low level of awareness of the pastoralist community. EPaRDA introduced tailor-made health and communication activities in the project area.

MOBILE HAMER BENA TSEMAI WOREDA

Sela Tamese from Arbore Kebele of Hamer Woreda has this to say: "I am a mother of six. I have given birth to children in birthing huts. One of them died at birth and the other is here with me. He is called Hussein. I guess he is around two years old. I was in labor for four days while receiving treatment from traditional healers. On the fifth day, the traditional healer brought me here since my situation was beyond her control. I finally gave birth here following serious care given to me by the medical staff here. I was also given follow-up treatment after giving birth"

IN COOPERATION WITH GOVERNMENT

Habtamu Lulawi is Hamer woreda's health bureau administrator and talks about the working relationship with EPaRDA:

"The government is doing a lot of work in regards to the provision of health care services in this regard other non-governmental agencies are working to help in meeting gaps in this health sector. EPARDA is one the few that has been working in our woreda trying to fill gaps in health care provision.
"It also works in immunisation programs, training traditional attendants, capacity building and training, setting up youth clubs to create awareness in HIV/AIDS. It has also brought about a revolving grant that allows the communities to purchase medicines. It also works in sanitation, setting up health associations, child and maternal health, the construction of birthing huts, malaria prevention and host of other health interventions.
"The changes are significant, pastoralist s are now going to prenatal checking, the training of traditional birth attendants are well equipped and can have the facilities, they also know how to maintain the equipment, people are now more and more aware of prevention of communicable diseases as well as person and environmental cleanliness".

KAPB survey

A baseline Knowledge, Attitude, Practice and Behaviour (KAPB) survey was undertaken. The survey, in addition to measuring the status of indicators before the project interventions, enabled EPaRDA to further understand the health and traditional practices situation in the communities. The survey findings informed the project management of the best, most appropriate means of communicating health messages in the context of the target communities. Accordingly, the uses of existing social institutions, such as markets and traditional events have been recommended as favorable times for dissemination of health messages. Verbal and pictorial communications including plays, songs and dramas have been suggested as suitable mediums.

Information, Education and Communication (IEC) Materials

Culturally appropriate IEC materials were developed based on the inputs from the baseline. With the aid of these materials the project has reached most of the communities with basic health education programs, including the prevention of communicable disease such as malaria, TB, HIV/AIDS and other sexually transmitted infections; prevention of childhood diseases through immunization; educating on harmful traditional beliefs and practices, and the importance of family planning and the use of contraceptives.

Health Education

A total of 57,305 (31,476 male and 25,829 female) community members have been reached through health education messages that cover water, hygiene and sanitation; nutrition of children and mothers; prevention of malaria, diarrhea and HIV/AIDS; the importance of child and maternal immunization and other relevant issues.

The approach included health education in the mobile outreach camps aided by audio and video records as well as on site health education through outreach to remote communities by youth club members, birth attendants and health committees. The health education made a significant contribution in raising the awareness of the community towards different diseases, as well as on avoiding harmful traditional practices.

Tangible achievements and impacts were registered by the end of the project period as a result of these activities. Some of these were:

- At least 75% of men and women report three or more ways of spreading HIV/AIDS and preventing HIV/AIDS
- At least 75% of men reported knowledge of correct condom use
- Taboo issues such as female genital mutilation and abortion are openly discussed in the communities
- Reported practice of female genital mutilation decreased by the end of the project
- Increased awareness of the causes and means of prevention of diarrhea among adult pastoralists
- The level of knowledge of target communities on the means of prevention of malaria was found to be at 85%
- Increased awareness of the causes and means of prevention of RTI among adult pastoralists
- Better communities participation in keeping their village environments clean, particularly near water sources
- Increased number of women and children using government health services. This has been noted from the increasing number of community members visiting health facilities.
- Increased use of mosquito nets by women, children and men (this assumes that the nets are available through government programs). The proportion of households possessing nets improved to 55.4%
- Households who reported nets to be used by women and children rose from 36.7% at the baseline to 45.1% in the same study.
- Increased number of women who treat their children suffering from diarrhea with Oral Re-hydration Solution (ORS). Information from health facilities indicates the consumption of ORS sachets in health facilities is on the increase.
- Increased demand for condoms in the area. Although no concrete data, information from the woreda health offices and the zone health office indicate demand for condoms has increased.
- Increased number of women who wash below the waist. Women groups have affirmed that there is change on this, with more women considering this aspect of personal hygiene as essential.

Community Mobilization

The pastoralists have their own traditional decision-making structures that do not fit well with the government hierarchy. For the Government, each woreda is divided into pastoral associations (PAs) – also called kebeles – of which there are 24 in Hamer and 25 in Bena–Tsemay. These formal structures have to be used to implement government programs. However, the pastoralists also have their own system of informal social institutions that enable people to deal with crises. This system is based around kinship (which provides a social and economic safety net) work party (for pooling labor for agriculture) and leadership divided by gender. The consequence of this and a centralized Government structure is that pastoralists have had little or no say in the way that health services are delivered to them. To fill the gap, the Pastoral Health Development Project organized and trained health committees and clubs constituting the various groups of pastoralist community members and different stakeholders.

Pastoralist Health Committees

EPaRDA established 370 pastoralist health committees and provided training to its members. The formation of these committees enabled the project to have a reach and presence for all of the pastoral associations of the two woredas very quickly. Monitoring and supervision visits to have been undertaken by the project staff in order to encourage the committee members to deliver their responsibilities. During the project period, much time was spent on the formation and follow-up support to the pastoralist health committees. Experience-sharing visits were also organized and undertaken to strengthen pastoralist health committees.

Woreda Health Committees

Hamer and Bena-Tsemay Woreda Health Committees were established and training was

provided to members.

The members of the committee are the woreda administration and health office, women's and children's affairs, youth and sports affairs, capacity building office, finance and planning and education office and project staff.

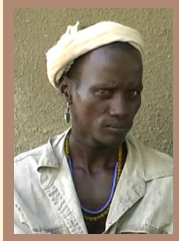
The purpose of establishing and strengthening the committees is to provide practical community advice and feedback to the Pastoralist Health Development Project managers on its direction, priorities and activities.
The woreda health committee is responsible for developing and reviewing the intervention mechanisms and priorities necessary to ensure the achievement of the project objectives through community mobilization and participation.

It also has the mandate for following up the project's overall physical and financial performance and providing support in areas of need to enhance the quality of the implementation process. Following the establishment of the health Committees, the training of members was carried out.

A supervisory link was also established between the woreda and the pastoralist health committees whereby the woreda health committees provided support to the pastoralist associations.

The two committees held a quarterly committee meeting. The committees had been active in communicating public views to the management of the project, as well as members giving community health education on basic issues.

Members were very instrumental in mobilizing communities for various project activities including the formation of community groups for the health insurance scheme, as well as immunization outreach activities.



COMMUNITY OWNERSHIP

Sika Salla is Kebele Justice and Peace Council Official. He is also a member of a community peace committee. He testifies to the work done by the elders and youth committees organized by EPaRDA aimed at overcoming health problems.

"We were organized under health committees by EPaRDA. While working with health professionals, we penalize, by using indigenous traditional culture or through kebele administrative structures, people the woreda health office fail to bring their children for vaccination, as well as those woreda health office discourage others from taking advantage of EPaRDA's health intervention activities.

"We were provided training on the importance of vaccination, health care, food, hygiene and sanitation, and child care and protection.

"The youth were on one side and we, the elders, on the other side transmitting the knowledge we acquired in these areas to the community. A lot of changes have been seen in the life of community.

"I want to request EPaRDA to provide us with additional training, as well as organize committees that provide health education and training to communities in other areas".

Youth Clubs

63 new youth club were formed and trained in various kebeles and villages of the two woredas. So far they have 393 members. Refresher training has been provided more than two times for most of the clubs. 16 tape recorders were given to 16 active youth clubs. Additionally, supportive supervision and encouragement was regularly administered to all members of the youth clubs.

The aim of establishing the clubs was primarily to promote health education at the grassroots level. The activities of the clubs included health education, and the production of drama, dance and songs containing vital health messages.

ENGAGING THE YOUTH

Kure Bata is a youth club member from Luka Kebele of Bena-Tsemay Woreda. She is married and a mother of one child. She elaborates on the different healthcare services she provided to various sections of the pastoralist community as a member of a youth club.

"First, I took training regarding personal hygiene and sanitation as well as the clearing of surrounding. As a result, I am now providing advice and training for the community to dig and use personal toilets in their backyards.

"However, we also provided adequate training regarding prevention of the transmission of HIV/AIDS. Before I got married, I used to go the cultural Evangadi dancing ceremony and train/advise them to be limited to one sexual partner, not to share razor or other sharp objects, and also inform them about prevention methods for the transmission of HIV/AIDS.

"After I get married, since it is forbidden to attend Evangadi, I provide training and advice to mothers and youth while they are holding their morning coffee ceremony.

"After we give training, most of the community members agreed to take a test for HIV/AIDS."

Capacity Building

Capacity building is identified by the project as a cross-cutting intervention that would substantially contribute to the improved health of the pastoralist community by enhancing the health service delivery system and awareness of the community.

It has been confirmed with research that the lack of capacity among the community and lack of health providing facilities and professionals have contributed to the low-level health status of the community. Therefore, capacity building activities have been undertaken through this project for the last five years targeting the community, government offices, and EPaRDA staff, as well as among different committees established to assist health

promotion and development.

The capacity building activities constitute material, financial and technical support, as well as training in different areas. Since capacity building is a cross-cutting concern of EPaRDA, it has been included in every activity of the project.

In this regard, in order to fill the gap in the low number of health promoters found in the area, promoters were given training. Health extension workers carried out the training in all kebeles based on the government's training manual. A total of 232 health promoters were trained for one week and 40 health extension workers were involved in the exercise. The project coordinator and officers played a major role in organizing, supervising and following up the training.

By contracting a private consulting firm to do an Organisational Development and management-training needs assessment of EPaRDA staff the major training needs were identified. Afterwards, Organisational Development and management in-house capacity building training was provided for 17 EPaRDA staff. It focused on team-building exercises and team-playing skills, staff performance appraisal, managing change, and monitoring and evaluation.

A management-training needs assessment was undertaken by a team composed of project staff and representatives of the zone health department to provide training for health workers. Subsequently, training was given to 30 health extension workers on supportive supervision.

Community health agents were selected and training was provided. 237 Health Professionals were trained and refresher training was also provided to them. 27 health extension workers attended training of trainers on health promotion.

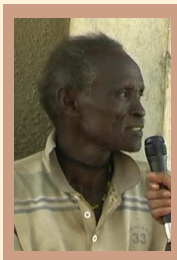
Training of Trainers in health education was provided for all government health sector office and community service providers in the two woredas. Capacity building activities of traditional healers and traditional medicines were also undertaken. While 24 traditional healers trained as health promoters, another 30 traditional healers trained on health education.

The summary of trainings and capacity building activities are presented in the table below.

Primary group/ Beneficiaries	Capacity Building Activity	Number of Beneficiaries		
		Male	Female	Total
Trained traditional birth attendants (TTBAs)	Training of new TBAs	3	52	55
	Supportive supervision for TBAs(periodically)	14	301	315
	Supplied with safe delivery kits	7	141	148
	Trained as PHC members, Participated in birthing huts experience sharing visit.	---	5	5
	TBA trained as health promoter		22	22
	TBAs trained on the use of birthing hut	3	66	69
	TBAs trained on health education	5	62	67
	Refresher training	4	126	130
	Total	36	775	811
Youth club members	Training of new youth club members	253	140	393
	Supervision for trained youth club members	789	333	1122
	Trained as peer facilitators, provide with supportive supervision and awareness on RDF, Birthing hut, HIS and prevention and control of communicable disease	---	---	134
	Refresher training	225	151	376

	Total	1267	624	2025
Pastoralist health committee (PHC) members	Training of new PHCs	245	125	370
	Supervision and follow up	705	311	1016
	Refresher training	214	148	362
	Total	1164	584	1748
WHC members	Training as committee members on the committee's TOR, on Health education skills on RDF, HIS, Birthing huts and prevention and control of communicable diseases and awareness on basic RH issues.	56	16	72
Patients at government health facilities	Benefited from the periodic consultation by the project staff; transportation support to referral facilities when in life threatening situations, two women benefited from a financial loan from health insurance scheme organized by the project	24	17	41

Traditional healers	Trained as promoters	19	5	24
	Trained in health education	20	10	30
	Supervision and follow up	87	26	113
	Total	126	41	167
Government administration officials and health service providers	TOT training of health promoters for health extension workers	3	24	27
	Orientation of RDF, QOC and birthing huts	116	31	147
	Training on the support of HIS	24	21	45
	Motorbike riding and maintenance training	6	2	8
	Stake holders planning workshop	43	3	46
	Birthing huts workshop	44	68	112
	Total	488	231	719
Health promoters	Training given for new health promoters			232
Pastoralist community	Health education on different topics	31476	25829	57305
	Received services from HIS	236	123	359
	Received services from RDF	6225	7120	13345
	Received services from birthing hut	0	319	319
	Total	37937	33391	71328
EPaRDA project staff	In house capacity building	13	4	17



ELDER'S ENDORSEMENT

Arklo Wotero is an elder from of Arbore Kebele, Hamer Woreda. He witnesses the role and contribution of EPaRDA's health development project in the woreda.

"As an elder, I want to thank EPaRDA on behalf of the community owing to the multifaceted support provided to the community by EPaRDA, particularly through training and financial support provided to the youth, and the support provided to women during child birth by trained traditional health attendants. I am happy because of the support provided to us by EPaRDA.

"Everybody knows our previous situation. The advent of EPaRDA's health-related training and financial support is change in itself. The message I want to transmit is the health station that used to be located here is transferred and stationed in Arbore Woreda. It used to save a lot of lives because of its proximity and reduces expenses that are spent on transportation and beds for patients. Therefore, I want to request EPaRDA to build a similar health station for the community".

Research, Knowledge Transfer and Networking

EPaRDA through the Pastoral Health Development Project carried out activities that would enable the transfer of best practices, while promoting the creation of partnership and networks between and among different stakeholders working towards health development of pastoralist communities.

The effective dissemination of lessons learnt to influence policy and practice at local, national and international levels has been the main focus and target of the project research-, knowledge transfer- and networking-related activities.

An introductory project briefing workshop for all stakeholders was held in Jinka in which the project activities and objectives were elaborated. Initially, baseline surveys were designed and executed to set realistic and tangible expectations and targets for the implementation of the project, as well as to provide concrete parameters for further monitoring and evaluation work. Subsequently, a project monitoring system was established to undertake proper supervision and support to ensure the sustainability and effectiveness of the project.

In the course of the implementation of the project, a mid-term evaluation was carried out from June 3 through June 14, 2007 by a review team composed of different stakeholders. Dissemination workshops at national level were conducted during which papers published in national and international journals were shared. The task of participating in national and international forums to share lessons learnt was partially accomplished by sharing lessons learnt from the meeting conducted in Assosa.

For effective communication and information dissemination, audio-visual documentation of the project was developed and major events recorded. With respect to research that has the twin purposes of serving as the critical input for project activities and instruments for the transfer of knowledge, a lot of research was carried out by the project.

With the purpose of identifying culturally acceptable means of preventing malaria in the target communities, as well as finding resources for a potential project aiming at malaria prevention and treatment, an in-depth study on existing traditional practices and traditional medicine against this deadly disease was done.

Similarly, an in-depth study on traditional practices and traditional medicines were undertaken in which case comments were given to the consultants for finalization and refinement.

YOUTH AS DRIVERS OF CHANGE

Duba Sika is from Arbore Kebele of Hamer Woreda. She is a member of a youth club organized by EPaRDA to provide various types of health-related training and education to the community in the area.

"My role is to provide training regarding the importance of vaccination and healthcare to the youth with health officials after I received training from EPaRDA.

"We provide training and advice for the community to dig and use latrines in their own backyards, clear their surroundings as well as distribute posters that educate about HIV/AIDS.

"Among the changes that we as a community have brought about include discouraging the use of river or any dirty water that exposes communities to various diseases, especially diarrhea. Therefore, we provide training to pastoralist youth as to the causes of diarrhea. We also provided training regarding the transmission of malaria, especially in relation to mosquito bites, as well as on the proper vaccination of children.

"The message I want to transmit now is that previously we used to leave food open after eating; sometimes even it is left open for the woreda health office night. In addition, people would drink milk and water without boiling it. But EPaRDA taught us not to leave food open after eating as well as to drink both milk and water after boiling, since these practices protect us from different diseases. Through the training provided to us by EPaRDA, we are able to take care of ourselves and transmit this knowledge to the community.

As a result of this, the number of people that used to be infected by tuberculosis has declined after we took training from EPaRDA and started to educate people.

"I want EPaRDA to continue working with us and provide additional training".

PART THREE:
THE WAY FORWARD

To suggest that better provision of medical services and medicines alone can offer solutions to the problems of community health issues is to ignore a whole range of social and economic factors which can affect health care problems in the South Omo Zone.

The experience of the project indicates that there is a need to come up with a holistic package when it comes to bringing about quality health care services to the marginalized by responding to the specific needs of the communities involved and promoting, accordingly, knowledge, skills and attitudes.

Local authorities can respond to the health care needs of the population by providing opportunities for residents to be involved in decision-making by promoting a broad range of community facilities, by giving higher priority to women and children by investing in infrastructures and strengthening communities' capacities.

REACHING THE MARGINALISED

SOUTH OMO *Pastoralist Health Development Project*

HEALTH UNLIMITED
Addis Ababa Ethiopia