

THE CHAMPION COMMUNITY INITIATIVE

ORIGINS, PRINCIPLES AND POTENTIAL





Academy for Educational Development

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By definition, the success of any Champion Community Initiative depends on community members themselves: mothers and fathers and grandparents, children and young adults, health providers, extension workers, and school teachers. Local leaders and local institutions—from schools to health clinics to religious groups to nongovernmental organizations of various types—are also central to every achievement. Our profound thanks first to these countless individuals and groups for their dedication, their energy, and their influence upon these different "champion" models. Special thanks also go to Awa, a tireless midwife from Dori, Burkina Faso, and Rova, an enthusiastic community animator in Antsirabe, Madagascar. Awa and Rova provided the inspiration behind the Champion Community model. Peter Gottert, Academy for Educational Development, designed the first Champion Community model under the BASICS Project in Madagascar and has been involved in many iterations since, including the youth programs in Ethiopia, Madagascar, and Jordan. In addition, the following people deserve special mention for their contributions to the models mentioned in these pages:

MADAGASCAR

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CHAPTER 1: INTRODUCTION

STARTING WITH THE COMMUNITY

In the last decades of the 20th century, public health throughout most of the developing world was a federal responsibility—highly centralized, like revenue collection or defense. Supplying vaccines to a nation’s children, or fighting deaths due to pneumonia or diarrheal disease or malnutrition, were battles planned at the top and orchestrated down to the village. Central decision making, central planning, and central funding were the norms.

Over the last five to ten years, one of the major goals of health reform efforts has been to shift some of the power as well as many of the *burdens* of planning and organizing and financing health interventions onto districts and local communities themselves.

Decentralization... local empowerment and ownership... bottom-up planning... participatory decision making... These are just a few of the buzz phrases of public health in the 21st century. The underlying principle is a very democratic one: As much as possible, decisions should be made as close as possible to the level of those who will actually be affected by them.

At the same time, this shift has given rise to an array of perplexing questions. Protecting the public’s health is about



Protecting the public's health is about understanding epidemics, about quality drugs, about effective technologies, and about balancing costs. How do communities know how to prioritize health problems? How do districts know how to motivate the involvement of myriad communities in these issues?

understanding epidemics, about quality drugs, about effective technologies, and about balancing costs. How do *communities* know how to prioritize health problems? How do districts know how to motivate the involvement of myriad communities in these issues? And can assistance in launching truly participatory approaches be supplied at the scale required to achieve health impact?

The following pages are the story of one attempt to address these questions. It grew from an idea piloted in Madagascar in the mid-1990s into a systematic approach applied in various countries to diverse health, environment, and education challenges. Originally known by the name *Champion Communities*, the approach was quickly adapted for varied contexts and under various names.

This document tells the first chapters of the story—the basic principles and the early successes and lessons of the *Champion Communities* Initiative, as the concept was originally conceived and developed by the Academy for Educational Development (AED), and as it has evolved and expanded through the interest and ingenuity of many committed partners.



CHAPTER 2

THE INSPIRATION

The inspiration behind *Champion Communities* was simple. As the name implies, it was a competition. Like all competitions, it was designed to push contestants to perform at their peak. Like most competitions—or contests—it was structured around entrance criteria, well-defined goals, and a clear time period in which those goals were to be met. Not all competitions are successful. This one clearly had those features. It created a high level of energy among entrants and the general public. There were many winners and they were feted in both local celebrations and in the media. The champions achieved new status in the eyes of those they cared about.

The unusual aspect of this championship was its focus—the survival of children in some of Africa’s poorest communities.

NOT YOUR USUAL CONTEST

Rewarding communities for taking care of their children—and organizing activities to promote their health— may sound unnecessary or even frivolous. It might seem an unlikely, even bizarre context for awarding some kind of “certification.” But the idea for *Champion Communities* grew naturally out of an array of activities—beginning around 10 years ago—that mobilized families and villages in Madagascar to believe they could make a difference in several critical health problems.



Between 1995 and 1999 the U.S. Agency for International Development supported its first multi-year program to improve child survival in Madagascar. The BASICS project¹ (a partnership of international non-governmental organizations including AED) launched a number of ambitious strategies. It supported the Ministry of Health in one the first attempts to introduce the Integrated Management of the Sick Child Initiative (IMCI) in a Francophone country. IMCI is a health center-based approach that ensures health workers assess any sick child in a holistic and comprehensive fashion.

But a facility-based strategy can only reach so many children, and can have only very a limited effect on *family practices* that are critical to both prevention of illness and appropriate care-seeking. This “gap” remains one of the conundrums of IMCI in many countries. In Madagascar, where only about 60 percent of the population live within five km (or about one hour’s walk) from a public health facility, other strategies are crucial for reaching families on a large scale.

When *BASICS* was launched, the decentralization of health services was just beginning. The first of about 111 district management teams were introduced around 1995. But “bottom up” strategies were being organized on a small scale by a few nongovernmental organizations.

¹ BASICS I (1993-1999) was funded by the United States Agency for International Development (USAID) and managed by the Partnership for Child Health, a joint venture of the Academy for Educational Development, Management Sciences for Health, and John Snow Inc.

MADAGASCAR’S CHALLENGES

Madagascar is an island nation of unique environmental features, rich natural resources, and stunning beauty. However, it is one of the poorest countries in Africa. When the BASICS Project began work there around 1996, the per capita GDP was \$198 and the average family spent more than 70 percent of its annual income on food. Only 13 percent of the population lived with 15 minutes of a potable water source. Only 33 percent of adult men and 30 percent of women finished primary school. Poverty, lack of education, and poor access to health services were all reflected in the nation’s critical health indicators:

- Nearly one third of the population had a life expectancy below 40 years
- Infant mortality was 96 per 1000 live births
- Maternal mortality was 159 per 100,000 live births
- 47 percent of births were attended by a skilled attendant
- 34 percent of births took place in a facility
- 48 percent of children under three were stunted
- 36 percent of children under two were completely immunized

A high fertility rate of 5.7 also put extraordinary burdens on families, as well as on government services.

Sources: DHS 1997 and Madagascar: Interim Poverty Reduction Strategy, 2000

NEW SYSTEMS, NEW ENERGY

AED’s role under BASICS was to help build a new framework for community involvement and outreach. The first task was to simplify and harmonize the literally dozens of health messages being promoted by the Ministry and various donors. AED worked with the Ministry to create a national task force to identify priority behaviors, messages, and “audiences” across ten health, nutrition, and family planning programs.

The clarity of focus on key family behaviors, or “small, doable actions,”² provided the foundation for a six-pronged strategy to mobilize communities. (See box.) The central task was to energize a diverse force of community-level volunteers, providing them with training in counseling and village theater. Innovative communication tools reinforced their efforts. A system of flags was developed to inform communities about when the vaccination team was expected. Families received diplomas for any child who was fully immunized by one year of age. They also received illustrated Family Health Records to remind them about important health measures for a child at different ages and to help track a child’s progress and any illnesses. Radio spots supporting each intervention assured the required “reach” of priority messages.

AED also developed communication “kits” with scenarios for village theater, cassettes of radio spots, and core print materials on seven different health themes. Thirty different organizations used these to expand the reach of the program beyond the project’s own implementation area.

From the start, the project aimed to foster a spirit of celebration and accomplishment in communities.

² Focusing on a limited number of feasible and locally appropriate health practices is a fundamental strategy of any effective behavior change strategy. The phrase “small doable actions” first came into use at AED under the USAID-funded Nutrition Communication Project, managed by AED from 1987 to 1995.

SIX PRINCIPLES OF COMMUNITY MOBILIZATION

Six basic principles drove the design of community-based activities in Madagascar.

PRINCIPLE 1: Agree on a small number of action-based messages. Each message should be based on a small, doable action—an easy-to-understand health behavior that is feasible for poor families. Qualitative research first illuminates motivational factors and obstacles that must be addressed. Messages must be carefully pretested with the target group.

PRINCIPLE 2: Develop easy-to-use front-line teaching tools. The initial “building block” in Madagascar was a set of counseling cards for health workers and volunteers that illustrated the do-able actions. Over time, additional materials (the family-friendly health card and low-cost newspapers) built directly on these.

PRINCIPLE 3: Launch short skill-based training activities. Training focused on practice, feedback and questions, and more practice. In Madagascar, the major training emphasis was on improving counseling skills and on use of village theater.

PRINCIPLE 4: Engage large numbers of volunteers. In Madagascar, volunteers from established community groups were able to integrate health into their activities. The program aimed to reach a critical mass of volunteers and anticipated heavy drop-out rates by periodically launching new waves of training.

PRINCIPLE 5: Provide intensive mass media support. Scale cannot be achieved without the reach offered by mass media. Radio penetrates most rural areas.

PRINCIPLE 6: Celebrate achievements. The project offered diplomas to individual mothers to help them celebrate a child’s being fully vaccinated. It also planned for community celebrations (usually on a seasonal basis) to highlight achievements, provide a channel for creativity and enthusiasm, and launch new activities.

Source: Gottert, P. (2000) Six Guiding Principles of Streamlining Community-based Programs. AED



It recruited volunteers from all levels of the community and brought together schools, churches, and women's groups. It promoted frequent celebrations to highlight achievements through song, skits, and public recognition of health workers, families, and volunteers. The celebrations were also an opportunity for the many health projects that might be working in a community simply to do something together.

As *BASICS* reached its mid-term in Madagascar, the idea of a celebration organized around **quantifiable goals** seemed natural.

In areas where the project had been operating more intensively, many communities were clearly performing better in terms of immunizing larger numbers of children, referring cases of severe illness to health centers and so forth. The wheels of collaboration among volunteers, families, and the health center were "well oiled." The idea was to challenge them to reach explicit targets before the project ended, focusing on just a few important health issues. *Champion Communities* would receive special banners and their successes publicized over the radio. Neighboring and even distant communities would hear about the activities and perhaps also become inspired.

In each district, a small number of communities were identified for the mini-pilot. Enthusiasm exceeded expectations. The opportunity for friendly competition proved a good motivator. Local mayors enjoyed the spotlight and found there could be a political pay-off associated with health. Communities were proud of their collective accomplishments.

CHAPTER 3

FROM “SIDE ACTIVITY” TO DRIVING FORCE

In the next five years, the Champion Community Initiative evolved from a project “add-on” to a program framework for motivating and measuring improvements in community health. It also became a method for promoting such improvements at scale.

BASICS had been limited to a pilot region of two districts with a total population of 665,000. From 1999 to 2003, the *Madagascar Smaller Healthier Families Project (or Jereo Salama Isika)*³ worked in two provinces with more than half the population of the country. Over time, *Jereo* expanded to 23 districts.

The new project also had a larger mandate and an even heavier burden to integrate different interventions at the community level. *Jereo* focused on child survival, reproductive health (including prevention of sexually transmitted illness and HIV/AIDS late in the project), and nutrition. It also collaborated with multiple non-governmental groups carrying out health programs,

³ The Madagascar Smaller Healthy Families Project was a five-year bilateral project funded by USAID and managed by John Snow Inc, with partners AED, the Futures Group International, and Private Agencies Collaborating Together. The Academy for Educational was responsible for the behavior change and communication/community mobilization component of the project. Other inputs supported quality of care, training for health workers, improvements in management information systems, and provision of essential drugs.



and with several other USAID projects. These included *LINKAGES*⁴ (managed by AED), with a nutrition mandate, and the *Environmental Health Project (EHP)*⁵.

Jereo faced two closely linked challenges that confront many large development efforts: how to streamline the goals and activities of many assistance “actors” so that 1) communities are not overwhelmed, and 2) the program is manageable beyond a limited area receiving intensive donor attention.

PARING DOWN IN ORDER TO EXPAND

Under *Jereo*, AED was once again responsible for community mobilization and behavior change strategies. The six principles of community mobilization that drove planning under *BASICS* served this project as well. Over 18,000 health volunteers and peer educators were trained through a pyramid system. Mass media helped reach the larger and more dispersed target population. The project trained 20 radio producers and 120 radio animators in 32 stations to develop short health-related spots. It produced 270 original spots and aired them in local languages on 27 participating radio stations. This extensive rural radio program was supplemented with television broadcasts to reach urban audiences.

The communication team first made a valiant effort to multiply the large package of innovative print materials (cue cards, gazetties, posters) to keep up with project expansion. However, they soon shifted gears and pared

⁴ *LINKAGES* is a worldwide project funded by USAID and managed by AED (1995-2006). It was active in Madagascar throughout this period, promoting breastfeeding, young child feeding, and the Lactational Amenorrhea method of birth spacing.

⁵ The Environmental Health Project (EHP) was a worldwide project funded by USAID and managed by CDM International, Inc. It was active in Madagascar between 2000-2004.

BUILDING ON PROJECT SYNERGIES

During the period of the Champion Community Initiative in Madagascar, two USAID projects worked especially closely together at the community level. The mandate of *Jereo Salama Isika* was to improve child survival. *LINKAGES* focused specifically on child nutrition. Both projects supported personnel at the district level, and these individuals worked as a team.

LINKAGES activities were vital to improvements in a number of indicators during its more than eight years of local presence. (See page 20–21.) Contributions at the policy, provider, and community levels included:

- Support to the Ministry's national policy activities, including establishing an intersectoral nutrition action group and reforming pre-service curricula
- Support for the Baby-Friendly Hospital Initiative (BFHI) and the Baby-Friendly Workplace Initiative
- Introduction at six critical health contact points of the Essential Nutrition Actions (ENA): i.e., promotion of breastfeeding, complementary feeding, feeding of the sick child, women's nutrition, control of anemia and vitamin A and iodine deficiency
- Integration of the Lactational Amenorrhea Method of family planning into reproductive health programs
- Capacity building for MOH and NGO service providers and training for community volunteers, local leaders, and others
- Training and launching of mother's groups to promote optimal child feeding practices
- Community mobilization and behavior change communication—development of counseling and other IEC materials, village theater
- Mass media to reinforce messages (local and national radio and television, traditional singers, and songs by Madagascar's female musical celebrity)

Jereo Salama Isika and *LINKAGES* worked together to harmonize messages from the national to the community level, and reinforce key “doable” actions through multiple channels.

The most difficult task of the new “competition” framework was to select a manageable number of goals.

down to essentials. These included the vaccination diploma, the counseling cards, the Family Health Record, and a new Youth Passport (to support adolescents in adopting healthy lifestyles). Both *LINKAGES* and *EHP* assisted in revising these to strengthen the nutrition and environmental messages, respectively.

The Champion Communities Initiative contributed to this process of streamlining, as well as the transfer of ownership to communities. The most difficult task of the new “competition” framework was to select a manageable number of goals. Each major project acting in the area had to be “represented” in the list, allowing seemingly little attention to any one intervention. In some cases though, a single goal could facilitate a cluster of behaviors. For example, including ownership of the Family Health Card as a goal meant that parents would have to make contact with the health facility, and would then have in their possession an educational tool that could help them carry out 24 different prevention and treatment practices. (This was also a way of ensuring adequate emphasis on nutrition, as 60 percent of behaviors in the revised card were nutrition related.)

It was important that communities could track their own progress. Some health targets could be counted rather easily (such as numbers of children

who received vitamin A). Others were best translated into educational goals (such as numbers of sessions on family planning).

Perhaps most important, communities needed to pick some goals they cared about, in addition to major public health indicators.

The final mix of goals was:

- Eighty percent of all children under 12 months of age are fully vaccinated
- Sixty-five percent of parents with newborns own a Family Health Record
- Seventy percent of children ages 6 to 59 months have received vitamin A capsules
- Information sessions (during vaccination days or in community meetings) are held on family planning at least every other week
- The community undertakes a clean-up campaign in a public area (the market, health center, or other place they designate)
- Three mini-festivals are held to celebrate achievements and a major festival is held to celebrate reaching Champion Community status

LETTING COMMUNITIES LEAD

Criteria were established for entering the program. The most critical was “good relations between the health worker and the community.” This may seem a very subjective requirement, but communities were clear about whether they qualified or not. No fixed time was set for completing goals, but nine months was the suggested target.

A team from the district came to orient communities who decided to participate. But a local team was responsible for energizing and monitoring progress. A Community Health Action Committee (CASC) was estab-

lished in each community. These consisted of six to eight members including the mayor, health practitioners, and local leaders.

Jereo was scaled back in 2002 and cut short due to a political crisis in Madagascar. By the end of the program, however, around 100 communities had achieved Champion status and proudly displayed banners announcing this fact. Countless more mayors and average Malagasy citizens learned about the importance of these major health objectives by hearing news of winners over the radio.



CHAPTER 4

BASIC PRINCIPLES

Principles for designing and carrying out the Champion Communities Initiative have emerged from experience in Madagascar and elsewhere over the last ten years.

1. SELECT GOALS SYSTEMATICALLY

Getting the mix of goals right is fundamental to success. When the package is right, people will “run for the finish line.” If the goals are too hard, too distant, impossible to measure, or allow for no flexibility or choice, people will be discouraged. If targets are too simple or don’t require teamwork, they will elicit little enthusiasm.

The right package of goals is:

- Small in number (six or eight)
- Achievable in the “medium term” (Goals should be reachable in six to nine months. A good mix will include some goals that can be met quickly. The end point should also be flexible—groups need not reach the finish line at the same time.)
- Challenging but feasible
- Allows for choice (Some goals should be “required” but at least one should be selected by the community from a list.)



- Combines both individual and collective actions (The community might be tasked with maintaining a well; individuals with having soap in their homes.)
- Monitored by the community (The goals must lend themselves to simple monitoring, and the program should include basic tools/instructions for self-monitoring.)
- Combines quantitative and qualitative “success” (Immunized children can be counted; a clean market requires consensus of opinion.)

2. SELECT GOALS TOGETHER

The process of selecting goals is also important. Communities are much more likely to buy into a program that has not simply been handed to them. At the same time, scale requires simplicity. The communication team under Jereo resolved this dilemma by conducting initial meetings to understand local concerns and elicit ideas about target activities. This helped to test the acceptability of some goals and select additional ones for inclusion in a standardized “menu.” Negotiation was also an important part of this process. (*See box.*)

Jereo did not rely on in-depth community participation in the traditional sense—typically a long-term process of building relations over time. *Jereo* was tasked with mobilizing large numbers of communities across several districts in a short period of time. It tried to strike the right compromise between “top down” and “bottom up.” Or rather, to combine them in such a way that the energy of grass roots commitment and enthusiasm would still drive the program.

3. CONSIDER ENTRANCE CRITERIA

Groups under severe stress or dealing with conflict may not benefit from this approach. (In Ethiopia, communities

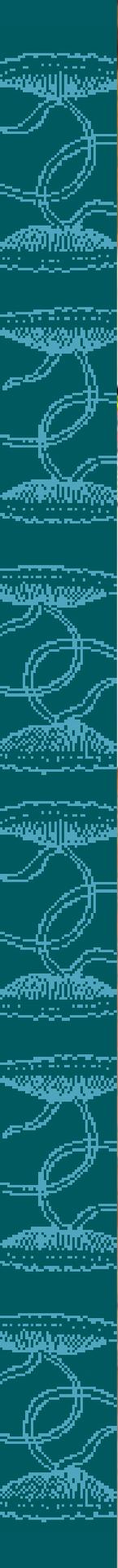
THE NEED FOR NEGOTIATION

A simple package of agreed on goals is the lynch pin of the Champion Community approach. Getting the balance right—between individual and collective activities, between public health priorities and perceived local needs, is always challenging. Negotiation is crucial to getting the package right.

Communities themselves often set the bar very high and negotiation is needed to come up with feasible targets. Activities requiring large amounts of concrete also seem to be irresistible. *Jereo's* experience was that communities almost always wanted to build something—a new school, a new 32-bed maternity. These are expensive and long-term projects. *Jereo* tried to direct people's initial attention to realistic short-term tasks for “round one.” This might mean building a latrine near the local market, for example. One of the underlying strategies should be to build a sense of community self-efficacy through achievable goals. “Round two” can entail more ambitious and independent planning.

Negotiation among those who may be providing assistance to communities can be especially difficult. The approach lends itself to the integration of interventions—health, family planning, education, protection of the environment. But this requires compromise by everyone. Paring down is painful to program managers. Discussing timelines can bring out differences in development philosophies. Different visions of “scale” have varying financial implications. Often the task of getting donors and development assistant organizations to agree on the right balance can be much more difficult than getting communities themselves on board.

facing famine were excluded). In Madagascar, *Jereo* required that communities already have good working relations with their local health center. A core team must take responsibility for the program. In Madagascar, starting in higher-performing communities also created an “updraft” in surrounding areas.



4. LAUNCH AND ADVISE VS. “SUPERVISE”

The energy for a Champion Community must come from within. The launch is aimed at creating this initial spark. The presence and support of respected community leaders and elders, women’s and youth groups, religious groups, and outside dignitaries is critical. Orientation for the central team should include a focus on the tools for self-monitoring. Outside assistance should then be limited to checking in.

5. CELEBRATE

The purpose of the program is to create winners and to instill a winning spirit that can counteract the fatalism common in communities that experience high levels of child illness and mortality and devastating diseases such as HIV/AIDS. Focusing on feasible, medium-term goals is one part of this strategy. Incorporating celebration as a requirement, rather than a final reward, is another. It assures that communities share accomplishments frequently and reflect on both how far they have come and how they will tackle remaining challenges. Discovering a sense of collective self-efficacy is more important than literally completing x number of goals.

6. PROMOTE WITH MASS MEDIA

For a poor community, the experience of hearing local leaders interviewed by the media and their own

accomplishments praised can be extraordinary. Radio and television can motivate communities who are trying to reach their goals, those who have reached them, and those who may want to join the program. The media can play a powerful role in both creating demand for the program in new areas, and in reminding the broader public about the program’s “simple doable actions.”

7. PROVIDE A FOUNDATION

A competition can motivate people to act but it cannot very easily tell them how to achieve goals. Changes in behavior may require new knowledge, new beliefs, and support from others. The Champion Community Initiative is not a replacement for teaching people new skills, giving them useful tools, or assuring supplies and services are available and reliable. It does provide a framework for making decisions about what changes are most important.

8. BUILD ON FIRST SUCCESSES

“Winning,” or meeting the requirements for certification as a champion, should be seen as an early step rather than a final one. In the follow-up phase, communities can be challenged to meet more difficult goals and also to set a greater number of goals themselves without guidance. They can also be challenged to help other groups meet their goals (as in the case of youth groups described later).

CHAPTER 5

THE ROLE OF CHILDREN

One of the principles of Champion Communities is to involve as many sectors of society as possible. This includes children.

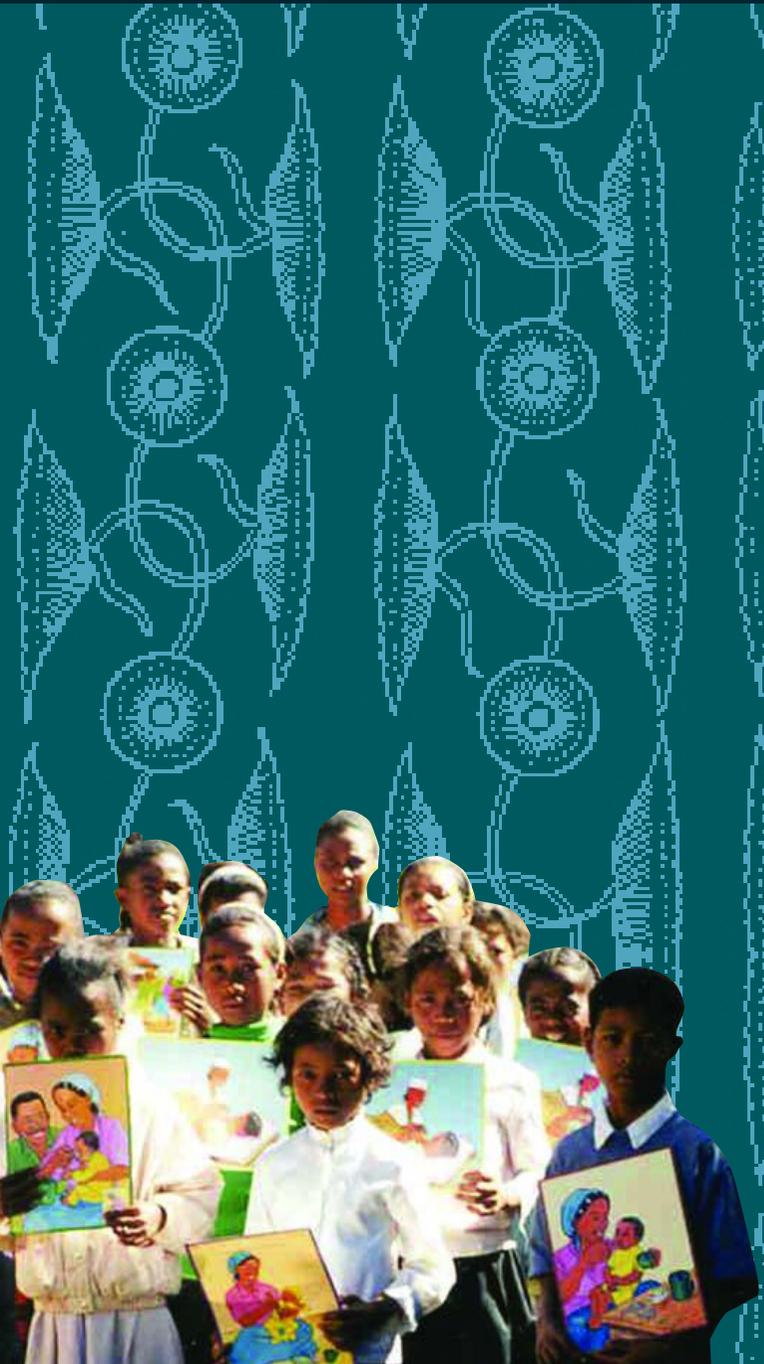
The potential role of children in development programs of all kinds is often overlooked. Children are more receptive than adults to new ideas. Skills or behaviors learned while young are likely to “stick” in adulthood. Children are eager to be involved in adult issues and can be passionate about them. They are natural communicators. They can act as the conscience of a community.

In Madagascar, UNICEF came to the *BASICS Project* around 1996 for help developing a school-based health curriculum for primary schools. An AED curriculum specialist worked with both the Ministry of Health and the Ministry of Education to create a pilot program that would inform, engage, and entertain children.

BEYOND THE CLASSROOM, BEYOND SCHOOL

The program focused on nutrition, immunization, diarrheal disease, and hygiene. It incorporated a child-to-community approach, and a school-to-community approach. The curriculum specialist worked with teachers and also families to create and test various learning activities for the classroom including games and other kinds of active learning, as well as assignments that would require them to talk to their parents, influence their peers, and carry out “real projects” with adults in their community.

Many lessons took children out into their neighborhoods to do a mini-survey. For example, they might be asked to find out how many under-one-year olds among their family's friends were immunized. Or they might be asked to observe practices in their



own homes. (Do the chickens walk freely in the kitchen?) Students were also asked to think about why a certain desirable behavior might be difficult. (Do parents not have enough time to do it? Do they not have enough information?) And then they were asked to think about some possible solutions to the problems they discovered.

In this way, children actually became informed advocates for many of the same “doable actions” central to the Champion Community Initiative. They learned how to carry out some of the actions themselves, and also how to help their communities achieve change. Groups of four to five children might work together to take responsibility for making sure at least one infant they knew received all of his or her vaccinations. Several classrooms might work together to clean up a public area.

BECOMING A BEACON SCHOOL

The program was integrated with the Champion Community Initiative. The curriculum laid out a pathway whereby schools could themselves become champions—or *Beacon Schools*. Criteria cut across the different health areas and included some of the same goals as the Champion Community Initiative. These combined both quantifiable targets and educational or community activities. Goals included:

- Eighty percent of infant siblings of students complete their vaccinations by one year of age
- Children know how to use and maintain a latrine
- Eighty percent of students wash hands before eating and after using the toilet/latrine
- The school and parents’ association work together on a clean-up activity (e.g., the school or another public area)

- The school makes safe drinking water available for students
- The parents’ association carries out at least one demonstration every two months on how to prepare nutritious food
- The parents’ association carries out awareness-raising at least twice a year on how to prevent and treat diarrhea

Targets for the Beacon Schools were refined during field testing. For example, it turned out that handwashing was an unreasonable goal in some schools because water wasn't available. So the first feasible target was to make safe drinking water available. Achieving all the targets meant that not only students but parents and administrators had fulfilled certain responsibilities.

The curriculum included instructions on how a school could monitor its own progress. A special poster was also created to help schools track and share this progress. Schools were encouraged to celebrate their accomplishments at several points during the year. And at the end of the year, administrative districts held impressive festivals to honor winners of the Beacon School banners. A spirit of friendly competition infused the program.

Beacon Schools was piloted in 39 primary schools in two districts. A newsletter publicized accomplishments of the schools and communities. The program was gradually expanded to 219 primary schools and 50 middle schools. Thirty-two schools received official Beacon School banners before activities in Madagascar were interrupted by political turmoil in 2001. However, the school program was later resumed and expanded to secondary schools with additional lessons on reproductive health. Both the *LINKAGES Project* and CARE helped with this expansion.

CHAPTER 6

CONTRIBUTION TO HEALTH IMPACT IN MADAGASCAR

The Champion Community and Beacon School Initiatives were integral to a major community health mobilization strategy in Madagascar. But a focus on families and communities was only one of several “pillars” designed to improve the health of children. Other pillars included advocacy at the policy level and support for changes in the delivery and quality of health services. Furthermore, several projects and multiple partners and grass roots organizations contributed to these changes. So it is not possible to link any one contribution directly to the improvements in health status that took place in Madagascar between about 1999 and 2004. But it is clear that impressive changes did occur in several major indicators.

EARLY RESULTS UNDER BASICS

Results associated with *BASICS*' early work in its pilot areas of Antananarivo and Fianarantsoa were striking. The project conducted baseline and follow-up surveys at both the household and facility levels to test the effectiveness of pilot strategies.

Results of the household surveys reflected the impact of the intensive community mobilization strategies:



TABLE 1

CHANGES IN KEY INDICATORS DURING BASICS PROJECT, HOUSEHOLD SURVEYS

INDICATOR	1996	1998
• Children 12-23 months fully immunized	57%	78%
• Women whose infants were protected against neonatal tetanus at last birth	53%	72%
• Women who began breastfeeding immediately after delivery	21%	69%
• Infants under 6 months of age who were exclusively breastfed	48%	72%
• Children 12-23 months receiving at least five meals per day	10%	42%
• Mothers who knew two or more danger signs for seeking care when their child was ill	40%	70%
• Women receiving 90 or more iron/folic acid tablets during pregnancy	6%	43%
• Women receiving vitamin A supplements within the first eight weeks after delivery	10%	37%
• Households with iodized salt available on the day of the survey	29%	81%
• Children 6-59 months who received a vitamin A capsule the last six months.*	--	29%

* Distribution of vitamin A capsules began after the baseline study. BASICS supported communities in achieving their initial nearly 30 percent coverage of that new intervention.

Source: (2004) *Improving Family Health Using an Integrated, Community-based Approach*. Published by the BASICS II project for USAID.

According to DHS data, the proportion of fully immunized children between 12–23 months of age was actually declining nationally in the five year period before BASICS began. In 1997, national immunization coverage was only 36 percent. These data contrast strikingly with improvements in the program areas of the two target districts. The percentage of immunized children in these areas rose to 78 percent by 1998. (At the start of the program, immunization rates in the two target districts were already higher—at 57 percent—than the national rate. Nevertheless, the increase of 21 percent in these areas between 1996 and 1998 was impressive.)

During this program phase before *LINKAGES* arrived, many nutrition practices improved. But nutrition also proved one of the most challenging areas. For example, between baseline and follow-up surveys, children who

received additional meals after illnesses increased minimally, from 18 percent to 19 percent.

CHAMPION COMMUNITY PERIOD— JEREO AND LINKAGES

The period during which *Jereo Salama Isika* and *LINKAGES* collaborated in Madagascar saw an expansion of the basic target area to 20 districts—or around 4.2 million people. This was the also the period during which the Champion Community Initiative was rolled out systematically (although not in all communities). Indicators during this time improved in three major areas: child survival, nutrition, and family planning.

Immunization. Once again, sharp improvements occurred in immunization rates, as measured against a program baseline in 2000 and in rapid assessments conducted in 2001 and 2002.

TABLE 2

**IMMUNIZATION COVERAGE IN CHILDREN
12–23 MONTHS IN PROGRAM AREAS**

Coverage Indicator	Program areas at baseline '00	Program areas in '01 (RAPS)	Program areas in '02 (RAPS)
BCG	92	96	97
DPT3	84	94	93
Measles	79	88	88
Fully immunized	78	87	88

Source: Agnès Guyon, et al. (2005). *Assessing a Behavior Change Strategy for the Essential Nutrition Actions, Immunization, and Family Planning—Antananarivo and Fianarantsoa Provinces, Madagascar*. Washington, DC: Academy for Educational Development, LINKAGES Project.

Local improvements were also associated with the Beacon School program. According to district reports between October 1998 and September 2001 in Antananarivo North, where the program worked with both primary and secondary schools, immunization rates increased 12 percent. Similar reports in Ambalavao District, where the program was also active, showed immunization rates increased 15.7 percent.⁶

Infant and Child Nutrition. Research by the LINKAGES project during this time period document large improvements in nutrition-related practices, particularly related to breastfeeding.

Figure 1 shows that initiation of breastfeeding within the first hour of birth rose dramatically from the baseline of 34 percent and remained at a high of

73 to 78 percent throughout the program period. Figure 2 shows improvements in exclusive breastfeeding rates. Rates for infants at three different ages showed gains of at least 20 percent throughout the program.

FIG. 1

**INITIATION OF BREASTFEEDING
WITHIN THE FIRST HOUR OF DELIVERY**

(infants 0–5 months)

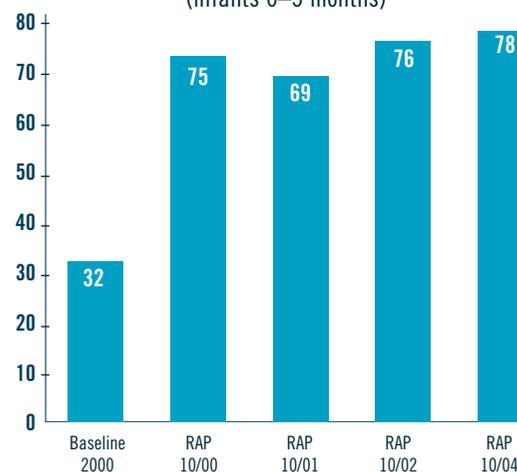
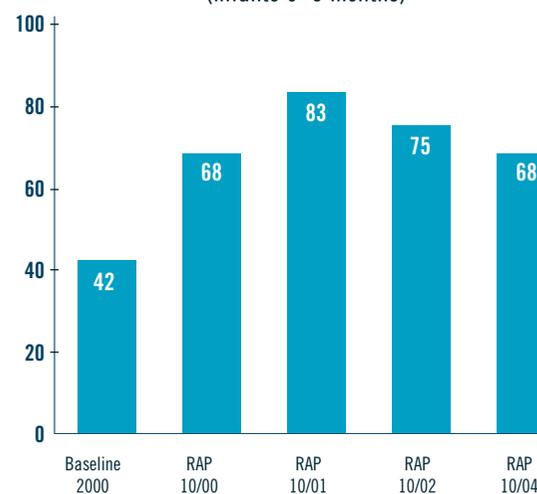


FIG. 2

EXCLUSIVE BREASTFEEDING

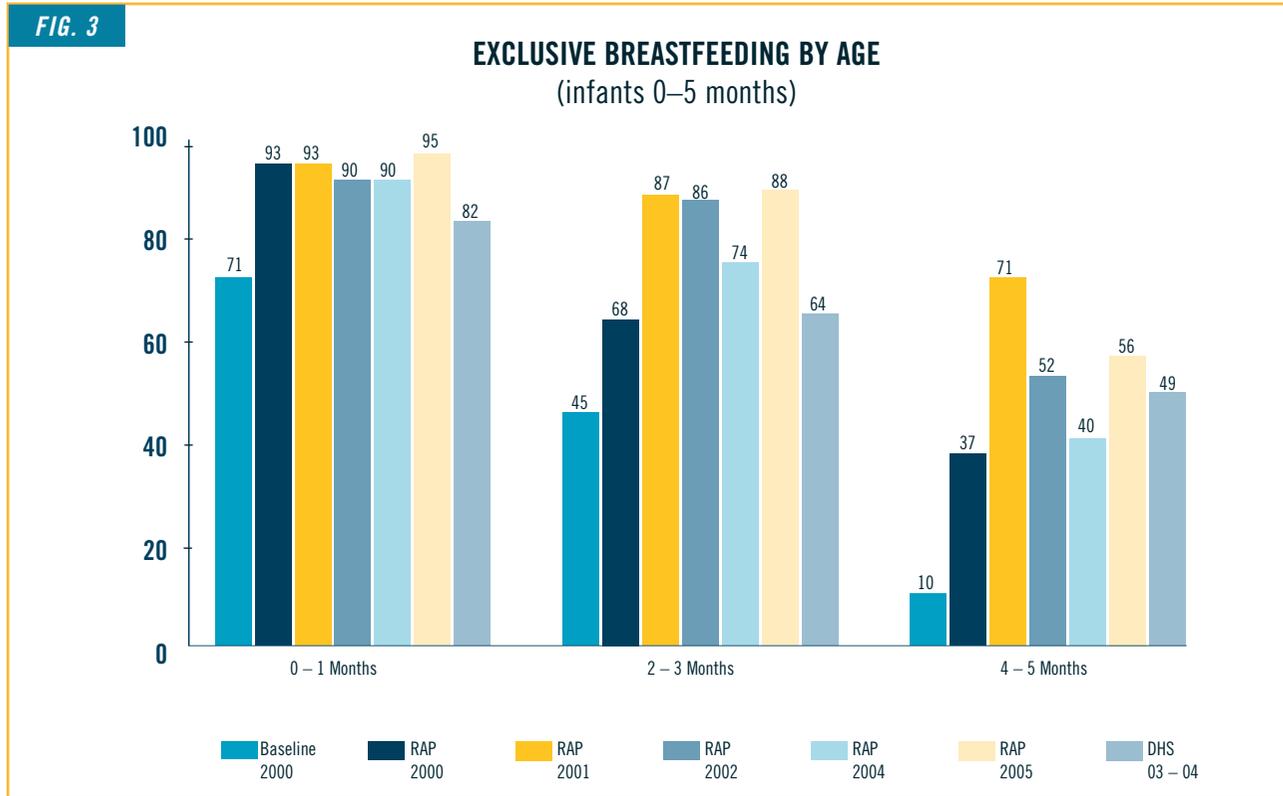
(infants 0–5 months)



Source: Agnès Guyon, et al. (2004). *Assessing a Behavior Change Strategy for the Essential Nutrition Actions, Immunization, and Family Planning—Antananarivo and Fianarantsoa Provinces, Madagascar*. Washington, DC: Academy for Educational Development, LINKAGES Project.

⁶ *Final Report, Jereo Salama Isika, 1999-2003*. Republic of Madagascar, Ministry of Health, and JSI. Boston: John Snow Inc.

FIG. 3

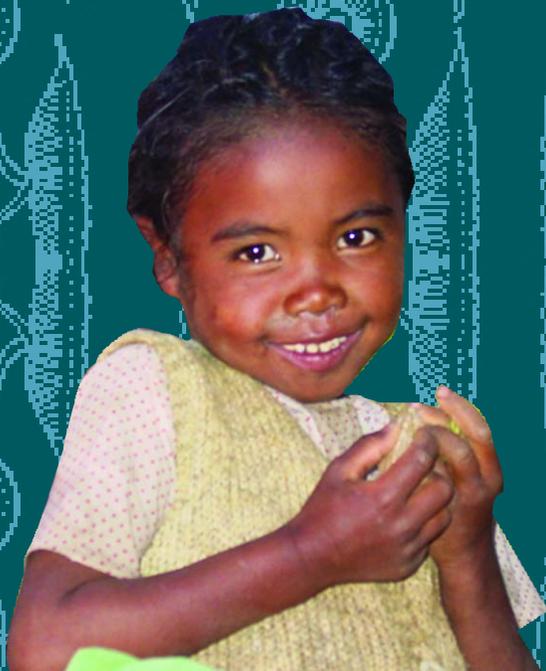


Reproductive Health and Family Planning. Family planning indicators also showed improvements. Between 1997 and 2000,⁷ the contraceptive prevalence rate in Fianarantsoa rose from 5 to 7 percent, whereas in program areas of the province they reached 15 percent. In Antananarivo, contraceptive prevalence during this period rose from 16 to 17 percent. In program areas of the province they reached a high of 23 percent.

⁷ *Improving Family Health Using an Integrated, Community-based Approach.* (2004). Published by the BASICS II project for USAID

CHAPTER 7

EXPANSION IN MADAGASCAR



Experience in Madagascar made the potential of Champion Communities clear to USAID (who funded the early evolution of the strategy) and to many partner organizations.

FOCUS ON POVERTY REDUCTION

When *Jereo Salama Isika* ended in 2003, USAID's next large project in Madagascar, called *SantéNet*, adopted the approach as the framework for its entire five-year program. Under *SantéNet*, communities are led through a process of negotiating goals in four different sectors: environmental and rural development, health, economic growth, and democracy and government. Each community signs a contract indicating its commitment to the selected objectives. After a 12- to 18- month implementation cycle, a community earns a star for achieving objectives in any given sector. The goal is to become a "four-star" champion community.

The project has established a ten-step process for the *Kôminina Mendrika* approach, as it is called. A local committee leads the process. Members receive both on-site and off-site training in how to conduct a participatory assessment, how to negotiate goals, and how to monitor progress. Three kits support their efforts in the community: a *Marketing Kit* with print materials to help motivate community-based agents; a *Mass Media Communication Kit* with songs, sketches, and promotional spots for local radio; and an *Interpersonal Communication Kit*.

SantéNet is working in four of Madagascar's six provinces. Between 2004 and 2008, the project aims to involve 4.5 million people in Champion Community activities (more than a quarter of the country's total population). In the first 18-month round of activities, 1.2 million people were involved.

FOCUS ON THE ENVIRONMENT

Other organizations in Madagascar are also building directly on the potential for the Champion Community Initiative to create synergies between different development sectors. John Snow, Inc. obtained funding from the David and Lucille Packard Foundation to work in areas of high environmental sensitivity in the country. Their aim is to improve basic health indicators while also protecting livelihoods that are dependent on the increasingly endangered ecosystems.

This work emerged from the unique collaboration among Jereo, *LINKAGES*, and the *Environmental Health Project (EHP)*. In the mid 1990s *EHP* helped establish a local nongovernmental organization, Voahary Salama (“Healthy Nature”)—an association of 20 conservation, health, and rural development partners from five biodiverse regions of Madagascar. The partners have a common vision of “a healthy population living in a healthy environment, based on a rational management of natural resources.”

NGO partners play a special role in this iteration of Champion Communities, providing training, technical support, and in some cases resources for new activities. In each community a partner NGO also helps to supervise and monitor progress towards specific objectives. (*See box.*) The NGO generally works with an intermediary group, such as the local resource management council, whose members are active within the community.

COMBINING HEALTH AND ENVIRONMENTAL GOALS

The Madagascar Green Healthy Communities Project targets the delicate balance between viable livelihoods, food security, and protection of natural resources.

Objectives for the *Champion Communities* cut across these different areas. They include:

- 80 percent of children under one are fully vaccinated
- parents of 65 percent of children under three years have a Family Health Record
- 500 or more trees are planted in 9 months
- management systems for farming practices are improved
- 10 percent of cultivated surfaces rely on improved agriculture techniques

Communities need technical support to achieve these goals. NGOs provide training in the System of Improved Rice-culture (SRA), System of Intensive Rice-culture (SRI), and reforestation. The project is also helping to engage households in new income-generating activities.

At the same time, the project has trained nearly 200 Community Service Agents (CSAs) to provide family planning services. In the first 14 months of implementation, 40,000 trees were planted and 12,300 contraceptive products were distributed.

One of the goals of this model is to develop a sustainable way of managing the overall champion process, and engage partners who can also leverage additional funds.

Sixty communities are now participating in the program. JSI is also adapting this health-environmental model of the Champion Community Initiative in Tanzania.

CHAPTER 8

INTEGRATING HEALTH AND EDUCATION GOALS

In Ethiopia, USAID has supported organizations in two different sectors—health and education—to work together and launch a Champion Community Initiative that will more effectively link their very different objectives and resources.

The synergy between health and education outcomes is clear. An educated mother is more apt to have safe and well-spaced pregnancies and healthy children. Adequately-nourished, healthy children are better able to thrive and to stay in school. But the strong connection between health and education indicators is rarely reflected in the level of cooperation between governmental ministries or even between the different arms of a donor organization.

In Ethiopia, the challenge of creating such a positive synergy is staggering. Nearly half of all children under five are malnourished. For every 1000 children born, 170 do not survive to their fifth birthdays.⁸ Only around 40 percent of the population complete primary school; for women, the rate is just 30 percent.

One of USAID's goals in Ethiopia is to promote social resilience in communities so that they are better able to mobilize resources and reduce their vulnerability to cycles of famine,

⁸ World Development Indicators database, August 2005. (The World Bank. Data are for 2003.)



disease, and poverty. This goal is supported by new structures in Ethiopia at the district level that combine education and health in one office. USAID’s hope was that a new *Kokeb Kebeles*, (or *Star Community Initiative*) would stimulate even more crucial collaboration at the grass roots.

MULTIPLE PARTNERS, MULTIPLE ROLES

AED’s responsibility in the new initiative has been to design the program framework, develop materials and monitoring systems, conduct training, and coordinate support by the several partners. These roles emerged out of AED’s participation in two major USAID programs in Ethiopia: *The Health Communication Partnership*⁹ and the *Essential Services for Health in Ethiopia Project*¹⁰ (or *ESHE*). ESHE and two other partners—Pathfinder and World Learning¹¹—are tasked with implementing the program on the ground.

Planning for the Kokeb Kebeles Initiative began in 2003 in the Southern National Nationalities and People’s Region (SNNPR). Regional stakeholders from different sectors participated in the design meetings. Intense

discussions also took place among the different USAID partners. AED documented agreed-on roles and processes in a Partners’ Manual and a 12-step *Activities Guide* for the communities (or Kebeles).

District-level orientations were conducted over two days. The first day brought together district (Woreda) officials connected with health, education, water, and

FOLLOW THE STEPS – AND THEN?

One of the principles of the Champion Community approach is to establish goals that can be met within a reasonable time frame.

As the approach has undergone different iterations, program designers have attempted to systematize the process of defining and reaching goals, and at the same time put increasing control in the hands of communities themselves. This encourages local ownership of the process and is also necessary to achieve scale.

The Kokeb Kebeles Initiative was built around a 12-step process laid out succinctly in a simple *Activities Guide*. The document provides a road map for the Kebele Action Committee to use in guiding its community through the program. Each step is accompanied by a basic checklist, examples, and tools (such as a sample monthly activity monitoring chart). Communities track their own progress. The Action Committee “reports” directly to a district task force.

Step 7 is designed to shift communities into a more independent mode. Groups are challenged to “select an open goal” and repeat the whole process (assessing the problem, selecting activities, monitoring progress, and so forth). The process of learning and practicing goal setting, self-assessment, collective planning and action, is therefore an explicit part of the program.

One of the ongoing challenges of all Champion models has been to design for round 2, and round 3. In a short time communities have “succeeded” and celebrated. And then what? One of the primary challenges is to assure “the end” is a beginning, and sustaining effort and enthusiasm is somehow part of the system.

⁹ The Health Communication Partnership (HCP, 2000-2007) is a global program funded by USAID and managed by the Johns Hopkins University, Center for Communication Programs. Partners include the Academy for Educational Development, the International HIV-AIDS Alliance, Save the Children, Tulane University, and the University of North Carolina. AED manages the HCP program in Ethiopia.

¹⁰ Essential Services for Health in Ethiopia Activities (ESHE, 2003–2008) is funded by USAID and managed by John Snow, Inc. Subcontractors include the Academy for Educational Development, Abt Associates, American Manufacturers Export Group, and Initiatives, Inc.

¹¹ Pathfinder International manages the USAID bilateral reproductive health and family planning project in Ethiopia. World Learning manages USAID’s Basic Education Systems Overhaul Program in Ethiopia.



women's affairs to build mutual understanding and consensus on roles. The second day brought in leaders from several Kebeles to discuss goals, gauge interest, and solicit feedback.

The Kebele representatives then returned to their villages to explain the program to elders and, with their support, conduct community orientations. In each community, one of the goals of this orientation was to select members to serve on a Kebele Action Committee. The small team—half of whom had to be women—would take responsibility for leading the whole process.

Members of several Action Committees took part in a short, joint training program to introduce the steps outlined in the Activity Guide. The teams learned how to help their communities collect information about local problems and document their “baselines.” They discussed how to work with their

communities to agree on goals, plan activities, and monitor progress.

In early meetings, Kebele members also reviewed and negotiated the goals of the overall program. Predictably, there was lively interest in possible construction activities. Some communities wanted to build schools or health posts. But for the limited number of required goals, they eventually agreed collective action should focus on smaller projects such as building latrines.

Initial goals for the Kokeb Kebeles Initiative were:

- Increase number of children under one year who are immunized
- Increase awareness of family planning services
- Increase enrollment of girls in school
- Construct pit latrines at schools and homes
- Increase HIV/AIDS awareness in the community.

The teams learned how to help their communities collect information about local problems and document their “baselines.” They discussed how to work with their communities to agree on goals, plan activities, and monitor progress.

Communities were also asked to select two goals from a list of nine options that had emerged as popular during program pretesting. These ranged from “ensure water is available in schools” to “increase number of households using insecticide treated mosquito nets,” to “construct health post.”

As in other Champion Community models, self-monitoring is crucial in the Kokeb Kebeles Initiative. When designing the Activity Guide, AED consulted with school directors on the easiest way to calculate enrollment and female dropout rates. Some behaviors that could not be easily measured were translated into activity goals. For example, instead of tracking numbers of modern family planning users, each community aimed to achieve a specific number of education sessions on family planning. As the program is scaled up, the lists of activities that satisfy the two goals to “increase awareness” (of family planning and HIV/AIDS) will be refined through community suggestions and practical experience.

Once communities achieve their initial goals, they are invited to select their own goal with no external guidance or restrictions—not even a list from which to choose ideas. The requirement is that communities go through the same systematic process: reach consensus on the goal, plan activities, and monitor progress.

Twenty Kebeles in SNNPR participated in the pilot program. The pilot is being followed by expansion into additional districts in SNNPR. The initiative will then be launched in the Ahmara region, followed by the Ormia region.

NEGOTIATING DIFFERENCES

One of biggest challenges of the initiative has been resolving philosophical and operational differences among the different collaborating organizations. The typical USAID bilateral project is funded for a short period (three to five years) and includes measurable targets. It must aim at reaching a large number of communities within this short time in order to achieve impact. On the other hand, many nongovernmental organizations believe in the importance of establishing a long-term presence in communities, gaining trust over time, and facilitating comprehensive community self-assessments and planning. They are frequently not comfortable with short-term goals and a relatively “hands-off” monitoring approach.

USAID resolved this philosophical difference to some degree by assigning different implementing partners to different communities and allowing varying degrees of support. Results will be monitored and will provide insight into the best model, or the range of possible range of models, for reaching scale effectively.

CHAPTER 9

FOCUSING ON THE CHALLENGES OF YOUTH



AED has taken a special interest in expanding the Champion approach to youth. Building on the early Beacon Schools experience, AED has designed programs for different ages—both in and out of school—in Madagascar, Ethiopia, and Jordan. These initiatives have all focused on adolescent health, but in the much larger context of empowering youth to make informed decisions about their lives, gain skills and confidence in dealing with peers, and help others.

A CONTINUUM OF SUPPORT

In Ethiopia, where the highest prevalence of HIV/AIDS is among youth between the ages of 15 and 24, young people are in desperate need of information, skills, and the self-confidence to make difficult personal choices. AED designed a stream of activities to provide a continuum of support throughout the pre- and adolescent years. Three curriculum-based programs include:

- **For grades 5 and 6: Life's Skills Curriculum¹²** to help young people define their own values, navigate the opinions and influence of their peers, and make personal decisions.

¹² The curriculum was produced by AED and Save the Children under USAID's BESO Project (Basic Education System Overhaul).

- **For grades 7 and 8: Sports for Life Program**, with additional emphasis on relationships, romance and sex, and prevention of HIV/AIDS and other STIs. The program is facilitated by physical education teachers and coaches (during PE, recess, or after school).
- **For ages 15 to 20: Youth Action Kit**, with additional emphasis on relationships and managing emotions, reproductive anatomy and health, sex and its consequences, gender-based violence, and prevention of HIV/AIDS.

The *Youth Action Kit*, developed for the oldest group, was created in response to a push by the government to form anti-AIDS clubs in each school throughout Ethiopia.¹³ Many clubs exist in name but are non-functional. The Kit also aimed to reach out-of-school youth who are served by some 10,000 clubs sponsored by the Ethiopian Orthodox Church, the Ethiopian Youth Network, and other organizations.

The basic curriculum of the Kit is highly participatory, youth-led, and designed to meet the needs of young folks with different personalities and learning styles. It is also designed to be fun. Activities center on three objectives:

- develop individual skills,
- strengthen group ties, and
- engage parents and communities

An accompanying book of around 20 skits lays out common scenarios (e.g., guy pressures girl to have sex; group pressures guy to prove he is a “man”). The skits have proven especially popular. Guided role plays encourage youth to tap into personal experiences and

¹³ The Kit was created in collaboration with Pathfinder International, the Ethiopian Youth Network, SAVE, various on-the-ground groups, and the active participation of Ethiopian youth.

STICKING TO THE INDICATORS

The Champion Community Initiative, in all its various iterations, is a behavior change program. The test of any behavior change program is whether it does in fact lead to positive improvements in designated indicators.

Both the Madagascar and Ethiopia youth programs described here were designed to address individual as well as community indicators. These are:

INDIVIDUAL INDICATORS

- Delayed sexual debut
- Secondary abstinence
- Partner reduction and mutual fidelity
- Increased use of ARH/SRH services and VCT
- Increased correct and consistent use of condoms by sexually active youth

COMMUNITY INDICATORS

- Stigma reduction and active acceptance and participation of PLWA
- Care and Support of PLWA
- Active youth leadership in community HIV/AIDS activities
- Increased involvement from parents and other adults

For the most part, these indicators were not put forth as the “simple doable actions” of AED’s youth programs. The real challenge was to design activities and goals that would address the key determinants of target behaviors in order to promote these desired changes.

Qualitative research can help reveal important determinants. Even more helpful to these programs, however, was the process of working with young people and families to come up with role plays and skits that “strike a nerve.” Through extended brainstorming and pretests with young people, the programs have tried to zero in on how young people can confront what to them are the most difficult challenges of HIV/AIDS.

In the end (or rather in a few months) a quantitative evaluation will measure whether these determinants, and these activities, do have a strong link to the desired indicators.

anxieties, as well as the creativity and high energy and humor of their age group. Role plays also push participants to reflect on how to negotiate typical situations successfully.

Another key element of the Kit is the illustrated Youth Passport. Each adolescent receives a Passport as his or her own personal resource about reproductive health and as a guide for assessing his or her own risk for HIV/AIDS, thinking about setting boundaries and resisting pressures, and a place to record personal thoughts.

THE GREAT JOURNEY

The curriculum was constructed along a well-defined framework: that of a Great Journey. Its fundamental objective is not just for youth to “learn” or “grow” or “help others,” but to reach a clearly defined destination—and to reach that destination as a group. It aims not only to create confidence among individuals, but to create collective self-efficacy and a sense that group norms can be changed.

The framework of the *Great Journey* is a variation on the Champion Community approach, with a few distinct features.

The goals of the Great Journey fall into five categories:

- Skill-building: Each member completes 15 skill-building activities.
- Peer education: Fifty percent of club members guide friends through the Youth Passport.
- Outreach: The group carries out three neighborhood activities
- Resource identification: Each member visits an AIDS counseling center or an orphanage.
- Celebration: The group selects and organizes a community-wide activity (festival).



Each of the objectives allows a degree of individual or group choice. For example, ten ideas are presented for ways a group can help support people affected by HIV/AIDS (the “outreach activity”). The Kit also includes a list of imaginative activities that could be included in the club's final celebration. And of course it includes forms for self-monitoring.

The Great Journey goals do not include specific health- or education-related “doable actions.” The underlying behavioral goals of the Journey are prevention of HIV/AIDS, and support for those who are already infected. A quantitative evaluation will assess changes in these key indicators among a cohort of youth after they have participated in the program for around ten months. However, the curriculum itself focuses on a list of behaviors that are linked to and support these indicators. These are the same age-specific behaviors that are the focus of role plays, for example. (*See box on previous page.*)

In order to orient parents and communities to the program, a town meeting is held whenever a club is about to begin the Great Journey. In addition, AED is helping to create 45-second radio spots featuring brief interviews with parents and community leaders. The broadcasts serve to “brand” the program positively and create a draw for new clubs.

In 2004 the Youth Action Kit and the Great Journey were launched in youth clubs in four urban areas. In 2005 the program expanded into rural areas with the support of the Ethiopian Orthodox church. To date it has reached 515 youth groups, 900 schools, and around 42,000 youth. The goal is reach to youth nationwide.

MADAGASCAR

In Madagascar, AED built on this model to create a youth program especially suited to the scouting movement. The idea of working towards well-defined goals and earning “badges,” and a system of “ranks” to indicate levels of achievement, is almost as old as scouting itself. Friendly competition between troops and celebrations of group achievement are also part of the long and popular tradition. AED created the *Ankoay Scout Program*¹⁴ to fit into this framework.

More than half of Madagascar's population is under the age of 20. And the highest prevalence of HIV/AIDS in Madagascar is among 15-19 year olds. Because the epidemic has already spread to the general population, however, few communication activities are targeted at specific groups. AED has been working with the National Anti-AIDS Committee¹⁵ to reach this critical population.

The scouting structure provided an opportunity to design a program with large-scale implementation in mind from the start. The movement is very popular in Madagascar and reaches throughout the country. Troops for both boys and girls are sponsored primarily by the Anglican, Lutheran, and Catholic churches.

¹⁴ *Ankoay* means “eagle” in Malagasy. The eagle is revered as a strong and wise bird. The Ankoay Program is not related to the Eagle Scout program familiar in the U.S. and elsewhere.

¹⁵ This work is being carried out as part of AED's role in Madagascar under USAID's Health Communication Partnership.

The Ankoay program is a minimum package in terms of complexity, training, and cost, and was designed for rapid start-up. To build early consensus, an Ankoay Stakeholders' Meeting (with regional scouting directors and other partners), as well as meetings with scouts themselves, introduced the objectives as well as sample exercises. This also helped generate concrete ideas early in the process.

As in Ethiopia, the task of mapping out “doable actions” and messages central to the program was highly participatory. Brainstorming and many rounds of testing with youth helped zero in on the “every day behaviors” that directly and indirectly support a youth in protecting him or herself and others from HIV/AIDS and other STIs. These became the primary focus of activities and skits. But the program focuses beyond the individual.

Ankoay goals fall into three categories. Broadly stated, a successful troop must:

- Actively engage in developing basic life skills
- Carry out a peer education program
- Reach out to educate and serve the community

Troops can take different paths to achieve these goals. In that sense the structure of Ankoay is more flexible than that of the Great Journey. Four different merit badges focus on different activities, with each badge also allowing for some personal choice. (For example, one of the merit badges is called “Actor, Story Teller,” and provides guidance and goals for more outgoing scouts to develop and perform skits for others.)

The Ankoay program has been launched in three urban areas. By October 2006 it will be rolled out to between 225 and 360 scout troops, serving at least 10,000 young people. The program is also being modified for expansion into secondary schools and sports teams.

CHAPTER 10

JORDAN—HEALTH TRANSITION AND HEALTH COMPETENCE

Jordan is another country with a very young population. Out of a total population of around five million people, three million Jordanians are under the age of 25. Unlike Madagascar and Ethiopia, however, Jordan is a country undergoing an epidemiological transition. Chronic conditions such as diabetes, obesity, and cardiovascular diseases are beginning to replace infectious diseases as the leading causes of morbidity and mortality. These conditions are associated with unhealthy lifestyles—in particular, smoking, lack of exercise, and poor nutritional habits.

Many unhealthy behaviors take hold at a very young age. In 2003, around 43 percent of youth between 13 and 15 had tried smoking.¹⁶ The Global School Health Survey for 2000 found that 13.5 percent of school-aged children were at risk for developing obesity. That year, around 90 percent of 12 year-olds and 92 percent of 15 year-olds suffered from dental caries. The prevalence of micronutrient deficiencies (vitamin A, iron, and iodine) are all high among youth.

USAID's Health Communication Partnership (HCP) has been working in Jordan with both the Ministry of Health and the Ministry of Education to design a participatory school-based program for youth in early secondary school (grades 7-10).

¹⁶ Global Youth Tobacco Survey, 2003.



The Ministry of Health asked HCP to focus on four basic health areas: exercise, nutrition, hygiene, and anti-smoking. The project combined these under the umbrella theme, “Our Health, Our Responsibility.” It structured goals, content, and activities around the concept of the “health competent school.”

The effort overlaps with several high priority programs in Jordan. Among these are the King Abdullah program for youth (modeled on the President's Challenge Physical Activity and Fitness Awards Program), an ongoing revision of the overall school health curriculum, and a national initiative to shift educational approaches in general away from passive memorization to critical thinking and problem-solving.

The Ministry of Health asked HCP to focus on four basic health areas: exercise, nutrition, hygiene, and anti-smoking. The project combined these under the umbrella theme, “Our Health, Our Responsibility.” It structured goals, content, and activities around the concept of the *Health Competent School*. A school that achieves this status has met specific criteria indicating that its students can make informed choices about their health, that students reach out to influence peers and family members, and that the school itself has developed a partnership with the community (parents and local leaders) to promote a healthy climate.

A major design workshop brought together a mix of representatives from the Ministry of Education, the Ministry of Health, school administrators, teachers, and parents. This group proposed an initial mix of “doable”

behaviors targeting the four health areas. These included ten student behaviors as well as eight supportive family behaviors. (See box on next page.) A menu of activities for each health area, as well as a list of school-community goals, were also proposed to support these behaviors. Supplemental materials are being created for the suggested activities. These are both curriculum based (for specific classes such as vocational education, science, and physical education) and extra-curricular.

Each participating school is expected to establish a steering committee (a small number of teachers, the school principal, community representatives, and students) to decide on yearly goals and pick the school-community activity. Examples of the school-community goals include:

- Introduction of healthy food and elimination of junk food in the school canteen
- Elimination of smoking on the school premises
- A yearly health festival including contests, theater, posters, youth-led advocacy, etc.
- Establishing a sports or physical activity program in the community run on a volunteer basis by parents



BEHAVIORS FOR “TRANSITION”

The Ministry of Health asked that HCP focus its school health program on four areas: exercise, nutrition, hygiene, and anti-smoking. The first task, as for all Champion programs, was to identify the small number of “doable actions” that would be central to all program activities. These are:

TEN HEALTHY ACTIONS

- Say No to smoking
- Help a friend to Say No to smoking too
- Earn the King Abdullah Fitness Award
- Exercise vigorously 30 minutes a day
- Have a traditional breakfast of cheese, egg, olives, thyme, olive oil and bread
- Eat at least 2 serving of fruits and 2 serving of vegetables every day
- Decrease the consumption of soda and sweets
- Brush your teeth at least twice a day
- Wash your hair at least twice a week
- Use soap to wash your hands before eating and after using the toilet

In addition the program devised “Eight Family Actions” to support the student in making these changes.

Involving family members is just the first point of outreach. Other activities in the program also involve parents and members of the broader community in facilitating healthy behaviors by youth. Although lack of exercise, smoking, and other personal lifestyle choices lie at the root of many chronic diseases, social and cultural norms make choices more or less difficult for young people to make. “Our Health, Our Responsibility” therefore applies equally to the individual and the community.



The process encourages choice and innovation by individual schools.

A draft *Activity Book* explains the package of goals, the process for selecting activities in each health area, and the various steps for carrying out the program. The program also includes a *Scenario Book* for role plays, and a *Monitoring Manual*. Feedback during the current pilot stage will help refine the whole process further.

The Health Competent School Initiative has been launched in a small number of pilot schools representing a mix of public, private, and military institutions in both urban and rural areas. The program will be rolled out district by district. The Ministry of Education is especially pleased that teachers are being introduced to more participatory approaches to learning. Ultimately, not only the behaviors of students, but the behaviors of teachers, may be changed in positive ways.

CHAPTER 11

MOVING FORWARD



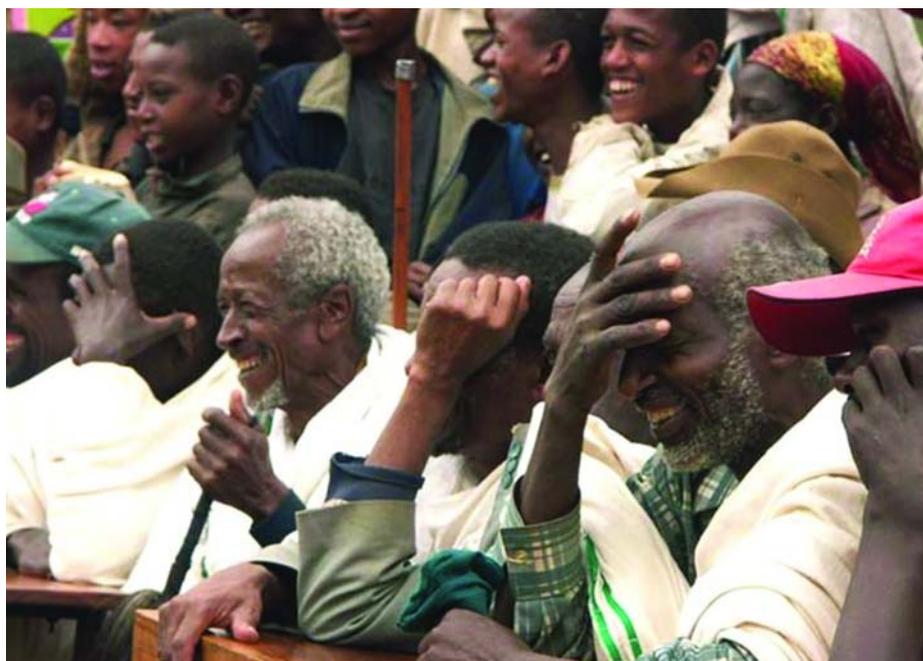
As the Champion Community Initiative has evolved over the last ten years, a number of basic principles and a few inherent challenges have emerged.

- The process of setting goals is critical. Objectives must strike a “happy medium” in terms of number, difficulty, time to completion, local choice, and other factors.
- Negotiation of goals is paramount. And consensus may be even harder for collaborating partner organizations to reach than for communities themselves.
- The enthusiasm of local populations is fundamental. Celebrating collective achievements and even challenges is more important than “winning” per se. The objective is to build a sense collective efficacy so that energy is harnessed over time.
- Mass media—to announce competitions and highlight specific goals as well reward the “winners”—contributes greatly to the scale of program impact.

Each of the various iterations of the Champion Community approach has aimed to balance public priorities—in health, education, or the environment—with the immediate concerns of local communities.

- Phasing of the approach, so that local energy is sustained and refocused over time, is being tried in different ways. (A purely linear process—where goals are reached and activities “end”—is not a successful development model.)
- Various ways of monitoring and advising the whole process are also being worked out. District teams, local NGOs, and other partners have taken different roles according to available resources and intended program scale.

Each of the various iterations of the *Champion Community* approach has aimed to balance public priorities—in health, education, or the environment—with the immediate concerns of local communities. Each of the programs has aimed to combine the urgency of major development indicators with the energy of grass roots enthusiasm. And each of the approaches has aimed to achieve short- to medium-term gains for large populations. These elements are all essential to development efforts in the context of decentralization. 11





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