Documentation of Best Practices in *Seqota Declaration* Program In Ethiopia

Shebedino Woreda, Sidama Region

International Institute for Primary Health Care (IPHC-E) — Ethiopia

In Collaboration with

Nutrition Coordination, Multisectoral and Sekota Declaration Desk, Ministry of Health-Ethiopia

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ACRONYMS

AFRO	African Regional Office for the WHO
AIDS	Acquired Immuno-Deficiency Syndrome
ANC	Ante-Natal Care
CHWs	Community Health Workers
CSO	Civil Society Organization
EPHA	Ethiopian Public Health Association
ETB	Ethiopian Birr
GtN	Growth through Nutrition
HEW	Health Extension Worker
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
IFA	Iron and Folic Acid
IPHC-E	International Institute for Primary Health Care — Ethiopia
KM	Knowledge Management
LMICs	Low-and-Middle Income Countries
MNHN	Maternal and Newborn Health and Nutrition
MOH	Ministry of Health
NGO	Non-Governmental Organization
NNP	National Nutrition Plan

PHC	Primary Health Care
PNC	Post-Natal Care
PSNP	Productive Safety Net Program
SDG	Sustainable Development Goals
SDSO	Seqota Declaration Strategic Objectives
UNICEF	United Nations International Children’s Emergency Fund
USAID	United States Agency for International Development
WASH	Water, Sanitation, and Hygiene
WHO	World Health Organization
WMS	Woreda Management Standard
WTP	Woreda Transformation Plan

SUMMARY

Background: Although Ethiopia has recorded a steady and impressive reduction in stunting over the past decade, levels remain high and stark geographical inequalities persist. To address these problems, on 15th July 2015, the Government of Ethiopia announced and implemented the Seqota Declaration that commits to ending stunting among children under 2 years by 2030. However, little is known about the documentation of this program's practices and the effective implementation of Seqota Declaration programs in Ethiopia. Identifying and documenting such practices could help strengthen health systems and improve health outcomes.

Objective: To document best practices (if any) of the Seqota Declaration and lessons learned with focus on intersectoral collaboration, structure and community engagement, and reasons behind outcome related factors in Ethiopia,

Methods: The study involved a mixed-methods data collection in one woreda (Shebedio in Sidama Region) where the Seqota Declaration has been implemented. The study site was identified in consultation with MOH and IPHC-E. Key informants were interviewed from experts within the Federal Ministry of Health, one Regional Health Bureau and Shebedino District Health Office, and health care facilities within the district. In addition to the health sector, the administration of the study woreda, as well as other sectors like education, agriculture, livestock, water, irrigation, energy that are parts of the implementation of the Declaration were included in the data collection. Documentation of best practices was also verified by observation and collecting and analysis of data on the experiences of implementation of the program activities within the selected woreda. The qualitative data were transcribed in verbatim and analyzed thematically.

Findings: The Seqota Declaration has adopted initiatives that include the ideals of primary health care — coupled with other innovations has made it possible for favorable health outcomes. The costed woreda based multi-sectoral nutritional plan

coupled with the political commitment gained from regional to woreda levels has resulted in the institutionalization of as a culture of multi-sectoral collaboration. Community labs and the first 1,000 days plus public movement have been instrumental in mobilizing households and the community at large to closely monitor and prevent stunting from the time of pregnancy until two years of age. At Farmers Training Centers, agricultural innovation and technology and data revolution are additional initiatives for knowledge and skill transfer as well as for using cutting-edge technological developments for local level health status gains in terms of enhanced implementation of nutrition interventions and improving nutritional status of the community.

Lessons learnt and conclusion: Addressing childhood malnutrition as an important health problem, the Seqota Declaration has demonstrated the effective operationalization of the main principles of primary health care (multi-sectoral collaboration to improve nutritional status of under two year children) in bringing about favorable health outcomes — by significantly reducing the prevalence of stunting in the program implementation areas. Leadership commitment, Intersect oral coordination, community involvement, focus on prevention, as well as using appropriate technology (in terms of adapting local cultural practices as strategies to serve health gains) are among the main conceptual bases for Seqota Declaration implementations — and can be considered as exemplar that can be adopted by customizing to the contexts of health care as well as other socio-economic development interventions.

1. INTRODUCTION

1.1. Background

Malnutrition in all its forms is a global burden that affects almost every country in the world, leading to serious public health risks and incurring high economic costs. Improvements in nutrition will contribute significantly to reducing poverty and to achieving health, education, and employment goals (1). Nutrition stimulates economic growth, which improves the mental health and physical productivity of the labor force. Globally, hunger and under nutrition reduce gross domestic product by US$ 1.4—2.1 trillion a year (2). The World Bank estimates that undernourished children are at risk of losing more than 10% of their lifetime earning potential, thus affecting national productivity, and recently, a panel of expert of economists at a Copenhagen Consensus Conference concluded that fighting malnutrition should be the top priority for policymakers (3). Although Ethiopia has recorded a steady and impressive reduction in stunting over the past decade, levels remain high and stark geographical inequalities persist. Eliminating under nutrition in Ethiopia would prevent losses of 8—11% per year from the gross national product (1, 3).

Sustainable development is a driver of malnutrition reduction; improved nutrition will propel sustainable development. Evidence indicates that the forces that prevent healthy growth and development in such a profound way—hunger, disease, poverty, disempowerment and unhealthy environments—are powerful. Therefore, these need to be counteracted by equally powerful multisectoral and multi-stakeholder forces combining actions that are nutrition-specific, nutrition-sensitive, and environmentally enabling at all levels. Hence, nutrition is placed at the heart of the SDGs—indeed, nutrition is vital for achieving 12 out of 17 SDGs. The remaining 5 SDGs support improvements in nutrition (1).

To address these problems, on 15th July 2015, the Government of Ethiopia announced its multi-year plan to end stunting in Ethiopia named after one of Ethiopia's worst

famine-stricken areas, the Seqota Declaration commits to eradicating the underlying causes of chronic under nutrition and ending stunting among children under 2 years by 2030, rearming its commitment to nutrition as a foundation for economic development. The Seqota Declaration has been endorsed and embedded into the National Growth and Transformation Plan, making it among Ethiopia's highest-level commitments (4).

The Seqota Declaration is a government initiative that was aimed to end stunting by bringing together relevant nutrition-specific, nutrition sensitive and infrastructure sectors of government to break the cycle of under nutrition. The initiative is divided into three phases, each of which supports and accelerates the implementation of the National Nutrition Plan II (NNP II) across multiple sectors (namely health, agriculture and natural resources, livestock and fishery, water, irrigation and electricity, education, labor and social affairs, women and children affairs) - while also driving six areas of innovation (PDU, AITEC, community lab, data revolution, CWPB, and the first 1000 days). The Seqota Declaration is supported by multiple development partners working collaboratively to facilitate the effective networking and streamlining of resources. This has included the deployment of technical partners and the implementation of joint financing by multiple donors to support the innovations. The first phase of the Seqota Declaration was implemented in 2016—2020 in 40 districts (woredas). It focused on spurring innovative interventions across 10 Seqota Declaration Strategic Objectives (SDSOs) to which all stakeholders (government sectors ministries, regional bureaus, development partners and technical partners) are contributing resources using the common planning framework (4).

Therefore, the aim of this "Best Practice Documentation" was to document best practices of the Seqota Declaration and lessons learned with focus on intersectoral collaboration, structure and community engagement, and reasons behind outcome related factors for scaling up to end stunting in Ethiopia.

1.2. Statement of the Problem

Although vast gains have been made in nutrition and health outcomes over the past four decades in Ethiopia in general, it is unclear to what extent these gains can be attributed directly to Seqota Declaration implementation. In spite of the significant gains achieved in the implementation of the Seqota Declaration in reducing malnutrition, reports highlighted that such progress has been uneven among and within Seqota Declaration implementation woredas, posing ongoing challenges to achieve equity in information or there is documentation gap especially in best practice in Seqota Declaration (5-8).

Improving the national nutrition status was therefore a priority area that needs urgent policy attention to accelerate socioeconomic progress and development. In 2013 the Government of Ethiopia together with the African Union Commission published "The Cost of Hunger in Ethiopia 2013," a report that quantifies the social and economic impact of under nutrition. The total annual cost of under nutrition in Ethiopia was estimated at ETB 55.5 billion, equivalent to 16.5% of GDP in 2009. Accordingly, Ethiopia could reduce losses by ETB 148 billion by 2025 if underweight rates were reduced to 5% and stunting to 10% in children under 5 (from 2014 levels of 25% and 40% respectively). Reducing child under nutrition rates to half to the current levels by 2025 could reduce losses by ETB 70.9 billion (9).

Similarly, according to a study in Thailand, Implementation of PHC goes back to 1977 which began to give service to its largely rural population. Successes include adequate child nutrition rising from 47% between 1979 and 1982 to 79% by 1989, through a program of nutrition surveillance, nutritional cooperatives and encouraging families to grow nutritional crops. Similar successes were achieved in immunization status, access to clean water and sanitation, and the availability of essential drugs. One of the strategies they used were intersectoral collaboration with education, agriculture, and community development (10).

It would be strengthened by extending inquiry to facility-level best practices at lower levels of care, especially in LMICs. Available positive deviance studies of primary care documentation of best practice, innovation and replication as key factors differentiating best performance (5, 11). The objective of documenting and sharing “best practices” is to enable persons and organizations working in the health sector to avoid reinventing the wheel; to improve performance and avoid the mistakes of others (13). Such exchange of knowledge not only facilitates improvement of current practices, but also helps those starting new interventions to avoid common mistakes (12, 13). This may create the opportunity to acquire knowledge on lessons learned, on how to improve and adapt strategies and activities through feedback and reflection in order to implement large-scale and sustained interventions in a manner that avoids wasting resources (14-16).

Despite vast advances in information and communications technology, those advances have not always been effectively taken up and used at scale to positively impact health and well-being and, in many countries, data have been of poor quality, limited or non-existent, or poorly documented. Therefore, the aim of the current study was to identify and document best practices in the effective implementation of the Seqota Declaration in reducing malnutrition in Ethiopia.

1.3 Significance and Justifications for the Study

Identifying, documenting, analyzing, and sharing best practices are among the key knowledge management strategies within an organization. By identifying, documenting, and analyzing best practices, important elements can be captured, including success factors and lessons learned as well as issues essential for scaling up the best practices (such as social, environmental or cultural aspects). In addition, sharing best practices helps to adopt innovation such as new techniques, technologies or methodologies (13).

Effective knowledge sharing and application enables countries to benefit from exchanging experience and hard-won solutions with one another. This means the

health sector have to be able to find, use, and share knowledge on experiences of what works and the lessons learned. As per one of its aims, the International Institute for Primary Health Care — Ethiopia (IPHC-E) planned to document and share the best practices of the *Seqota Declaration* implementation as part of its activities in knowledge generation and management. The knowledge generation and management focuses on generating and synthesizing evidence for policy/practice input and making accessible for national and global knowledge on PHC to its constituents especially ministries of health and implementing partners. IPHC-E plays a key role by generating innovative ideas, testing these and other ideas in community innovation centers, and consolidating learning and best practices to facilitate knowledge transfer among PHC facilities and achieve the highest possible impact, in the transformation of PHC systems (27).

Thus, since the *Seqota Declaration* requires a continual feedback loop to integrate lessons learned into subsequent activities and design; the main rationale of this project was documenting and sharing best practices of the Seqota Declaration to enable MOH and other key concerned organizations working in the health sector to avoid reinventing the wheel in the efforts to end stunting by 2030 (13).

Moreover, within this assessment and documentation of the best practices in the implementation of the *Seqota Declaration* activities, the parameters used will be: effectiveness, relevance, feasibility, innovation, collaboration, accountability, and potential replicability. The documentation also serves as a stepping-stone for other researchers who are interested to conduct studies in similar settings for further best practices documentation and dissemination.

2. LITERATURE REVIEW

Despite Ethiopia's significant progress over the past 15 years in reducing stunting by achieving on average a 1% reduction every year, 37.6% of children under age 5 are still stunted (17). There have been a number of nutrition related interventions in Ethiopia among which is the USAID-supported and Feed the Future-funded Growth through Nutrition (GtN) (2016-2022) project. This was a multi-sector, integrated nutrition program that aimed to reduce stunting/chronic under-nutrition by 20% with the objectives of strengthening government capacity to develop and institutionalize national nutrition programs and policies; Increasing access to diverse, safe, and quality food for rural communities; and improving nutrition and health care services (18). Nutrition International has supported a Maternal and Newborn Health and Nutrition (MNHN) care package that includes: increased antenatal care (ANC) quality and attendance; provision and consumption of iron and folic acid (IFA) supplements in pregnancy; newborn and postnatal care (PNC) including facility delivery with skilled birth attendant, optimal timing of cord clamping, timely initiation of breastfeeding, cleaning the umbilical cord, and nutrition counseling (19). CARE also has the "Feed the Future Ethiopia — Livelihoods for Resilience Activity" - a 6.5-year USAID project running from December 5, 2016 through July 31, 2023. This project has supported Productive Safety Net Program (PSNP) households to build resilient livelihoods with improved food and nutrition security, even in the face of shocks and stresses (20).

Furthermore, the government has recognized that this pace is not sufficient and requires innovative strategies to meet the ambitious goal of ending stunting by 2030. *The Seqota Declaration* (which was managed under the National Nutrition Strategy II and implemented by the sectors) envisions fundamentally addressing the root causes of under nutrition in a highly challenging environment by fostering intersectoral collaboration; and reaching vulnerable households with integrated, high-impact interventions. The plan encompasses: climate- and nutrition-smart investments and

interventions; improving diets, water and sanitation at the household level; and ensuring sustainable agricultural production and practices (21). It is aimed at improving the health and nutritional status of women, children under two and adolescent girls through: ensuring 100% access to adequate food, transforming productivity, confirming zero post-harvest food loss, enhancing innovation around promotion of sustainable food systems (climate-smart agriculture), providing universal access to water supply, as well as through improving gender equity and women's empowerment, multisectoral coordination and capacity building at all levels.

The need for an initiative for ending stunting by 2030 has been justified by the fact that stunting was decreased only by 1.3% per year between 2000 and 2015 (from 57% to 40%) — and moving with such pace will result in the rate to be 27% by 2030. Therefore, an innovative approach has been required to achieve a target of 0% by 2030, and the Seqota Declaration Implementation Plan is being executed in three phases over a 15-year period in which the first five years innovation phase was (2016 — 2020) focuses on prioritized innovative and proven high impact interventions that was tested and evidence generated for the expansion phase is (2021 -2025) to more stunting prevalence Woredas with in the regions and scale up will be (2026-2030) phase throughout the country. The innovation phase was implemented in selected high stunting prevalent Woredas in Amhara national regional state (26 Woredas) and Tigray regional states (6 Woredas) along the Tekeze River Basin. Again, the Seqota Declaration innovative phase was divided into two. The first part was preparatory period (2016 — 2017) and the second part was implementation period (2017-2020) where this comprehensive multi-sectoral coasted nutrition sensitive, nutrition specific and infrastructure interventions were implemented (22, 23).

Countries are expected to benefit tremendously from exchanging experiences and hard-won solutions with one another. However, one of the significant barriers to knowledge-sharing and reapplication of experience is the limited culture of information and knowledge documentation and sharing. Although relevant knowledge may exist in

people's minds, it cannot always be tapped or it may exist in formats that limit people's ability to know about it or find it. This underscores the need for decision-makers, health professionals, communities and other key stakeholders to be able to find, use and share knowledge on experiences of what works and lessons learned (24).

A "Best Practice" is commonly defined as "a technique or methodology that, through experience and research, has proven reliably to lead to a desired result (25). Best practices are exemplary public health practices that have achieved results, and which need to be scaled up so as to benefit more people or is knowledge about what works in specific situations and contexts, without using inordinate resources to achieve the desired results, and which can be used to develop and implement solutions adapted to similar health problems in other situations and contexts. The expansion and institutionalization of successfully tested best practices requires strategic planning. There are several creative and constructive actions by people and organizations in the health sector to improve the health outcomes of people. Disseminating knowledge of such actions widely may prevent the repetition of mistakes and loss of valuable time. Documenting and sharing best practices affords one the opportunity to acquire knowledge on lessons learned, how to improve and adapt strategies and activities through feedback, reflection and analysis, and implement large-scale, sustained and more effective interventions (24, 26).

3. OBJECTIVES

3.1 General Objective

The general objective of this assignment is to identify, case study, analyze, and document for dissemination of best practices in the effective implementation of *Seqota Declaration* programs in Ethiopia.

3.2 Specific Objectives

1. To collect and analyze data on the experiences of implementation of the Seqota Declaration program activities within the selected site; and

2. To prepare a document on best practices of Seqota Declaration for dissemination

4. METHODS

4.1 Study Area and Period

According to the Seqota Declaration baseline report, implementation has been taking place within two regions (Amhara and Tigray); 40 woredas (districts); 1,970 schools; 11 hospitals; 179 health centers; 741 health posts; 227,700 households; 4,685,744 people; 255,106 children under two; and among 158,659 pregnant and lactating women and later it has been expanded to other regions like Sidama and Oromia (27).

The study for the best practice documentation was conducted in Shebedino Woreda of Sidama Region — which was purposively selected through consultation with the Seqota Declaration program Office at the Federal PDU and the International Institute for Primary Health Care - Ethiopia. Shebedino is one of the 30 woredas within Sidama Regional State — and it has an area of 148.60 sq km. The population of the Woreda was estimated to be 199,626 (99,251 females and 100,375 males) in 2012 EC, residing in three urban and 21 rural kebeles[1].

[1] Sidama Regional Bureau of Plan and Development. Regional Statistical Abstract. 2012 EC.

Within the selected district for studying the best practices documentation observation and assessment was conducted during September 10 to October 20, 2023.

4.2 Study Design

The study used a mixed-methods approach in which both observational and desk review quantitative and qualitative data were collected.

4.3 Study Population

Initial desk review was conducted regarding the formulation and implementation of the Seqota Declaration — coupled with country experiences in the design and implementation of similar initiatives.

The study population for the qualitative study were: health care providers, health extension worker, managers employed in district health offices, primary hospitals, health centers in Shebedino Woreda and experts from MOH and the selected Regional Health Bureaus, and all other sectors that had been on the job for more than six months. The key informants for the qualitative study were selected purposively from: Federal Ministry of Health; Sidama Regional Health Bureau; Shebedino District Health office; Shebedino District Seqota Declaration Office; Shebedio District Agriculture Office; Shebedio District Education Office; Shebedio District Water, Mine and Energy Office; and Shebedino District Women and Social Affairs Office. All key informants interviewed were technical committee members.

The data collection tools were prepared before undertaking the study, and the draft of these tools are attached in the annex of this report.

4.4. Study Variables

4.4.1 Outcome variables

- Identified best practices from implementation in the Seqota Declaration Program;
- Best practices for documentation in the Seqota De*claration* Program.

4.4.2 Predictor variables

- Programmatic factors - Training: duration of pre-service training, type of training institution, type of training;
- Health system factors: feedback system, organizational communication, relationship with top managers, availability of financial resources, availability of job description, mechanism of assignment to position, mode of career advancement, opportunities to share with peers, and having collaborations with other sectors outside health sectors.

4.5. Criteria for Identifying Best Practices

Effectiveness, feasibility, relevance, replicability, innovation and learning, partnership and multi-sectorality, accountability, novelty, and documentation were used to identify best practices site — in collaboration with the Seqota Declaration Program and IPHC-E.

4.6 Data Collection

An in-depth interview guide was prepared for the qualitative study. A checklist for collecting quantitative data was also prepared. The two investigators themselves conducted the data collection activities.

Using the questionnaire, data were collected and identified best practices were documented from key informants working in woreda health office, health center, health posts, woreda education office, woreda agriculture office and from a key informant from an NGO working closely with woreda health office.

Before and after the assessment extensive review of literature was conducted on best practices, policy and strategies of Ethiopia and other documents.

4.7. Operational Definitions

- **A best practice** is a relevant policy or intervention implemented in a real life setting and which has been favorably assessed in terms of adequacy (ethics and evidence) and equity as well as effectiveness and efficiency related to process and outcomes.

Other criteria are important for a successful transferability of the practice such as a clear definition of the context, sustainability, inter-sectorality and participation of stakeholders (28). According to WHO's guide for documenting and sharing best practices in health programs, identification of best practices was done by considering the criteria based on the following aspects:

- **Accountability (Good governance and transparency):** The extent of transparency with clear structure for participation, management and decision-marking.
- **Effectiveness:** The extent to which the practice's objectives were achieved (measurable results) figure out the major factors influencing the achievement of the objectives.
- **Feasibility:** Ease of possible implementation which is not complex and complicated and benefit the beneficiaries easily.
- **Innovation and learning:** Perceived new approach related to new technology or technique, managerial process and participation approach.
- **Partnership and multi-sectorality:** Degree of collaboration between stakeholders, especially the local community and national or local authorities in all phases of activities.
- **Potential for replicability:** Obtaining consistent results across studies aimed at answering the same scientific question, each of which has obtained its own data.
- **Relevance:** The degree of addressing the priority problem of the community.
- **God father and Mother:** These are community members who are influential and highly regarded by the community, and selected based on their willingness and commitment to support growth and monitoring of nutritional status of children in their respective kebeles. Three - five children from low income households are

assigned to them in order to support screen and monitor the nutritional status and the growth of the children. They give order to the mother to bring their children to the health post to monitor the weight of the children and to screen nutritional status of the children every month. If the weight of the children decreases or is not increasing, they link them with the health center for additional nutritional supply or better treatment.

- **Primary health care unit** referred to the district health system comprised of a primary hospital, a health center and five health posts that are connected by a referral system.
- **Primary health care unit managers** included district health office managers, assistant district health office managers, managers of health centers, unit leaders (case team leader, nursing head, etc.), health extension worker supervisors, and the chief executive officers, chief clinical officers and general managers of primary/district hospitals.

4.8. Data Analysis

Qualitative data were analyzed thematically (based on best practice and experience of implementations of Seqota Declaration) and narrated in the pattern of effectiveness, relevance, feasibility, innovation, potential for replicability linked way.

The entire audio taped interviews were transcribed to local language and then translated to English. The translated responses were read thoroughly line by line by the investigators independently and common codes were given through discussions. Finally, the codes were summarized into the pre-defined major themes, and then triangulated with the quantitative data. Verbatim quotations were also used to illustrate individual responses.

Regarding observation of best practice sites, documents and practices were reviewed from selected sites. A guideline on 'How' to review and document and 'What' to document was prepared by the research team.

The desk reviews were also be analyzed descriptively as appropriate. Open-code software was used for coding and analyzing the qualitative data.

4.9. Ethical Considerations

Project proposal was presented and ethical clearance was obtained from Institutional Review Board (IRB) of **the Ethiopian Public Health Association (EPHA)**. Letters of support to conduct the study were obtained from MOH as well as the from Sidama Regional Health Bureau.

This is a study that used mainly desk reviews, administrative official interviews, and observations of program activities. Even though there were interviews with program implementers and beneficiary individuals, these did not involve manipulations or experimentation of participant human subjects. Before data collection, participants were informed about the purpose of the study using study information sheet prepared for this purpose. Their right to refuse participation and discontinue the interview were also explained. The interviewers discussed the issue of confidentiality and obtained verbal consent from all study participants before actual data collection. In addition, study participants were assured that any identification information including their names are not going to be written in the questionnaire. No interviews were conducted unless the informed consents of the participants were obtained.

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5. FINDINGS

5.1. Characteristics of Key Informants

A total of 20 key informant interviews (KII) were conducted for the assessment of the best practice for the initiative. The key informant interview participants were program delivery unit officers at federal Ministry of health, Senior Program Manager at the Sidama Regional Office, Head of Shebedino Woreda Health Office and all team members of Seqota Declaration at woreda level, Sediqa[2] Kebele Community Lab Demonstration Site Coordinator, and eight beneficiaries (four males and four females of the Seqota Declaration at Sediqa Kebele of Shebedino Woreda.

The majority of the participants were married at the time of the interview. The educational backgrounds of the KII participants were ranged from no education to PhD level. The age of the key informant interview varied from 28 to 61 years. The work experience in the current position of the key informant ranged from 3-6 years in this specific project. Each KII took on average 1hour (25-1:40 minutes) (see annex table 1).

5.2. Implementation of the Practice

5.2.1 Organizational arrangements

The Seqota Declaration is an Ethiopian Government commitment which was launched in 2015 GC to prevent and end stunting among children of age less than 2 years. Its name was derived from the Seqota Town of Waghimra Zone, Amhara Region where it was launched initially - as the Waghimra Zone was one of the areas where high burden of stunting existed. Initially started in 40 woredas of Tigray and Amhara Region, the program planned to avert 7.8 million children from being stunted, and thereby, end stunting by 2030 within three phases that include: Phase one (2016 - 2020); Phase two - expansion phase (2021 - 2025); and phase three - national scale-up phase (2026 — 2030). The 40 woredas were selected as they had high level of stunting at the time,

[2] Sediqa is a kebele found in Shebedino Woreda where a community laboratory activities are being practiced, and beneficiaries were selected from this kebele.

and the lessons learnt from these woredas are to be scaled up to further 700 woredas — according to the initial plan.

The Seqota Declaration came up with six innovation activities that include:

1. **Federal and regional level delivery units** — that involve coordination at Federal and Regional levels as well as woreda level multi-sectoral platforms;
2. **Community labs** - a social mobilization model used to identify, prioritize, and solve problems by community members themselves;
3. **First 1,000 days plus public movement** — an innovation strategy based on the fact that this is a critical period for child development (physical as well as mental). Thus, the target time for the prevention of stunting is focused from pregnancy up to two years of childhood;
4. **Agricultural Innovation and Technology Center** - Financial self-sustainable modernized medium scale enterprises to enable the agricultural transformation of small farmers and medium scale enterprises to modernized entities through knowledge and technology transfer from Israel;
5. **Costed woreda-based multi-sectoral nutrition investment plan**; and
6. **Data revolution** (an online web-based system linking with linkage from kebele tofederal ministry level). Data revolution is an important component of the monitoring and evaluation of the progress of the program. In addition, it is a key and mandatory component for accountability and for taking corrective actions based on set indicators that are high impact and with high sensitivity and specificity for nutrition. The program is monitored and evaluated every month at woreda level, every quarter at regional level, and every six months at federal level. Data for monitoring and evaluation come from all sectors as well as from all woredas and kebeles included in the program.

The leadership of the program is cascaded from the federal level (chaired by the Vice Prime Minister); to regional levels (chaired by Regional Presidents); to woreda levels (chaired by woreda health offices); and to kebele levels (chaired by kebele

chairpersons). In addition, the following ministries are also included as stakeholders: Health; Agriculture & Livestock Resources; Water, Irrigation, & Electricity; Education; Labor and Social Affairs; Women, Youth, and Children Affairs; Environment, Forestry, and Climate Change; and Livestock and Fishery. At regional and woreda levels, the respective bureaus and offices of the above ministries were also represented.

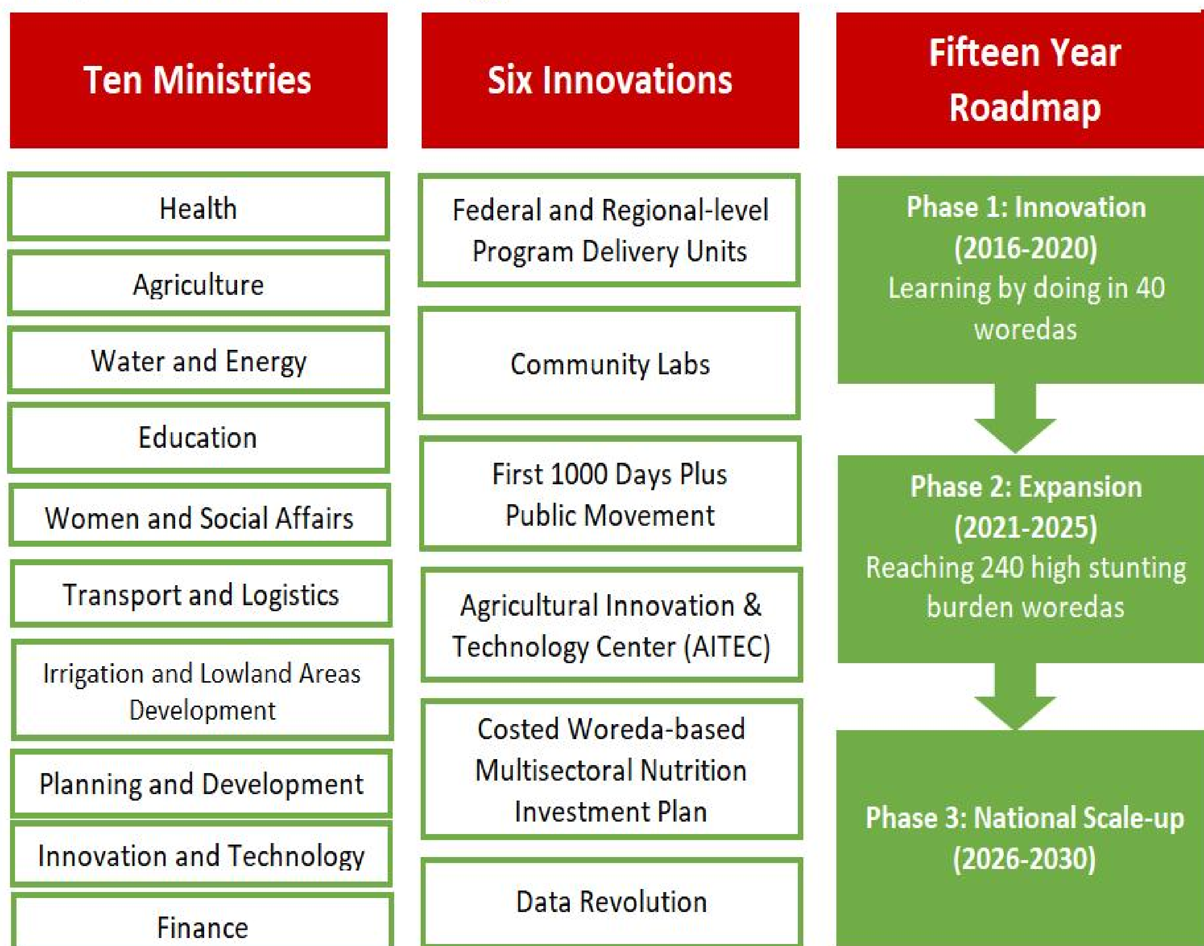
The coordinators at all levels are heads of woreda health offices - and the activities are already institutionalized and monitoring and evaluation is at its cabinet level. All these arrangements ensure that there is high level commitment, accountability, and transparency among the government structure of the program.

The Sidama Regional Government has established and launched a Food and Nutrition Council that governs all food and nutrition multi-sectoral interventions (that include the Seqota Declaration Roadmap) within an overall framework of the National Food and Nutrition Strategy[3]. The Council, therefore, closely monitors the planning, implementation, and evaluation of the initiative. There is also a Seqota Declaration Coordination Office with a main function of bringing all sectors together to bring about change in the implementation of the initiative's activities. These functions include: planning of all activities, supporting the woreda team in the implementation of each of the activities, monthly and quarterly monitoring of the activities, providing supportive supervision, and budgetary support to each of the sectors involved in the implementation of the *Declaration* activities.

[3] Sidama National Regional State. Food and Nutrition Strategy and *Seqota Declaration* Expansion Phase Aligned Four Years Strategic Plan (2015-2018 EFY). Hawassa; *Seqota Declaration* Program Office, July 2022.

The overall implementation strategy for the Seqota Declaration has been depicted in figure 1 below. At the regional level, bureaus corresponding to the ministries involved are represented.

Figure 1: Implementation Strategy[4]



Shebedino is one of the woredas where the implementation of the program was launched in 2014, and at that time the prevalence of stunting in the woreda was around 35%. Within the Woreda, beneficiary kebeles were selected for the program based on availability of extreme poverty, prevalence of stunting, absence of other donor activities, and willingness of the community members to implement that program

[4] Sidama National Regional State. Updates on Seqota Declaration Program Implementation. Hawassa; 2023.

activities. Among the 27 kebeles in the Woreda, six of them are beneficiaries for material support (goats, chicken, seeds, and other items) — in addition to support in health promotion and awareness creation. Full packages are given for pregnant and lactating mothers who are living in poverty (verified by a screening committee at the kebele levels). As the rest 21 kebeles are food self-sufficient by themselves, they are being supported only in terms of awareness creation and health promotion activities in a manner that lead to change in sanitary and dietary practices — including harvesting and utilization of diversified and fortified foods to prevent stunting.

5.2.2. What are the main activities carried out?

The Sidama Region Seqota Decalaration PDU coordinates all nutrition-sensitive and relevant sectors to work together to prevent stunting in under- two years of children. There are foods in the area which are nutritionally very important, but not being consumed for cultural reasons. The Coordination Office worked to bring about behavior change in this regard among community members. In addition, it provided goats, chicken, and vegetables to community members with the goal of preventing stunting among children.

According to Sidama Region Coordinating Office, the following activities were performed within the various sectors that are involved in the program:

1. **Agriculture -** there is farmer demonstration center where demonstrations are made on bi-fortification, chicken house construction, cooking corner, and dietary diversification. The center is open for the surrounding community all the working days. In addition, food and seedlings are distributed to community members. Pregnant and lactating mothers are also provided with three goats and five chickens each — coupled with awareness and nutrition-related literacy on the productivity and utilization of these items for food. Different types of vegetables are also provided to prepare forage by mixing with animal products. Furthermore, women are encouraged and to get empowered through harvesting food items

beyond their consumption so that they can market them to other community members as mechanisms for income generation. Demonstration and trainings are also given by the sector on how to prepare land and plots for planning seeds and vegetables and on how to become productive in all aspects. Seedlings are also provided for the farmer after approval of land preparation as per the training given to them.

2. **Women and Children Affairs** — Activities have been done to increase awareness in the prevention of early marriage and school dropout among girls. Low-income households are selected among community members to enhance their economic status and empowerment. Women and children affaires office activities are integrated within the school system in which awareness activities are carried out in schools with the collaboration of school community. If early marriage or school dropout come as problems, the specific school sends report to the Women's and Children Affairs Office which will take immediate action on the issue.
3. **Health Sector —** What is being done in the health sector is counseling on micronutrient, immunization, increasing health seeking behavior, growth monitoring, increasing iron or folic acid supplementation for pregnant mothers, as well as cooking demonstration at community and facility levels.
4. **Education sector-** Increasing awareness at schools for children is being conducted using mini-media on the topics of prevention and control of infection and easily transmittable diseases, as well as on promotion of hygiene and sanitation. Key messages are regularly delivered on the subject of sanitation — coupled with the setting up of mini hand washing facilities at school levels. In addition, demonstrations are made at school levels on food and gardening. Students are also considered as change agents for the program as they are expected to teach and transfer hygiene and sanitation related behavior to their families.
5. **Water sector —** Around 12 million Birr has been allocated the previous year for Water, Sanitation, and Hygiene (WASH) related activities from this sector, and seven million has been provided for the same program from Sidama Region for

2023/2024 budget year. Water holes are being dug in areas where there is water shortage. The above budget is being used to dig water wells in areas where there is water shortage in the Woreda.

5.2.3 Who were the key implementers and collaborators?

The implementation of the Seqota Declaration activities mainly used the government structure — coupled with community organizations that include religious leaders, local community groups and structures. In addition, popular public figures were also used as champions for the program.

From the beginning, sector offices are working collaboratively to end stunting in the Woreda (agriculture, health, education, water, women and children affairs).

5.2.4 What were the resource implications?

Budget support for the Declaration activities come partly (50%) from government and the rest through partnership and community involvement. The Federal Government has allocated 500 to 700 million birr for the program. Regional governments also allocated resources and, for instance the Amhara Regional Government has allocated 260 million for the program. Primary SD budget flows from two directions. One is from government treasury and the other is from donors or development partners. Both are sent to the Ministry of Finance and Economic Cooperation (MoFEC), and then it is sent to Regional Bureau of Finance and Economic Cooperation (BoFEC), and then to the Zonal Office of Finance and Economic Cooperation (ZoFEC), and then to the Woreda Office of Finance and Economic Cooperation (WoFEC), Finally, it is expended for purchases of goods and services as well as for personnel costs at the Woreda level. The Region and the Woreda are also expected to allocate a one to one matching fund for the program.

According to current estimates and projections, the program needs additional budget to meet its final target. Budget availability is ensured through:

- Partner mapping to mobilize resources tracking system;
- A web-based fully operationalized resource tracking system tools;
- Training to woredas on how to find and track resources;
- Universities helping in resource tracking, data, collection, and analysis.

5.3. Results of the Practice — Outputs and Outcomes

5.3.1 What were the concrete results achieved in terms of outputs and outcomes?

According to Federal level key informants, the overall progress of the program is promising, and at the time of this report the average scorecard performance nutrition indicators in the district were 72% in 2014 EC and 79% in 2015 EC (showing 7% percentage points improvement per year in reducing stunting). The target 3% per year reduction of stunting has been achieved, and the program is moving in the direction of scaling up from 40 to 240 woredas. Projections also show that the overall goal will be achieved by 2030 as per the plan of FMOH.

As health outcomes are results of multi-dimensional factors, attribution of the achieved results solely to the program may be difficult. However, the fact that the program implementation also considers the roles of all sectors and partners can take control of this problem. Furthermore, wherever the inputs come, the program focuses on what has been done and what has been achieved. In the long-run, the plan is to have one plan, one goal, one report, and one financing system for the program. In this manner, all contributors to the program celebrate the successes equally without any separation, and there will be a single report on the outcome of reduction of stunting.

Among the achievements of the program mentioned by key informants in Sidama Region include:

1. Households are able to multiply the chickens and goats they are given in addition to utilizing products (meat, goat milk, and eggs) as food for lactating women and small children;
2. They have instituted a monitoring mechanism where it is impossible for the household to sell the goats or the chickens without the knowledge and permission of the Sekota declaration committee members which is available and working at woreda level. Furthermore, if chickens or goats die because of some reasons, they will take pictures of the dead animals and give wittiness to this committee. So, the monitoring and support mechanism for the beneficiary is very strong.
3. Households are producing and cultivating vegetables (cabbage, carrots, etc.) and variety of fruits — using them for food as well as selling the excess for neighboring community members;
4. Setting up of information revolution system that includes the development of mobile application software to track behavioral change within communities regarding food habits and nutrition behavior;
5. Change the behavior of the community on food fortification, breast feeding complimentary feeding, husband engagement in prevention of stunting, mobile application software is developed and data was tracked using this system,
6. Joint supervision as well as joint review meetings with all stakeholders have been made to assess nutrition-sensitive indicators, and performance of activities within all sectors has increased by 10%;
7. Water wells dug in kebeles are used for drinking, hand washing, as well as for irrigation;
8. In terms of environmental sanitation, latrines are constructed and open defecation has been avoided in the area;
9. Water for drinking, for irrigation and for sanitation at household level.

Figure 2: Goats and chickens multiplied by households

One best practice that was mentioned among key informants in Sidama Region is the fact that there is a practice of selecting **God fathers and God mothers (Waka Alah)** from within the community who will be responsible to follow up and monitor the nutritional status of their God-children by regularly bringing them to health facilities for growth monitoring and screening for signs of stunting. Another intervention used was to bring about the influence of local priests to persuade community members to consume goat milk (rich in protein and important in preventing stunting) — which, otherwise was considered a food taboo in the area.

In addition, households are clustered for demonstration of different initiative related activities that include clusters for milk production, chicken production, meat production, as well as fruits and vegetables production.

Figure 3: Harvesting cabbage by households

5.3.2 Was an assessment of the practice carried out? If yes, what were the results?

According to key informants in Sidama Region, the data revolution platforms of UNISE at Woreda and kebele levels provide information on what is going on at household level. These platforms report consumption patterns from ten districts every week, and help to display how much productivity has increased. In addition, continuous online and in-person supervisions that are conducted every ten days provide pictures on the situation and the progress of implementation of program activities.

Indicators that are used in monitoring and evaluation of the program implementation include: number of households with folic acid supplementation and number of pregnant mothers screened and counseled at ANC; seed and seedling production; egg production; and fruit production. Regular supervision and periodic review meetings are among the mechanisms used in monitoring and evaluation of activities.

In addition, table 2 below demonstrates the success of the health sector performance as per the plan in Shebedino Woreda (extracted from the Declaration activity report for 2015 EC). Accordingly, most of the reported activities have shown high performance. More specifically, acute malnutrition has gone down to below 2% in the Woreda — and this was because awareness has been created among mothers who made it their culture to continuously monitor the weight of their children at health facilities - based on the first 1,000 days initiative. Mothers with children who are found to be underweight are counseled and provided with supplementary feeding with TSFP. In addition, those with severe malnutrition are referred to health facilities (Table 1).

Table 1: Excerpts from 2015 EC Health Sector Plan Versus Performance Assessment (Shebedino Seqota Declaration program)[5]

Indicator	Plan	Performance	%
Woreda Performance			**96.76**
Health -Sector Performance	**# and or %**	**# and or %**	**93.16**
Proportion of pregnant women supplemented with iron and folic acid at least 90+	7,080	6539	92.36
Proportion of PLW screened for acute malnutrition	7,080	6340	89.55
Proportion of pregnant women counselled for nutrition during ANC	7,080	6340	89.55
Proportion of GMP participation among children under 2 years of age	10,599	10340	97.56
Proportion of PLWs that participated on cooking demonstrations (at list one)	7,080	6340	89.55
Proportion of children 6-59 months of age received two doses of vitamin A	28,524	28540	100.06
Proportion of pregnant women who received deworming tablet	7,080	6665	94.14
Treatment outcome (cure rate) for management of severe acute malnutrition	100	91%	91.00
Proportion of children of 24-59 months dewormed biannually	21,342	21450	100.51
Proportion of adolescent girls supplemented with iron and folic acid (IFA)	16,679	12,450	74.64
Percentage of households with access to improved latrines & hand washing facility	22,425	21197	94.52

[5] Sidama Region. *Seqota Declaration* performance report for 2015 EC. Hawassa; 2023.

Percentage of open defecation-free kebeles	14	11	78.57
Percentage of health facilities with access to safe and adequate water supply	6	5	83.33
Percentage of health institutions with access to improved latrines & hand washing	29	16	55.17
Proportion of health facilities providing nutrition assessment and counselling services for people with HIV/TB and other infectious diseases	6	6	100.00
Proportion of clients with HIV/TB and other infectious diseases who received nutrition assessment and counselling services	189	215	113.76
Proportion of people with MDR TB screened and received therapeutic feeding	5	7	140.00
Proportion of clinically undernourished people on ART receiving food supplement	28	11	39.29

The performance pattern for the other sectors also extracted and shown in annex table 2. To mention some of these achievements:

- **Education sector:**
    - Gardening in schools is being practiced;
    - There are school clubs where plots are prepared and with seeds provided, students practice gardening to become productive as well as to transfer the knowledge gain to their families. Plots are prepared by school clubs, and seeds are supplied. Students practice gardening to become productive and share what they learn with their families;
    - Mini-media in schools are used for health promotion activities;
    - Water harvesting and rehabilitation activities are also performed in schools;
    - WASH systems are also implemented in schools.
- **Water sector**
    - Coverage of water at household level increased by 2%;
    - Water treatment at household level is now practiced;
    - Water-agar has been provided to households to clean drinking water;
    - Hand washing practice has increased from 43% to 45% at school level the preceding year.

- **Women and Children Affairs office**
    - Awareness creation activities on prevention of early marriage, school drop-out, as well as on first 1,000 days feeding activities;
    - Enhancement of male involvement in supporting pregnant mothers;
    - Enhancement of growth monitoring activities;
    - Enhancement of immunization service utilization;
    - Income generation activities for females initiated.

The following are verbatim quotations from some of the key informant interviews:

According to head of the Shebedino Woreda Health Office, stunting was being prevented using innovation system as well as cultural practices such as GOD father and mother: According to head of the Shebedino Woreda Health Office, stunting was being prevented using innovation system as well as cultural practices such as GOD father and mother:

"We prevented around 27 children from stunting using GOD fathers and God mothers. GOD fathers and God mothers follow the families of those children and bring them to health facilities to monitor their growth. They also follow them through home visits and give nutritional advice to their families"

KII Respondents (Shebedino Woreda Health Office)

Another key informant from the Woreda explained her activities as follows:

"*By now, we have increased awareness of our community on food preparation. Food items are available at their homes. However, because of low awareness and cultural issues, they never eat these foods in proper manner, and they usually used to expect getting food from other*

area or other sources. But now they have realized that the food items at their homes can be used appropriately for their consumption".

KII Respondent (Seqota Declaration Coordinator at Shebedino Woreda)

Another KII respondent added his experience as follows:

"Yes……, goat milk is rich in protein and it will prevent stunting. Therefore, we use priests to drink this milk and show it to the community. From that day onwards, community members believe that goat milk can be drunk and can serve as medicine for their children in order to prevent stunting".

KII Respondent (Regional Coordinator of Seqota Declaration)

According to a beneficiary at Sedika Kebele:

"They gave me seeds for all type of vegetables, and I started to harvest them here in my village. We use some of the products for food, and I sell the rest earing about 3,000 birr at one time. In addition to these my children are in good health conditions."

KII Respondent (Beneficiary from the Program in Sedika Kebele)

A female beneficiary at Sedika Kebele feels:

" … oh now I am very happy, look at my children they are healthy, we cultivated the vegetables given to my family here , goats are given to me, in addition water wells are dug in my garden, I get water for household and for the vegetables from here. So, my children get everything from their garden. I thank you all of you"

6. DISCUSSION

This study aimed at assessing implementation of best practice of the Seqota Declaration in averting acute malnutrition among under two years children in one of the program woredas. Accordingly, the aggregate nutrition indicators in the study woreda (Shebedio) 72% in 2014 EC, and 79% in 2015 EC — showing 7% improvement per year in in intervention coverage between the two years. The target 3% per year reduction of stunting has been achieved, and this shows, the overall progress of the program is promising. Projections also show that the overall goal will be achieved by 2030 as per the plan at national level. This finding is comparable to the results of studies done in Thailand and Gurage Zone of Ethiopia as well as the best practices assessment of primary health care in Eastern Ethiopia [10, 28, 29]. This achievement could be due to: high level commitment from leadership in implementation of the program, the inter-sectorial collaboration (as seven sectors were collaboratively working together to end stunting in this Woreda). Use of innovative approach such as God Father and God Mother to screen and link malnourished children to health facilities, as well as community engagement and ownership of the program were also among the key pillars for the success of the program in the Woreda. This achievement could be due to: high level of commitment from the leadership at all levels, the accountability and transparency in implementation of the program, as well as due to the inter-sectorial collaboration (as seven sectors were collaboratively working together to end stunting in this Woreda). Use of innovative approach such as God Fathers and God Mothers to screen and link malnourished children to health facilities, as well as community engagement and ownership of the program were also among the key pillars for the success of the program in the Woreda.

According to key informants from the study Woreda, there are many achievements related to program implementation. For instance, households are able to multiply the chickens and goats they are given in addition to utilizing products (meat, goat milk, and

eggs) as food for lactating women and small children. They are also producing and cultivating vegetables (cabbage, carrots, etc.) and variety of fruits — using them for food as well as selling the excess for neighboring community members. This is considered as one of the best practice of the community to sustain the interventions, and the practice is similar with many studies [4, 10, 31], and could be due to proper implementation and monitoring of the program as per plan. In addition it could be due to engagement and ownership of the community in implementing social and Behavior Change Communication (SBCC) activities in implementing of a diverse diet for women and children, providing fruit and vegetables to children and improving household security.

Another implementation factor that led to the success of the program is setting up of information revolution system that includes the development of mobile application software to track behavioral change within communities regarding food habits and nutrition behavior and data tracking system. This application is uploaded on the mobile apparatuses of HEWs and on community members. Then using this application, information related to the nutrient provided for children are sent to them and to the Woreda Coordinator on daily bases. Then the Coordinator gives feedback on obtained data on weekly bases for each household using the same application and unique household ID. This is supported by different studies [30], and it can be due to the fact that nowadays information communication Technology (ICT) is becoming vital tool in changing behavior as well as tracking data among communities.

In terms of environmental sanitation, latrines are constructed and open defecation has been avoided in the area, and this is among the least achieved activities within the implementation plan. Water for drinking, irrigation and for sanitation at household level is being used. This is in line with the government agenda the possibility of achieving regarding environmental sanitation related sustainable development goals in Ethiopia [32, 33].

According to data from Shebedino Woreda, acute malnutrition has gone down to below 2% from the previous rate of 35%. This is because awareness has been created among mothers who made it their culture to continuously monitor the weight of their children at health facilities - based on the first 1,000 days initiative. Mothers with children who are found to be underweight are counseled and provided with supplementary foods. In addition, those with severe malnutrition will be referred to health facilities for additional food supplementation [4, 33].

Regarding education sector, students started practicing gardening in schools with consequent transfer of such knowledge gain to their families. Mini-media in schools are used for health promotion activities. Water harvesting and rehabilitation activities are also performed in schools in addition to implementation of WASH systems. Because of such activities, the coverage of water at household level has increased by 2%, and hand washing practice has increased from 43% to 45% at school levels and significant number of students have transferred this knowledge to their households to start the practice of gardening their residential areas. Similar findings were reported in a study in Rwanda where school level gardening is an important means for prevention of malnutrition among school children [34]. This practice can also be helpful in transfer of nutrition-related information and improving household food security with the result of increasing children's chances of growing to adulthood. Furthermore, school gardens and school-feeding programs can encourage school attendance and bring direct nutritional benefits to children.

According to the findings of the assessment, Women and Children Affairs Office also supports the implementation of the program in awareness creation activities for the prevention of early marriage, school drop-out, as well as on the "first 1,000 days" feeding activities. Furthermore, this Office has contributed in the process of enhancement of male involvement in supporting pregnant mothers. growth monitoring, and immunization service utilization. These findings are also supported by a study done on school dropout and early marriage as a cause of malnutrition [35]. Such

activities of this sector are critical in averting the root causes of malnutrition and are important parts of the national strategy for improving nutritional status of children.

7. LESSONS LEARNT AND CONCLUSION

7.1. Lessons Learnt

7.1.1 What worked really well — what facilitated it?

According to key informants at the Federal level of the program leadership, the following were considered as success factors (especially for the innovative phase):

- Commitment and ownership by federal and regional governments;
- Rigorous planning, approval and leadership during implementation at all levels;
- Financial allocations from the treasury and regional governments;
- Collaboration and effective networking with development partners;
- Deployment of technical partners and assistances to support the innovations;
- Community lab related activities;
- Focus on first 1,000 days and social movement;
- Global and regional recognition;
- Active participation of communities in problem identification and discussions on solution options within their own kebeles.

In addition to capacity building training given to members of the woreda leadership, volunteer service providers (Bego Melektegna) were trained at each of the kebeles. Awareness creation activities are also conducted among members of kebele councils so that they take full ownership of the program activities for preventing stunting at household levels. More specifically, the interventions that brought about significant reduction in stunting are:

1. Agricultural interventions resulting in improved coverage of complementary feeding among infants and young children averted the greatest number of child deaths.

2. Based on program performance records, 75% of households in the target population were reached; and
3. Improvements in infant and young child nutrition (achieved through complementary feeding and reduced household food insecurity brought about by improved access to nutrient-dense and diversified foods) accounted for 90% of the stunting cases averted.

Based on information from key informants in Sidama Region Coordination Office, changing awareness and behavior of communities regarding nutritional practices to prevent stunting has been considered as successful. Some households also improved productivity of nutritional items by multiplying the number of goats and chickens they were originally provided. In some instances, neighbors of these households have taken lessons from them to adopt the practices and change their livelihoods.

Among the opportunities that facilitated the implementation of the activities include:

1. All the districts in the Sidama Region are accessible with all-weather roads, and this is especially so for Shebedino Woreda — as relatively compared to other woredas in the country;
2. There is political commitment from the regional as well as district level leadership. For instance, there is a regular integrated supportive supervision at the woreda level that monitors stunting prevention activities of schools, health facilities as well as farmer training centers (FTCs).
3. When there is any gathering or meeting at cabinet level, Sekota declaration program and averting malnutrition among children less than two years of age is the primary agenda for the first 5-10minutes
4. The community is willing to be engaged in the initiative activities;
5. They engaged from beneficiary identification to implementation of the program
6. The presence of highly motivated and functional women development army at kebele levels;

7. The presence of previous experience in vegetables and fruits production in the woreda and in the region in general.
8. Presence of fertile soil as well as the farming culture of the society that facilitates vegetable and fruits production

What did not work — why did it not work?

Of course, there are practices and activities that did not work as planned. Among such practices and activities are the low achievements against plans for:

- Proportion of health facilities with access to safe and adequate water supply services was only 51% and those with access to improved latrines and hand washing facilities were only 47.8%;
- Achievement in the number of established nutrition demonstration centers was only 53.7%, and those of established nursery sites in kebeles were only 48.7%;
- Proportion of primary schools with school feeding programs was only 14.5%, and
- Proportion of HHs engaged in fish production was only 1.3%.

However, the program uses a learning-by-doing approach and, therefore, modifies those practices according to lessons learnt and based on local context. As the innovation activities are implemented at small-scale, it is easy to make corrections — as well as to scale-up successful ones through diffusion to local households.

Among the obstacles faced during the implementation of the program activities, one can mention the following:

1. There is deep-rooted poverty among the community — and most households rely on their work as daily laborers for their livelihood;
2. Rapid population growth and land degradation are threats for community development unless actions are taken to control them;

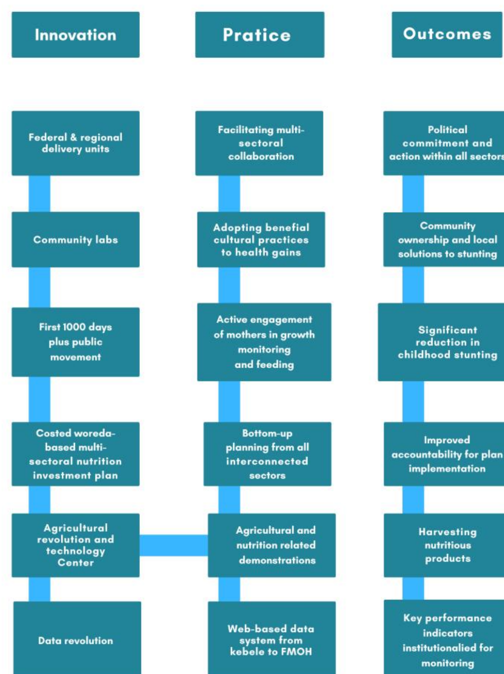
As there are no separate human resources (due to shortage of budget) for the program activities, there are work-loads on personnel that take the responsibilities across the various sectors, and these might have implications in terms of affecting the sustainability of the program.

7.2. Conclusion

7.2.1 How have the results benefited the population?

The benefits to the population from the program activities can be demonstrated on the basis of innovation-activity-outcome framework that has been adopted by the initiative. Accordingly, each of the innovations have led to various program activities that in turn resulted in outcomes of that correspond to the objectives of the program. Based on the findings from the assessment, the innovation-results framework that facilitated the outcomes can be summarized as in figure 2 below.

Figure 4: Innovation-Results Framework



7.2.2. Why may that intervention be considered “Best Practice”?

Among the reasons for considering the Seqota Declaration interventions as “best practice” would be the fact that they are implemented in a manner that also address the issues of equity. The program has a scheme for systematically selecting pregnant and lactating mothers within low-income households to be in the priority list among the beneficiaries. The selection process is made with full engagement of community members. Women with disabilities, those with no husbands (single, widowed, and divorced) were among those prioritized. The beneficiaries in the priority list were offered goats, chickens, seeds, vegetables, as well as financial and technical support.

According to key informants in Shebedino Woreda, the following were to be considered as success stories for the program:

1. The fact that it is a multi-sectoral nutrition-sensitive activity with regular monitoring from all sectors. For instance, all the seven sectors (health, agriculture, education, water & energy, innovation technology, women & children affairs, and plan & development office) work together as one office on planning, implementing, and monitoring of the stunting prevention activities in the woreda; Even though they did not get additional incentives from the program, in addition to their regular activity they are fully committed to support in averting malnutrition in the woreda.
2. Political commitment that led to the allocation matching funds from regional and woreda governments as well as other partners. For instance, the
3. President of the Region and the leaders of Shebedino Woreda always raise the issue of stunting during each and every political meeting and give directions on prevention strategies; Sekota declaration is a primary agenda in all of their meetings they conduct.
4. The culture of using “God Fathers and God Mothers within the community for the involvement of growth monitoring and referral of children to health facilities.

These "**God fathers and God mothers**" are assigned by the Woreda Steering Committee (see operational definition).

7.2.3 Recommendation for those intending to adapt the documented "Best Practice" or how it can help people working on the same issue(s)

Among the recommendations that can be forwarded from the lessons learnt from the Seqota Declaration best practice — for those who may want to adopt the experiences include:

- That leadership commitment is mandatory since the effectiveness of the program highly relies on the support of the political leaders in its implementation and monitoring. Even though leadership commitment is essential for the program, the fact that the program activities are institutionalize within the system would make it eventually sustainable even in the face of change of personalities in the leadership positions;
- That health-related practices need multi-sectoral implementation to bring about required outcomes — as it has been seen that the involvement of all the development sectors are working together to achieve the goals of the program;
- Innovation is required to come up with new practices that can be enriched through learning by doing as one can mention the assignment of "God fathers/mothers; and
- Community involvement and empowerment is mandatory.

The institution of cultures like '**God-fathers/mothers**' is also a practice that can be taken as a lesson for adaptation in other circumstances, but need to contextualize it accordingly. The activities in behavior change coupled with the tracking system by the change agents; learning journeys that take place every three (at district level) to six months (at regional level) are also practices from which others can learn.

In addition, the fact that the program activities are institutionalized by the government has made it resilient even in drastic situations. For instance, the government did not

discontinue its support during the period of COVID-19 as well as during the conflict in Tigray Region.

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