ADDIS ABABA UNIVERSITY
RESEARCH AND GRADUATE PROGRAMS OFFICE
REGIONAL AND LOCAL DEVELOPMENT STUDIES
(RLDS)

The Impact of NGOs on child well-being through Child-Centered Community Development In Antsokia-Gemza Woreda: The Case of World Vision Ethiopia

BY

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THE IMPACT OF NGOS ON CHILD WELL-BEING THROUGH CHILD CENTERED COMMUNITY DEVELOPMENT IN ATSOKIA-GEMZA WOREDA
(The Case of World Vision-Ethiopia)

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ACRONYMS

BCG	Bacille Calmette Guerin
CARE	Co-operative for American Relief Everywhere
CIP	Child In Program
CRDA	Christian Relief & development Association
CSA	Central Statistics Authority
CSR	Customer Relations Service
DPPC	Disaster Prevention and Preparedness Commission
DPT_3	Diphtheria, Pertusis and Tetanus
E	East
FY	Fiscal Year
HHH	Household Head
HH	Household
HIV/AIDS	Human Immunodeficiency Virus/Acquired Human Immunodeficiency Syndrome
ILO	International Labor Organization
Km.	Kilo meter
MEDAC	Ministry of Economic Development and Cooperation
MES	Malaria Eradication Service
MICAH	Micronutrient And Health
MOE	Ministry of Education

MOH	Ministry of Health
MM	Millimeter
Mt	Meter
N	North
NGOs	Non-Governmental Organizations
NNGOs	Northern NGOs
NNGOs	National NGOs
INGO	International NGO
ICA	International Cooperation Administration
OECD	Organization for Economic Co-operation and Development
Oxfam	Oxford Committee for Famine Relief
PHC	Primary Health Care
SNNPR	South Nations, Nationalities and Peoples Region
SSA	Sub-Saharan Africa
STD	Sexually Transmitted Disease
TB	Tuberculosis
TGE	Transitional Government of Ethiopia
TT_2	Tetanus Toxoid
TTI	Teacher Training Institute
UK	United Kingdom
UN	United Nations
UNDP	United Nations Development Program
UNICEF	United Nation Children's Fund

URTI	Upper Respiratory Tract Infection
WVE	World Vision Ethiopia
WHO	World Health Organization
WVI	World Vision International

Translations of Amharic Terms: -

Ato: -	In Amharic, a title of an adult person that replaces Mr.
Birr: -	Ethiopian Currency, 1$=8.56Birr
Kebele: -	Locality
Tsebel: -	Medicated water
Kolla :-	A tropical type of zone
Woina Dega:-	A warm temperate type of zone
Dega:-	Cool temperate type of zone

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Abstract

These days child well-being is becoming a universal issue to many academicians, scholars, governments and international organizations since their basic needs are not being met. Most of the children do not have the best start and most of them suffer from war and violence, poverty and economic crises, and diseases including HIV/AIDs. This is also true to Ethiopia.

Based on this fact, the study tries to assess the impact of World Vision Ethiopia on the well-being of children in the area of education and health through child centered community development in Antsokia-Gemeza Woreda.

The study used household, sponsored children survey, focus group discussion, interviews, and collect data to be analyzed. The result shows that most of the community has benefited from the program in which sponsored children, the main source of fund, seems abandoned to have direct benefit from the program for the last four years.

Therefore, the well-being of today's children as a whole and the coming generation can be changed if NGOs and other agencies keep their commitment and make the necessary investment in primary education and basic health services. These services have the power to pave a way for a lifetime of improved health and education and contribute to economic growth too.

INTRODUCTION

1.1 BACKGROUND OF THE STUDY

The study focuses on the impact of World Vision Ethiopia on the well-being of children both in the area of Education and health through child centered community development in Antsokia-Gemza Woreda. Sponsored Children are also considered.

Non-government controlled welfare and community organizations have existed long. However, in the last two decades, Non-Governmental Organizations (NGOs) have mushroomed and grown enormously everywhere, which are voluntary agencies. These include religious groups, private foundations, and charities, research organizations, and federations of dedicated physicians, civil society organizations, and citizen associations. Sometimes they are established as one people's organization, disseminating its principles and ideas to other places; or they can be an amalgam of people's organizations.

The scope of the worry the organizations have widened, to the extent that they are now involved in a single country and frequently function with local community at a grass root level, rural development projects, in urban areas, in relief and refuge camps, that is, almost in every aspect of human need and endeavor. Some of them have global impact and significance and while others deal with individuals, particular communities or groups at the local level. Some of the international NGOs include Save the Children, CARE, Oxfam, World Vision International, and Plan Parenthood, Green Peace, Amnesty

International and others that serve the public on a national and international level. It is believed that NGOs are motivated by the desire to care and develop society and help bring important changes in the life of the society through establishing and operating programs of education, health, social welfare and economic improvement, specially among the disadvantaged groups (UNDP, 1993)

In recent years, NGOs have also been involved in sustainable social, environmental and economic development. They are also engaged in issues of peace, democracy, human rights, and gender equity and in the right and well-being of children. In doing this, they directly or indirectly encourage and extend democratic practice.

NGOs have also long been tackling with alternative approaches of community development as early as the 1960s. Though in many countries the number of institutionalized public services were growing, but had weakness as most of the institutions created dependency and stripped of human dignity. Their efficiency to bring equity and the ability to solve problems or meet emergency needs were their major weaknesses. Was this really development? In an attempt to answer this question, alternative community development approaches began to develop; by the time NGOs were involved. The new alternative is engaged more in change and development rather than in care and welfare activities. This approach is based on human involvement, participation, empowerment, human resource mobilization, creating new means for human needs fulfillment and influencing government polices and systems. This was a new approach and has changed the relationship between Governments and NGOs.

The size of the NGO sector varies widely across countries. The United Nations Development Program estimates that probably 250 million people are " touched " by NGOs (20 per cent of the 1.3 billion people living in absolute poverty in developing countries) in developing countries across the world and the figure will move up considerably in the years ahead (Dunn and Bell, 1996). Recent information estimates that there are about 25,000 registered and experienced International NGO working at grass root level through out the world (Paul, 2000).

Regarding their relationship with governments, most NGOs have different methods as to how they work with. Some organize noisy protests and demonstrations while others prefer sober education or quiet diplomacy. Some, "name and shame" those in power who abuse citizen rights and produce detailed studies to inform policy makers (Campbell, 1996, Edwards and Hulme, 1992), while others work closely with government authorities. There are others who are not often accused of corruption, violating of the law, gross failure to live up to their mandates or other serious abuses compared to the frequent scandals of corruptions and abuse of authority by officials of nation states. However, there are some who are undemocratic and unaccountable.

World vision Ethiopia, is also one of the International NGOs, which has been in Ethiopia since 1975 due to the enduring and harmful drought that causes poor health, education, sanitation, and poverty as a whole where most of the people of Ethiopia were exposed to famine specially children and women. Since then, it has been working with the

disadvantaged and poorest groups of the community at a grass root level and plays an important role in carrying out with its diversified development activities such as agriculture, environmental protection, education, health, gender development and other programs where child well-being is the main area of focus. These days, the organization has about 54 projects with a total sponsored children population of 114,741 in the national states of SNNPR, Amhara, Tigray, Oromiya and Addis Ababa (WV, 2002).

Having said this, the study attempts to see the change that World Vision has brought on the well-being of children as a whole and sponsored children in particular, since they are the main source of World Vision's fund, in Atsokia-Gemeza Woreda.

1.2 STATEMENT OF THE PROBLEM

Children who have better access to education, nutrition, immunization, clean water and sanitary environment opportunities are likely to be better in their physical, social and emotional status and making them more productive, healthy and law abiding adults. However, children were seen invisible as individuals and expected to work as soon as they get physically strong. Children have been also neglected and most of the governments failed to give due attention to the well-being of children in providing basic social services like safe water and sanitation facilities, educational and health services. They are rather exposed to poverty, death, and HIV/AIDS infection. In the last decade alone two million children were slaughtered, six million seriously injured, 12 million left homeless and over a million orphaned (UNICEF, 2001)

Nowadays, at least twelve of every thirteen children born will live to see their first birthday, millions of children are used as weapons of war and displaced due to war, 8500 children are infected in HIV/AIDS every day and millions died in Africa. About 200,000 children died from conflicts, others suffer from debt bondage, serfdom or forced labor, prostitution, drug sell or traffic. Some 250 million between the ages of 5-14 work in developing countries out of which 50 to 60 million work in hazardous environment. About 103 million school age children in developing countries are deprived of education out of which 60 percent are girls. Many give hands in the day-to-day domestic chores, others have economical problems to cover school expenses and others are restricted by school distance. More than 40, 000 children die from malnutrition, water borne diseases and poor sanitation every year (UNICEF, 2001)

In Africa, millions are affected by drought and become orphans. Annually some 7 to 10 million households in Africa have had their livelihood wiped out by war and this led to the displacement of many children. Around 20 million people become refugees out of whom 80 percent are women and children. Due to these and other conditions the nutrition, health, education and normal development of children are severely hampered (World Bank, 1996).

Regarding the status of education in Africa, the post-colonial era has contributed a lot for the decline of educational expansion and this has left the continent the least in the world in its educational status. This is also true for SSA in which literacy rate is 64 percent for males and 46 percent for females respectively. But in Middle East and North Africa the figure is 74 for males and 53 percent for females and in the industrialized

countries it is 99 for male and 97 percent for females. The Gross and net enrollment ratio is low, repetition rate is high, and other educational facilities are also poor in SSA (World Bank, 1996; UNICEF, 2001).

Regarding health situation in Sub-Saharan Africa, the situation has worsened. Of the total 40,000 under the age of five who die in a day in the world, 40 percent are from SSA, where an estimated five million children die each year. Mortality rate in general is high, only 65 percent of the children had been immunized against tuberculosis, 50 percent DPT, polio and measles. As far as immunization is concerned it is about 91 percent in the Middle East and North Africa, 66 percent in South Asia, East Asia and Pacific 85 percent and in Industrial countries is 92 percent. Only 44 percent of the children in SSA have access to ORT, which is low coverage as compared to other regions (UNICEF, 2001).

Therefore to respond to the well being of children, nations have developed a plan of action to carry it out. To this effect alliance is formed, conferences, workshops, meetings conducted. Nations have created institutions and signed agreements with NGOs for a better future of children. Religious groups, intellectuals, NGOs work together for the betterment of children. Governments and Institutions have paid little attention to problems of Street Children, orphans, and others but nothing is said about those children who live with their parents and deprived of education, health facilities, nutrition, water and sanitation (UNICEF, 1990).

The United Nation General Assembly adopted a convention on September 1990 regarding the well-being and Rights of children as a whole. World leaders gathered and adopted a Declaration on the survival, protection and development of children. The participants made the following declaration.

> We have gathered at the world summit for children to undertake a joint commitment and to make an urgent universal appeal to give every child a better future (UNICEF, 1990).

The meeting adopted a 10-points program to work for the well-being of children; that is to intervene in health, food and nutrition, education services, clean water and adequate sanitation and to bring a better world to all children. Social services need to develop with the coordination of national, local governments, non-governmental organizations, donors and humanitarian organizations. In doing so the "voice of the child" needs to be better heard in the process. But, the convention is violated everyday ranging from failure to provide access to health care services and primary school to abuse of armed conflicts, forced labor and sexual harassment.

It is during the last three decades that non-governmental organizations also have been involved in development program in developing countries and children have been recognized as the most vulnerable, poor and oppressed. It is to this response that most non-governmental organizations designed child-centered community development programs to address the basic needs of children like health, education, nutrition, literacy and spiritual nurture and work with the poorest of the poor to promote sustainable and transformational development where possible.

When we look at the situation of Ethiopia, the population has grown to 65.3 million in 2001 out of which 44 million are children under the age of 15 (MOH, 2001). However, these children are deprived of education, health and other social facilities. About 80 percent of those 1-year-old children are Immunized of TB, 64 percent of DPT, 64 percent of polio and 53 percent of measles. Regarding Nutrition, 16 percent of infants are born with low birth weight and 47 percent suffer from underweight. Only 24 percent of the total population use improved drinking water sources and 15 percent using adequate sanitation facilities. But the status of developed countries is quite different, water and sanitation is 100 percent fulfilled and 93 percent of 1 year-old child is fully immunized of DPT, 94 and 89 percent are immunized of polio and measles respectively (UNICEF, 2001).

In response to the situation of Ethiopian children, there were different measures taken to improve the well-being of children during the last two regimes. However the TGE has adopted the Convention on the Right of Child and committed to the well-being of children and has given the responsibility to Children, Youth, and Family Welfare Organization. NGOs also begun in the 1940's but they were religious based and they were working with churches providing clothing, food, health care and education especially for the poor children.

However, the 1973/74 and 1984/85 drought of the country attracted many NGOs to the country to help the drought victims through relief and rehabilitation activities. Most of them were assigned to the drought prone areas of the country by DPPC, authorized

government body. However, some NGOs like Redd Barana Ethiopia-Norway, Catholic Relief Service, OXFAM, Save the Children (UK), Save the Children (USA), and CARE Ethiopia were involved in community development mainly by giving attention to the well-being of children through child-centered community development program.

If the situation of child well-being is getting worse in third world countries in general and in Ethiopia in particular, will it be true in Antsokia-Gemeza Woreda too? Or do the intervention of world Vision has brought any change in the status of child education? Is school enrollment of boys and girls are increasing? Is there any construction of school related infrastructure? Are schools supplied with educational materials? Does World Vision also bring change in the availability of health stations for children? Is there any change in the health status of children, immunization? Does the community have access to clean water and sanitation? Do sponsored children benefit from all the activities carried out?

1.3 OBJECTIVES OF THE STUDY

As mentioned in the problem statement, the main objective of this paper would be to assess the impact of World Vision on the well-being of children in the area of education, health, and water and sanitation through child-centered community development program in Antsokia-Gemza Woreda. In addition the study focuses how World Vision program benefited sponsored children in the Woreda and gives policy issues for future research endeavors. Though the government has contributed in the education and health development in the Woreda, the main objective of the study is not to asses the

changes that the government has contributed to the well-being of children in the Woreda.

1.4 SPECIFIC OBJECTIVES

The following are the specific objective of the study: -

1. Assess the Impact of World Vision intervention on the educational status of children,
2. Assess the impact of World Vision program on the Health status of Children,
3. Assess the impact of World Vision intervention on the situation of child meal/day,
4. Assess the impact of World Vision on sanitation and clean water to children,

1.5 THE RESEARCH QUESTIONS

In order to meet the objectives set, the following study questions were raised.

1. Has World Vision brought about any change in the accessibility of education to children?
2. Has student enrollment increased?
3. Has World Vision changed the situation of school facilities?
4. Has World vision brought about a change in the accessibility of health?

5. Has health and immunization coverage of children improved because of World Vision intervention and brought about change in infant mortality rate?
6. Has World Vision intervention brought about a change in water and sanitation?
7. Has World Vision brought about a change in the meal status of children?

1.6 SIGNIFICANCE OF THE STUDY

The findings from this paper will primarily benefit World Vision and other NGOs who are implementing child-centered community development programs, as it evaluates the impact of the program on the well-being of children and will suggest some key issues for further redesign. Those NGOs who did not include child centered programs in their development works may benefit to revisit their approach as to how children become the focus of community development and bring a better change in their education and health status. Still many NGOs are expected to invest more on children since many children are suffering from the lack of education and health. Therefore, those who have concern to invest in the well-being of children in donor countries, international agencies, and charities may also find the paper useful to design, implementation and monitoring of child development program.

1.7 HYPOTHESIS

The interventions of World Vision in Antsokia-Gemza Woreda has brought a change in the well-being of children, sponsored children too, especially in their education and health through child-centered community development.

1.8 STUDY AREA SELECTIONS

World Vision has about 54 projects in 24 Areas in Ethiopia. Nevertheless, most of the projects are recently initiated and they are not the out come of 1985/86 famine. But World Vision Antsokia-Gemza project is one of the oldest projects and has passed through Relief since (1984/85), Rehabilitation (1986-89) and Community development (1990-99) phases.

On top of this, the researcher had a chance to travel to the project area on field visits, trainings, and workshops while working with the organization that help him to develop a better knowledge of the project. Due to these reasons, the researcher used purposive sampling technique and selected Antsokia-Gemeza Woreda as a research site.

1.9 DESIGN AND METHODOLOGY OF THE STUDY

In order to assess the impact of World Vision on child well-being in the area of education and health status through child-centered community development in Antsokia-Gemeza Woreda a combination of several data sources have been used. Primary and secondary sources are used to collect data and information to be interpreted and analyzed.

1.9.1 PRIMARY DATA SOURCES

Primary data was collected from households/families, sponsored children, community members, World Vision staff, Woreda Education, Health and Malaria Eradication Service sector offices, Elementary and Junior secondary School Directors' and students.

Household heads: - They are the main source of primary data since they are the beneficiaries of the program next to sponsored children. They have better information on the impact of World Vision and the changes achieved in the Woreda in the area of education and health as compared prior to World Vision Intervention. Therefore, using a household questionnaire, household heads' view was collected from 169 households with the help of eight enumerators.

Sponsored Children: - Sponsored children are those who have sponsors in the supporting office to whom fund is raised. The information collected from this group is vital to the study since they are assumed to be the target group of the program. The data is collected from 30 school going sponsored children with a help of sponsored children questionnaire and data is collected.

World Vision Staff:- staffs who have been in the project from the beginning and have a direct attachment with sponsored children are taken since they have information on the changes that World Vision has brought about on the life of sponsored children and also

on the benefits the children received. For this reason a discussion is conducted with three project workers. A discussion is also conducted with some of the staffs on project activities and their relationships with government sector offices and community members

Focus Group: - The group is composed of community members, farmers, employee, businessmen and students and they are 12 in number. Information is collected from this group through discussion. The Information is significant to observe a very clear background of World Vision intervention in the area. Most of them are also beneficiaries of the program, were there for a long period of time and know the past and the present situation of the area, and the change resulted due to World Vision intervention.

Woreda Sector Offices: - Health, Education and Malaria Eradication service sector offices were interviewed on different issues regarding the contribution and the impact of World Vision in the Woreda in the area of education and health.

1.9.2 SECONDARY DATA SOURCE

In order to have secondary data books, reports, publications and documents of governmental bodies like Ministry of Education, Health, DPPC, and MEDAC. UNICEF, Save the Children- Norway, Internet and Microsoft CDs like Britannica and Encarta are used. Also sponsored children files, documents and reports of the Woreda Sector offices, and documents of three schools are used.

1.10 SAMPLING PROCEDURE

Sampling Frame: - In order to have household sampling frame; a list of Kebeles from World Vision Antsokia is taken and stratified into agro-ecological zones since it has a direct and indirect impact on the socio-economic life of the people. Based on this, three from Kola, two from Woina-dega and one from Dega were randomly selected, which represents 37.50 percent of the total Kebeles of the Woreda.

Regarding the Households to be surveyed; refreshed list of Households of each Kebele were taken from World Vision Antsokia and 3 percent of the total HHs are selected for the survey. Accordingly, 97 HHs are taken from a total of 3212 HHs from Kola zone, 42 HHs from a total of 1383 from Woina-Dega, 30 HHs also from a total of 1012 HHs from Dega zones. Therefore, a total of 169 households are taken randomly and a household questioner was administered for household heads with the help of eight enumerators by going from house to house. The enumerators had a one-day training as to how they handle the questionnaire. A thoroughly discussion was conducted on the HH questioner before and after a field test on some HHs. Besides the enumerators have proven experience in data collection for long.

Regarding sponsored children, purposive random sampling method is used and 30 school going sponsored children are taken out of 600 and data is collected using sponsored children questionnaire.

1.11 DATA ANALYSIS

Various methods and procedures were used to analyze data collected from the HHHs and sponsored children. The analysis is disaggregated into different variables. Before the data is entered into computer, it was checked with enumerators in the field/study area for errors. A computer program, Statistical Package for the social science-SPSS, has been used for data entry and analysis. The SPSS has given the result in a frequency table. In addition to quantitative data, qualitative information collected were summarized and integrated to the findings while organizing the research paper.

1.12 LIMITATION OF THE STUDY

In undertaking of the study, there were some limitations that appeared to be barriers, which assumed to affect the findings of the study. The major limitations faced were;-

1. Bureaucracy: - It was a problem to get secondary data from ministry offices in Addis Ababa, even after having a letter from RLDS. I recall a ministry office that refused me to show its record rather a lady was assigned to read to me the data I am in search of. In some offices you have to go from door to door to an official sign or will have an appointment by the secretary for some other day. However, Woreda sector offices are so cooperative that it was simple to get information and dates if available.

2. Time: - To get any data in any ministry office, NGO and others it is normal to go twice or three times on appointment to have permission from officials and or in order to get information, data and or use libraries as it is mentioned

earlier. This put visible pressure in terms of budgeting the time. Therefore, in order to meet the deadline set by RGPO, I have increased the number of enumerators.

3. Data: - Some offices have no written, well-organized data, or report rather you read from charts put on the walls, or they may go around and look for report papers and collect data and give you after days but they provide you with contradictory information or data for an issue. Some have rich libraries with old books but not well organized to find out materials that you need. Data collected from household heads are attitudes of the people and also about 27.21 percent of the sample HHH were not involved in responding the questionnaires and will have some limitations.

4. Finance: - The financial constraint forced the researcher to look the issue under discussion only in one organization. However, it would have been better if other similar NGOs were included in the study.

5. Accessibility: The physical feature and the scattered type of settlement had been a problem of using a means of transport in three Kebeles of Dega and Woina-Dega. However, Enumerators used to walk from house to house to collect data specially those of the Dega Zone have been there for 3 days and nights to collect data from 30 HHs. This has significant impact on both finance and time.

1.13 ORGANIZATION OF THE PAPER

The paper consists five chapters of which Chapter I is Introduction, Chapter 2 is the Literature part, Chapter 3 deals with the socio-economic life of Antsokia-Gemeza Woreda and World Vision Ethiopia, Chapter 4 deals with the findings, and discussion. Chapter 5 presents the conclusion and recommendations of the research.

1.14 DEFINITION OF TERMS

The following terms will be used in this research as defined here below.

Community: - is a group of rural people living in a certain geographical area. The people of Antsokia-Gemeza Woreda are the community that is referred to in this research.

Child-Centered: - is used interchangeably with Child-focused to show that children are the main target in community development where their basic need like education and health, is addressed to create a condition of survival.

Child well-being: - is used to denote the rights of children to receive adequate care, education and health, from a development program.

Sponsor:- is used to denote the person who has an attachment with one child in the project area and raise fund to fulfill the basic needs of that child through World Vision.

Child In Program (CIP): - is a child who is in the sponsorship program where budget is allocated to, but may not have a sponsor.

CHAPTER II

LITERATURE REVIEW

2.1 INTRODUCTION

Non-Governmental Organizations-NGOs take many different organizational terms and names in different countries. Some of the terms used to describe NGOs include private voluntary organization, voluntary organization, national voluntary organization, and voluntary development organization widely used in Britain since there is a tradition of voluntary work. In The United States they take different names like non-profit organization, not-for-profit organization, intermediary organization, umbrella organization and they receive fiscal benefit from the state if they claim that they are non-profit making organization and many others (Tegegne 1994, Paul 2000, Lewis, 2001).

Korten used four different terms to mention NGOs: -

> Voluntary Organizations that pursue a social mission driven; Public Service Contractors that function as market-oriented nonprofit businesses serving public purposes; People's Organizations that represent their members' interests, have member accountable leadership, and are substantially self-reliant; Governmental Nongovernmental Organizations that are creations of government and serve as an instrument of governmental policy (Korten, 1990).

Edwards and Hulme (1992) also tried to show that the term NGO also embraces variety of institutions like International NGOs such as Save the Children and Christian Aid, 'intermediary' NGOs in the South who support grassroots work through funding, technical advice and advocacy; grassroots movements of various kinds like grassroots organizations, and community based organizations which are controlled by their own

members. Clark (1991) also mentioned different NGOs like Relief and Welfare, Technical Innovation Organizations. Northern NGOs, which focus on self-help, social development, and grassroots democracy, Grassroots Development Organizations. Locally-based southern and many others.

2.2 DEFINITION Of NGOs

It is very difficult to give a full and precise definition of NGOs as they form a heterogeneous and changing group. Moreover, their legal status varies from country to country like, charities in the Netherlands, non-profit-making organizations in Portugal and Public Interest Associations in Germany. According to Wellard and Copestake the definition of NGOs is challenged by a host of alternative usages like officials, independent sector, volunteer sector, civil society, grass root organizations, transitional social movement organization, and non-state actors (Wellard & Copestake, 1993). However, different scholars and academicians tried to define what NGO is? According Korten's (1990) definition, NGOs are organizations that possess four defining characteristics that enable them to be distinguished from other organizations in civil society: they are voluntary, independent, not-for-profit and not self-serving. Each of these characteristics is described here below.

VOLUNTARY: -They are formed "voluntarily" The word "voluntary" distinguishes NGOs operating in democratic societies from government - i.e. statutory - agencies. NGOs are non-compulsory, or non statutory - i.e. formed voluntarily.

INDEPENDENT: - Within the laws of society, they are controlled by those who have formed them, or by Boards of Management to which such people have delegated, or are required by law to delegate, responsibility for control and management.

NOT-FOR-PROFIT: - They are not for personal private profit or gain, although, NGOs may have employees, like other enterprises, who are paid for what they do. But in NGOs, the employers - Boards of Management - are not paid for the work they perform on Boards.

Other scholars also tried to define non-governmental organizations as follows: -

> NGOs are voluntary organizations that work with and on behalf of mostly grass roots people's organizations in developing countries. They also represent specific local and international interest groups with concerns as diverse as providing emergency relief, protecting child health, promoting women's rights, alleviating poverty, protecting the environment, increasing food production, and providing rural credit to small farmers and local businesses (Todaro, 1996).
>
> NGOs are voluntarily. Most of them are charitable benefiting the community embody the idea of altruism and not for profit; self motivated and committed to help the poor; the needy and the weak independence from outside interference and control. (Tegegne, 1994)

Wellard & Copestake, (1993) mentioned that Non-governmental Organizations are registered, private, self-governing, non-profit making organization that works with the poor. Drabek (1987) tried to show what NGOs are and the relationship between NGOs and governments. Accordingly, he mentioned that non-governmental organizations, as their name specified, are any of those organizations that are working independently

where the government has no control over, and also they are not a result of an agreement between governments. Mufune, (1996) also tried to define what NGOs are.

> NGOs are to some degree organizational embodiments of Volunteerism. Volunteerism entails a capacity on the part of the individual to serve of " their own free will without expectation of monetary or other personal material gain.

For the purpose of this research, NGOs are those voluntary and independent organizations established for the purpose of providing assistance for the well-being of children through child centered community development program, also work for poverty reduction at grass root level, and build up the economical base of the community.

2.3 HISTORICAL BACKGROND OF NGOs

This section of the paper describes how the current spectrum of NGOs has emerged from the 19th century and been shaped in the last 30 years by the search for alternatives and by emerging new needs and concerns.

Paul (2000) mentioned that charitable and community organizations, separate from states, have existed in many historical settings. But NGOs are primarily a modern phenomenon. With the extension of civilization of citizenship rights in Europe and The Americas in the eighteenth and nineteenth centuries, people founded increasing numbers of these organizations, as instruments to meet community needs, defines interests or promote new polices. Paul quoted a French writer and emphasized the

importance of what the writer called "Political Association" as institution of democracy, uniquely numerous and influential in the U.S.A. in 1831. New legal rules for private corporations, emerging at this time, provided modern juridical authority for the organizations and increased their defense against state interference.

The anti-slavery movement of England in the late eighteenth century also gave rise to many such organizations which led to the world Anti-slavery Convention in 1840, a milestone gathering to coordinate the work of citizen organizations on the international levels. Following this, the World Alliance of YMCAs and International Committee for Red Cross came into existence in 1855 and 1863 respectively. In a number of countries, NGOs started after the First World War and again gathered a new strength at the end of the Second World War, with much of the focus on relief and rehabilitation in the devastated European countries.

Mostly famine and civil wars are used to be the starting point for the establishment of most NGOs. French Médecine Sans Frontiéres highly specialized in medical assistance founded in 1971. In 1962 International Council of Violations agencies, which had concern of refuges and displaced persons was created. Following the drought of Bangladesh and Ethiopia, end of the Vietnam War of 1975, Guatemala's earth quick of 1976 and the flight of Somalia and the Sudanese refugees also brought about new NGOs (OECD, 1988). The independence of most third world countries in the early 1960s pressed most of the NGOs towards development. To meet the demand for local talent NGOs established training centers in the developing countries and after wards

they demand qualified personnel supported by official funds like Voluntary service overseas of United Kingdom, the Association Française des Voluntaries du progress in France and Peace Corps of U.S.A formed by President John of Kennedy in 1961.

Tsegaye (1994) mentioned three phases of NGOs development as the era of religious and ethical voluntary organizations, welfare and charitable phase after Second World War and developmental phase in the Third World.

The survey of Organization for Economic Co-operation and Development (OECD) mentioned that in the United States, NGOs involved in planning aid to Europe established as early as October 1943. Two of the largest US NGOs, Catholic Relief Service and CARE were founded in 1943 and in 1945 respectively. In United Kingdom, the Oxford Committee, which later becomes OXFAM, started in October 1942 and Save the children Fund UK was founded in 1919. In Denmark a major NGO was founded in 1944 under the name of " Friends of Pease Relief Work".

The above and many other independent organizations addressed many issues including women and children's rights and the condition of the poor. Some observers assumed that NGOs involvement as a late twentieth-century phenomenon, in fact it has occurred for over 200 years (Paul, 2000; Lewis, 2001).

Like churches' agencies and NGOs, Food and Agriculture Organization (FAO) launched a program freedom from hunger with a motto of "Give a man a fish, and you feed him for a day, teach him to fish, and you feed him for a life time." In the formation of NGOs,

the church also played undeniable role and had been an initiator to the formation of NGOs in the 1960s in promoting the concept of partners in developing countries. The early church and its leaders were powerful instrument for the creation of today's NGOs in showing that human beings are the goal of development. However, it was not until the end of the Second World War that these non-governmental groups began to acquire legal form and an increasingly important presence in international relations. They were recognized for the first time in the Charter of the UN, Article 71 of which allows the Economic and Social Council to make appropriate rules to carry out consultations with non-governmental organizations. To day, NGOs have an undeniable relevance in sectors as important as the building of peace, development cooperation, the environment and human rights and Emergency humanitarian aid (OECD, 1988)

2.4 NGOS, GOVERNMENT AND CIVIL SOCIETY

NGOs are one form of civil society organizations which are formed voluntarily to assist the needy or disadvantaged; or formed to pursue a common interest in and/or to take action on a particular subject or issue which causes disadvantage or is detrimental to the well being of people or society as a whole. NGOs are part of the civil society, but distinguishable from other groups and they focus on the disadvantaged, or wider concerns and issues that affect people's well being. When we consider the relationship of governments and NGOs it takes different forms. Some are adversarial and others act smoothly, friendly, cooperatively and businesslike; some act alone while others work in coalitions. Some organize for protest and demonstration while others prefer sober education or quite diplomacy. Some refuse those in power who abuse citizen rights,

while others work closely with the authorities. However, strong government regulates and controls the relationship and activities through administrative regulations at the level of line ministries, local governments and national forums and code of conducts, procedures and legislations and NGOs are expected to abide and act accordingly (Edwards and Hulme, 1992; Farrington & Bebbington, 1993; Campbell, 1996). Their relationship will be smooth when NGOs tasks are not against government objectives and when government are not challenged by NGOs too. In fact the living standard of NGOs and government officials may create difference between that brings misconception. Though governments recognize the economic value of projects, but the worst tension arises due to people's participation, empowerment and democracy approaches that NGOs' advocate and implement at the grass root level since most governments are anti-empowerment and democracy (Clark, 1991).

NGOs often relate very closely to governments, because: some NGOs have contractual relationships to deliver services on behalf of government departments; some NGOs mobilize resources in support of government policies and programs, such as literacy, unemployment, adult education, health and community development and some NGOs undertake research or establish innovative programs and want to report to governments of their results,

Sometimes in fields and activities where NGOs are involved but government is unable to operate, NGOs often seek the government to take over programs from their hands and run on its own. When governments are willing to take over programs from NGOs,

provide support and adopt polices it is an achievement to them and keeps their relationship more smooth. The following are the broad objectives of NGOs.

2.5 THE OBJECTIVES OF NGOs

There are various objectives, but the following two are basic and broad objectives of NGOs. These are: -

1. To improve the circumstances and prospects of disadvantaged people who are unable to realize their potential or achieve their full rights in society, through direct or indirect forms of action; and/or

2. To act on concerns and issues which are detrimental to the well-being, circumstances or prospects of people or society as a whole?

2.6 THE ROLE OF NGOs

According to Lewis (2001), NGOs have three main roles; Implementers; Catalysts Partners and he also quoted Najam and mentioned four distinctive types of roles for NGOs.

> ... Service delivery, advocacy, innovation and monitoring, and sees NGOs as 'policy entrepreneurs'. There are in this model four NGO role within the 'policy stream': service provider, advocates, innovators, and finally monitors (Lewis, 2001).

Clark (1991) also mentioned the role of NGOs and said that through strategic use of their grass roots experience, NGOs can make an invaluable contribution to development understanding.

2.7 NGOs' COORDINATING COMMITTEE

Though NGOs are effective when they are working together, pulling their resources and coordinating their lobbing efforts, but their coordination have to improve in two areas: In professional and coordination.

Perhaps the biggest coordination effort of the NGOs in the field of humanitarian aid was the Coordinating Committee for Emergency Actions of the NGOs (CCEA-NGO), started on 31 January 1984 by 22 NGOs. In March 1992, ECHO also was founded with a composition of 80 NGOs to centralize all the humanitarian aid of the European Union in a single bureau. In 1993, almost 50 percent of ECHO resources were managed by NGOs. Finally, it is better to draw attention to one original feature of this area of cooperation between the NGOs, Northern and Southern countries on identifying more specific objectives of pulling their resources and coordinating the lobbing efforts. Perhaps the leading coordination effort of the NGOs in the field of humanitarian aid was the coordinating committee for emergency Action of the NGOs.

2.8 THE SOURCE OF FUNDING

Most NGOs are said to enjoy independence in the administration of funds, i.e, in receiving from donors and extending to the recipients.

Mostly, these NGOs cannot be seen as a potential source of funding and always be limited in their action and will need support in order to fulfill their objective. Therefore, they receive their funding from bilateral donors or business grants or contracts from governments and International Institutions, fees for services, funding from private foundations, corporations and wealthy and even poor individuals and pensions or governmental international assistance programs and use them "in house" for the implementation of their work programs. In fact some have established themselves in developing countries specifically because this gives them greater access to donor funding.

Lewis (2001) mentioned how NGOs raise fund in such a way that;

> While there are clearly a great many NGOs, which depend on international development assistance, there are others, which seek to go it alone, relying instead on the voluntary labor of their staff or members, on contributions from the local or the International community, or on using market for other sources of income.

Clark (1991) also mentioned the way that NGOs raise funds.

> Most Northern NGOs spend a small portion of their budgets on "development education" - to influence their own societies about Third World issues. They seek to give a more accurate impression of the Third World, particularly to schoolchildren (Clark, 1991).

Within the framework of enabling policies, these NGOs can make an important contribution. They are generally in contact with a large group of national NGOs and are well informed on the work that these NGOs undertake and the measure of their

success. The grants that they receive allow them to analyze the work of national NGOs and draw conclusions on their effectiveness, potential and future role.

As is the case with international NGOs in general, the possibility of expanding the role of international NGOs in developing countries will depend on an increased level of funding made available to them.

2.9 WHY COUNTRIES WORK WITH NGOs?

Many donors understand that NGOs are more likely to go to the grassroots level and identify local needs and addressing women's and children's' issue. Most of them are also independent, small in size, have participatory approach and advocate the empowerment of the poor.

According to the views of some NGOs, governments' interference in development activities may result in paralyzing the work; and they might revise their approach and adopt new and diversified methods of development. However, it has become clear for them that development without sufficient community participation and mobilization, mostly leads to limited and unsustainable results. On the other hand, most governments of developing countries consider NGOs unresponsive to the national development program and guidelines and unaccountable to their activates and follow their own rules and objectives but most NGOs are efficient in this respect.

No matter what is being said of democracy and what type of democracy is implemented, everyone has to play in socio-economic development. In this respect, grassroots

associations have a key task and it is for NGOs to support them to the extent they require.

2.10 ACTIVITIES OF NGOs

NGOs have been rising dramatically in recent years in its outreach through the funds they spend and the numbers of beneficiaries they deal with. In the early 1980s, it is estimated that NGO activity "touched " 100 million in Asia, 25 million in Latin America and some 12 million in Africa. In the 90s, the total is probably nearer 250 million-and will rise considerably in the years ahead (World Bank, 1996)

Regarding the major activities of NGOs, Lewis mentioned that NGOs in many developing countries operate primarily in agriculture, health, education programs and micro-credit extension to transform the life of the community. Generally, the major activities, direct or indirect, commonly performed by NGOs fall across "care and welfare" of the disadvantaged to "change and development" (Lewis, 2001).

2.11 NON-GOVERNMENTAL ORGANIZATIONS IN ETHIOPIA

Though NGOs in Ethiopia begun back in the 1910s but they were few in number. Until 1973/74 there were about 18 registered NGOs. Due to the 1984/85 drought of Ethiopia their number increased to 58. As of April 2002 the number reached to 429 (DPPC, 2002). In Ethiopia there are different forms of NGOs and the main types are the following.

2.11.1 TRADITIONAL VOLUNTARY ORGANIZATIONS

Traditional voluntary organizations have been long in Ethiopia. The most known are Equib, Debo, Maheber, Senbete and Idir can be mentioned (CRDA, 1998). The traditional voluntary organizations have come into being due to the willingness of a community to perform a certain activity; it could be social or economical. Tsegaye(1994) mentioned the Traditional Voluntary Organizations of Ethiopia as:-

> Idir and Equib are voluntary mutual Aid association organized by the people at the grassroots with varying sizes, invariably small. Idir is organized for certain social functions and Equib is organized to perform certain economic objectives and serve as a saving cooperative. Idir is socially broad based and Equib is invariably composed of the same economic class.

2.11.2 PROFESSIONAL ASSOCIATIONS

They are a body of scholars, artists and literacy men who encouraged learning, literature and art by research and publications. These associations are responsible in promoting the professional know how of their members and preserving their professional ethics. Moreover, they are involved in protecting the rights of their members, provide professional, technical, financial and information assistance to the members. There are about 1000 registered professional and other Associations in Ethiopia (CRDA, 2000)

2.11.3 DEVELOPMENT ASSOCIATIONS

In Ethiopia there are different Development associations some of which are regional based like Amhara, Oromo, Tigray and Southern regional development associations. These Associations promote a nation wide campaign of fund raising and collect a huge

amount of money in addition to the money that they receive from regional states. They involve in different development activities in their respective regions like social and infrastructure development (CRDA, 2000).

2.11.4 NATIONAL NON-GOVERNMENTAL ORGANIZATIONS

The National NGOs also called Indigenous NGOs. The NNGOs, which are religious based or secular, work relief, rehabilitation and development in which most of them have child care development program. Most of them work with churches and provide clothing, food, health care and education for the poorest of the poor households. Their main source of fund is their members or churches in the North who sponsor the program. However, the NNGOs are not strong enough to perform large development programs but they are growing fast and INGOs also support them to grow up to carry out development activities and replace them.

2.11.5 INTERNATIONAL NGOS IN ETHIOPIA

Most of INGOs in Ethiopia are religious based or secular and had been working relief, rehabilitation and development works and they are active in their operations. Most of them are working with the people at the grass root level using local resources. Their head offices or supporting offices are located in the North and they are responsible in fund raising to the program.

During the 1973/74 and 1984/85 droughts of Ethiopia some INGOs came to carry out relief and rehabilitation activities. Since DPPC was the only authorized government

body, these INGOs were assigned to the drought prone areas of the country. However, some INGOs Like Redd Barana-Norway/Ethiopia, OXFAM, and CARE Ethiopia involved in community development where child-well being is the main area development through child centered community development.

2.11.6 INTERNATIONAL NGOs AND THE STATE OF ETHIOPIA

The 1974/75 drought of Ethiopia has pulled many INGOs and work in relief and rehabilitation work however the existing Military Government put them under strict control. The outbreak of the 1984/85 droughts again increased the number and most of them remain working rehabilitation and development programs. During the military government there were also INGOs who oppose the state until they were expelled out. Tsegaye (1994) explained the situation as follows: -

> Similar to other African countries like Kenya (Fowler 1989) and Zimbabwe (Bratton 1989), development NGOs (DNGOs) and their operations in Ethiopia were surrounding by some vagueness and uncertainties in their relations with government.

The weakness of their relationship resulted from the ideology of the state, misunderstanding of the INGOs by the state and the absence of clear guidelines as to how INGOs were expected to work. There was also a problem of accountability within the state sector offices and created confusion within the organizations for not having a clear guideline to which sector office they are accountable for. On the other hand some INGOs interfere in the political situation of the country and threaten the state that resulted in aggravating their incongruity with the state.

Following the military government, the TGE was willing to work with INGO, learn from them, and integrate their program into national development objectives. Recently there are some INGOs who go against the guidelines of the state and for this reason they have missed their licensee. However, there are others who have smooth relationship with the state so that they are working together.

2.11.7 COORDINATION OF NGOs IN ETHIOPIA

Most of INGOs have been working individually for long but the recurrent drought of Ethiopia brought them together and form a body that unify them to work together. The body that is created for is CRDA (Christian Relief Development Association), which is founded from the common interest of various organizations.

Father Kevin Doheny, a veteran catholic priest with other 13 Ethiopian churches to over come the recurrent drought, has founded the organization in 1973. The body that was founded is first named as Christian Relief Fund and replaced by CRDA later. (CRDA, 2000)

Regarding the membership of the association, those NGOs who intervene in relief, rehabilitation and development work in Ethiopia can be members of the organization and World Vision is one of the INGO, which is the member of CRDA.

2.11.8 WORLD VISION INTERNATIONAL ETHIOPIA

After Second World War many different Humanitarian, International aid agencies and child development agencies came into existence in many developing and developed countries. World vision Ethiopia is also one of the INGOs that involved in community development with a particular emphasis on child well-being since 1974 through the fund collected from institutions, individuals, churches and donors in the North.

Regarding the beginning of World Vision, Bob Pierce, a young American Evangelist, visited China in 1947/48 and preached about Jesus to a mission school and a little girl was converted to Christianity. However, her parents throw her away from home. When Pierce heard the situation he was surprised and decided to send $5 per month from his pay. He also coordinates others to help other children in China too. This action did not stop with Chine's children but continued to reach others and give birth to World Vision International.

By the year 1979 ninety-eight percent of the sponsorship projects were institutional or family-to-family projects where the immediate needs of children were met by the organization in the context of social welfare. On September 1979 the organization came with a new approach of childcare ministry and changed from Institutional care to community development. At the end of 1981, forty percent of child sponsorship projects were either family or community development projects. Since then the organization has undergone many changes until it moved back to development in sponsorship.

Nowadays, the organization works community development activities through child sponsorship fund in more than ninety-nine countries around the world.

World Vision International has been also actively involved in Ethiopia since 1971 based in Nairobi, and established its office in Addis Ababa in 1975. Some World Vision primary programs were to settle Sudanese refugees along with victims of the Ogaden war and also to help needy children with their basic needs (WVE, 1998)

After sometime its approach has changed and start to work through indigenous partner agencies (Churches and Organizations) to assist the communities with a combination of agricultural help (tools, seeds and etc) provision of clear water, health care, primary education and income generating schemes. In 1990 it moved to participatory rural community development through the sponsorship fund where the well-being of children is the main focus.

2.12 COMMUNITY DEVELOPMENT

Community development was first imitated from Egypt, Jamaica and others in the 1930s. It grew after the end of World War II in the UK and the US, where there was a need to assist the social needs of the urban poor in the industrializing cities and it was designed to make citizens involve in the local decision-making process. At this time the developed nations also tried to assist the developing countries with programs of adult education and community betterment.

> Such people's material needs at that time were obvious and specific and many of them were too poor, too ignorant, and too disorganized to do very much to help themselves. In this context the newly formed social agencies necessarily took the initiative in planning and providing for people (Abbott, 1996).

2.12.1 DEFINITION OF COMMUNITY DEVELOPMENT

The term community development gives a form suited to the twentieth century to the long-standing tendency of membership of a group to act together to improve the life-style of the group as a whole. Klonglan and Head in Chekki (1976), UN (1956) and ICA (1957) in Ray also viewed community development as a process designed to create conditions of economic and social program for the whole community with its active participation and the fullest possible reliance upon the community's initiative.

The Cambridge Summer Conference on African Development defined community development as a movement designed to promote better living for the whole community with the active participation of the community (Ray, 1998)

Taylor in Ray (1998) and Chekki (1976) defined community development as: -

> Community development is a method by which people that lives in local villages or communities are involved in helping to improve their own economic and social conditions and thereby become effective working group in program of rational development.

2.12.2 THEORETICAL APPROACHES OF COMMUNITY DEVELOPMENT

Community development theory appears in the last decades as a social force in the process of planned change and come up with different approaches. Sanders viewed

the notions of community development approach as a process, with a focus upon sequences of interaction and puts emphasis upon what happens to people; as a method, it places emphasis upon some end; as a program consisting of contents as well as procedures and emphasizes on activities; and movement, involving personal commitment and an emotional dynamic and it tends to become institutionalized, building up its own organizational structure, accepted procedures, and professional practitioners (Chekki,1976).

Lee also mentioned two approaches of community development as directive and in-directive in community development process. Directive approach is one where a community development worker identifies people need for their own good and in the in-directive approach is where the community workers tries to get people's to decide for themselves what their needs are and organize, plan and implement the project. In the in-directive approach of community development, the community becomes a decision-making body (Chekki, 1976).Some community field theory practitioners considered community development as a social or activity field. Mookherjee develops the context of community field theory as model of effective community development organization for balanced development; program grows out of the needs of the individuals in the local society (Chekki, 1979). It is dynamic, based on self-help, voluntary cooperation, and the participation of the groups.

Theories regarding the advantages of community development has been given by Moryhtin and Head mentioned that it is a response to felt needs of communities, thereby

increasing their self-reliance, capability, confidence and awareness. It engages the rural poor in improving their living conditions; it complements government development effort; stimulates local leadership and initiatives (Chekki, 1976).

In order to handle and carry out community development there are basic elements involved. Head mentioned these elements as: - A planned programmer that focuses on total community needs; self-help, which is a basic requirement of community development; technical assistance from government and voluntary organizations which include personal, consultation equipment, supplies, or money and integration of various specialties which includes public health, home economics, education, agriculture, social welfare, recreation service and others (Chekki, 1979).

As to the approach of community development it is recognized as a form of participation in developing countries but there are different and contradictory applications that Ward mentioned;

> In preparation for the eventual independence of its African and Indian colonies, the British employed community development as a method of encouraging the growth of political democracy, and local initiative (Ward, 1995).

However, those African countries and others that need their independence understood that community development is a tool for neo-colonial expansion. Others thought that the primary motivation was to promote political democracy and the integration of the poor into society in order to counteract the spread of communism using community development as a tool of policy.

Abbott (1966) mentioned community development approach to developing countries as a technique of bringing social changes in both rural and urban settings.

2.12.3 CHARACTERISTICS OF COMMUNITY DEVELOPMENT

The characteristics of community development have broader indicators that have been developed. The main indicators are interaction with government, decision-making, community dynamic, and role of external actors (Abbott, 1996).

2.12.4 MODELS OF COMMUNITY DEVELOPMENT

Even though there are a large number of poor people in the developed nations to be assisted by a means of welfare program to shield them from the effects of poverty but this approach was more important in the third World countries to reach and meet the basic needs of the poor population than the developed nations. Therefore, three model of community development were introduced in the theory of community development (Chekki, 1979).

2.12.5 ALTERNATIVE HYPOTHESIS FOR COMMUNITY DEVELOPMENT

Community development grew to a sub-discipline of social work, which is an applied method of bringing about change in the lives of children and other social changes in developing countries. However, community development had failed in some countries and succeeded in some other areas. To be successful in implementing community development Ward mentioned conditions like the openness of the government in community involvement by the complexity of that process, the participation of

community in decision-making, empowerment of the community and service delivery (Ward, 1995). However, NGOs and Charity organizations tried to rethink a method through which the lives of children can be improved and move from the traditional community development approach to an effective method to address children's need. Therefore, most NGOs shifted to child-centered community development approach. What is child-centered community development? Next we will see what child-centered community development is.

2.12.6 CHILD-CENTERED COMMUNITY DEVELOPMENT

Socialization theory focuses on the process by which Children become adults. It is based on this approach and has dominated man's thinking about children for generations. As a result of conceptualizing childhood in this way, children are largely viewed as passive, immature, ignorant, and vulnerable. But Children need education and guidance from adults in order to become mature and responsible members of their community. In the international community development program, three main types of programming approaches are sighted by This in a working paper in 1996.

The first is social work, which largely concentrates on specific groups of children (street, disabled, orphan children). The second is health and education project, which is largely oriented towards children, which sees children within the context of their community. The third is agriculture, forestry, water, credit, and infrastructure projects almost always ignore children completely and they are assumed to benefit from the positive effect of the projects as the overall situation of their community and family improves. In such

projects children are invisible, largely treated as passive beneficiaries rather than active participants.

With such understanding the approach of community development should be reassessed whether it is social, health, education or agriculture, credit or infrastructure. Considering community development from child-centered development perspective, it has to start with children's interests, concerns, capacities and needs. This is the center of the whole child-focus development debate. Children are diverse group and their need is also divers and this need be clear. If development is designed to be participatory community development, children should have a place to work in all the project activities. The development program should also clearly understand that children are part and parcel of the community, which can be affected by the changes of the project (Myhren, 1990;UNICEF, 1993,This, 1996).

2.12.7 WHY CHILD CENTERED?

There are reasons why community development needs to be a child-centered development. In child-centered development, children will be guaranteed that the development work is serving and bring impact on them, children will be more visible within the community and outside of the community, they will be active participant of community development, and to keep the rights of children to survive, they will attain proper education and health, and protected according to UN child right convention set (UNICEF, 1990). Tsegaye (1993, 1994) mentioned child-focused rural development as the approach that addresses the household to reach the best interest of the child, with a saving and credit service for the household. In his report, he mentioned the activities

carried out to develop the well-being of children like health, where immunization is carried out and awareness is created on AIDs, Agriculture to secure food security to increase the nutritional value of the children and the supply of Ox, Plough, Cow, tools and selected seeds, water supply activity, and the promotion of savings.

Tsgaye continued and explained the measures taken by the projects to the well being of children and mentioned the accomplishments like; health infrastructure upgraded-clinics, health centers, mother and children's training, seminar are undertaken, cattle's are provided, cows, sheep soil conservation is carried out, water, road infrastructure and educational activities handled.

The annual report of Save the Children Norway (1999), reported that a child centered rural community development project planed to promote basic education and strengthen health services. According to the report the project established one health post where 1200 people can have access to health facilities, a new school was constructed and 420 children got access to basic education, and 498 children completed the first stage of non-formal education and become literate.

Englesand and Chandler (1994) mention on the activities of child centered community development and said that projects should be a mixed bag of activities.

> The emerging projects were a mixed bay of activities such as home-economics and house makings, horticulture, health education, and literacy which very often took place in women's groups. Nutrition education and childcare became increasingly important. ... Often, preschool and child/youth welfare activities are central"

Egilwam, (1994) mentioned that an effective child-centered community development should have a way of attachment with children need. Therefore, Child-centered community development would be most effective if it could "plug in" to what parents/children want for their children rather than trying to interpret those needs for them.

He also mentioned that Child-Centered community development activities will be unsuitable and ineffective unless communities primarily prioritize children's needs as a main concern independently. According his explanation both health and education are the pressing needs of young children in community development activities. Therefore, since children are future parents and leaders, they should not be wasted or neglected, their potential should be developed and all development activities should impact children's situation in a positive way that is addressing their needs and problems. UNICEF (1990) also mentioned the well-being of children in a workshop paper that attention should be paid by all nations to reach women and children who are at risk, through managing of child care and social service; health facilities, education, and water supplies. Following are the major social services where the Ethiopian government has given attention to address social needs through which children are impacted.

2.13 HEALTH IN ETHIOPIA

Though Ethiopia experienced an old aged traditional methods of treating diseases, but its leaders have been using and also took advantage of foreign cures until Minlik II established hospitals with Russia in 1890. Subsequently Foreign Medicine made further

advance and other health related work also becoming functional (Paulos, 1975; Pankhrast, 1990). The above development led to an increase of government expenditure on health, which is about 555,000 Ethiopia dollars.

However, Ethiopian traditional Knowledge and its early awareness to health does not bring any development rather it is far behind in its health status where communicable diseases, nutritional deficiency and many others are the leading ones. The situation aggravated due to its economical weakness, distances from health centers in the rural areas, settlement pattern especially in urban centers, and many others. As it is mentioned elsewhere the health condition of children in Ethiopia is worse as compared to other African countries. Generally one can say social, cultural, economical, biological and environmental factors influenced the health status of the people (MEDAC, 1999; MOH, 2001).

Therefore, better health requires much more people participation, as individuals, families, and communities in taking action on their own behalf in adopting healthy behavior and ensuring a healthy environment.

2.13.1 ETHIOPIA HEALTH POLICY

In the area of health there was no comprehensible policy until 1978, the thirty-second Health Assembly launched the Global strategy of "Health for All by the year 2000" and it invited the member states of WHO to act individually in formulating national polices, strategies and plans of action for attaining this goal using the guiding principles issued by WHO as a basis. (WHO, 1981)

Though a health policy had been formulated during the period of Emperor Haile Sellassie and during the time of Derg (Pankhurst, 1990) but the Transitional government of Ethiopian has adopted a new and detailed policy in 1993 based on the guideline principles set by World Health Organization.

According to the TGE health policy, some of the main objectives are democratization and decentralization of the health service system, health services for all, health care for all, health care assistance to the poor and strengthening the private sector (MOH, 1993).

2.14 EDUCATION IN ETHIOPIA

Before the coming of modern education to Ethiopia in the nineteenth, the Ethiopian Orthodox church has contributed a lot to the development and growth of education in the country. Clergy in the surrounding area of places of worship often conducts Christian education at the primary level. But Emperors Menilek II (reigned 1889–1913) has contributed for modern education but Haileselassie I (1930–74) established an excellent, but limited, system of primary and secondary education (MOA, 1994). When the leaders of Ethiopia started modern education in the last one hundred years, it was assumed to build up communication skills to run a modern bureaucracy, however the effort was broken down by the II World war and Italian invention to the country. After the war, many attempts were taken to strengthen education in the country but with no success as compared with many countries and that is why Ethiopia is last in its educational status in the Sub–Sahara African countries (MOE, 1994). If we take adult

literacy rate it is 40 for male and 27 for female and primary school enrollment ratio for male is 43 and for female is 28 (UNICEF, 2001).

2.14.1 EDUCATION POLICY OF ETHIOPIA

In regards to educational policy, there had been policy in the past, but the TGE adopted a new policy on education and training in order to over come the problem of relevance, quality, accessibility and equity of education in Ethiopia. The policy is composed of specific objectives and Implementation strategies at all levels. According No 2.1.1, the policy declares that all citizens have the right of basic education.

> Develop the physical and mental potential and the problem-solving capacity of individuals by expanding education and in particular by providing basic Education for all (MOE, 1994)

Generally, the educational and training policy emphasized the following points: - universal primary education, civic education, skill formation, and language of instruction and development orientation.

CHAPTER III

SOCIO-ECONOMIC OF ANTSOKIA-GEMZA WOREDA AND WORLD VISION ETHIOPIA

3.1 BACK GROUND OF ANTSOKIA- GEMZA

Antsokia-Gemza is one of the rural Woredas' of Amhara National Regional State located 350Kms. Northeast of Addis Ababa, in Northern Shewa Administrative Zone at $10^0 37'$N latitude and $39^0 52'$E Longitude (MOE, 1982, Selam, 2001). The Woreda has fifteen Peasant Association where Mekoy is a Woreda center (capital) having 2 Kebeles. Mekoy is linked with Addis Ababa-Dessie main road with 12Kms. gravel and all weather roads (WVE, 1999, Selam 2001). The Woreda has a total area of 386.10Km^2 (CSA, 1999) and lies on the watershed of Borkena river. Regarding its land use pattern; 47 percent is cultivated, 20 percent is currently uncultivated and only 3 percent is a grazing land. About 30 percent of the land is covered with forest, bush, grassland and wasteland too (WVE, 1999, Selam, 2001).

3.1.1 PHYSICAL FEATURE

It is an area of low, mid and highlands, out of which 45 percent is lowland, 44 percent is midland, and 11 percent is highland. Its mean annual precipitation is 800-1200mm with a mean annual temperature of 20.10^{0}c (WVE, 1999).

3.1.2 POPULATION

The total population of the Woreda is 89,100 out of which 44,264 are Male and 44,836 are female. Out of the total population 11 percent is living in Mekoy town, the Woreda Capital, and 89 percent are in the rural areas and have a family size of 5.9 where the fertility rate is 6.37 (WVE, 1999). It has a population density of 225,4/km^2 (CSA, 1999) and a total household of 17015. Literacy rate in the Woreda is 51 percent. The major ethnic groups are Amhara, 90 percent, and Oromo belonging to Orthodox 70 percent, Islam 27 percent and Protestant 3 percent (WVE, 1999).

3.1.3 ECONOMY

About 90 percent of the people practice mixed agriculture as a means of livelihood. The major crops produced in the area are Sorghum, Teff, and Maize and people also have domestic animals like cattle, sheep, goat, and pack animals. Regarding social infrastructure there are 2 health centers, 5 clinics, 6 health Posts, 1 high school, 23 primary schools, 56 protected springs, 26 collection chambers, 4 hand dug wells and 135 water points. (WVE, 1999).

3.1.4 HEALTH

Though the government is responsible to improve the health status of its entire population, but the Woreda health coverage was 9 percent, and immunization was nil. Infant mortality rate was 15 percent and access to safe water was also nil. The major

health problems of children in the Woreda were Malaria, acute Upper respiratory and Intestinal infections and many others that lead to death (Selam, 2001).

At present the major root causes of poor health is getting minimized through improved clean water supply, promoting household food security to have adequate nutrition, developing of health services and facilities, and through health awareness promotion within the community.

3.1.5 EDUCATION

The government constructed schools in the area since the 1950's with poor buildings and facilities. Their accessibility was also limited to a few number of school age population and those people who were economically strong send their children to a near by towns until recently. However, the policy set by the present government, the construction of schools, the assignment of certified manpower and better facilities open a way for the increment of students' enrollment in the area.

3.2 WORLD VISION IN ANTSOKIA-GEMZA

It was in 1984/85 Ethiopian droughts that World Vision Ethiopia entered to the Woreda and picked up women and children, the most vulnerable group of the community, and helps them to start a new life. The intervention of World Vision to the area had three phases (WVE, 1999; Selam, 2000).

3.2.1 RELIEF WORK OF WORLD VISION (1984/85)

World vision Ethiopia was driven to intervene to Antsokia-Gemza Woreda due to the famine that occurred in 1984/85 resulted in environmental degradation, drought, malnutrition, and epidemic diseases and family disintegration. The immediate action of World Vision was to meet the pressing need of the community through the distribution of food, provision of shelter, and health care where children and women were the main focus. During that year, 68,000 beneficiaries including women and children were saved and got relief aid like wet-feeding, medical assistance, grain, supplementary food, clothing and the like (Selam, 2001, World Vision 1999). Since relief efforts remain an essential and appropriate response to emergency situation, soon World vision moved to rehabilitating the community instead of continuing with relief work.

3.2.2 REHABILITATION WORK OF WORLD VISION (1986-1989)

After losing many lives, a bright day has begun with World Vision through rehabilitating the community since the people were exposed for food insecurity, shortage of agricultural inputs and poor accesses to basic services. However, their had been a problem of communication between the community of Antsokia-Gemza and World Vision Ethiopia due to the low awareness and participation of the community in the program.

Since World Vision had the objective to help the victims to recover, it tries to approach the community through creating awareness to have attitudinal change and participate in the program.

Therefore, World Vision supplied the community with agricultural inputs like oxen, fertilizer, and farms tools for about 10,550 households.

However, direct benefits bring a non-disaster situation but it contributes little or nothing to meet the needs of the poor on a sustainable basis. Therefore, it was reasonable to move to area development program in recognizing the limitations of Relief and Rehabilitation works.

3.2.3 AREA DEVELOPMENT PROGRAM (1990-99)

After rehabilitating the community it was unwise to abandon the area without which the community is self sustained and attend household food security. Therefore, recognizing the limitations of relief and welfare approaches as a development strategy; World Vision decided to undertake community development such as improving agricultural production and secure community food security, enhance PHC program, improve social-economic infrastructure, train community on disaster reduction, create awareness in women and in the community as a whole to participate in development, and quality sponsorship relations service that is Child development. This is an approach that creates project sustainability when World Vision phasing out from the project and move to neighboring area.

3.3 OBJECTIVES AND ACTIVITIES OF THE PROJECT

The project started its development work with a view of bringing about social, economic and spiritual change in the community that impact the well-being of children since they are the main source of project finance. The major project components are agriculture extension, aforestation and conservation, health, education, infrastructures, capacity building, gender development, credit schemes and child development. Before proceeding to the discussion of education and health, it is better to have a highlight on the major activities carried out in the Woreda by the project since they contribute on the well-being of children directly or indirectly.

3.3.1 AGRICULTURE

In order to bring a transform the agricultural production of the community and secure household food security and bring a change in the quality and quantity of child's diet, the organization provided inputs such as improved seeds, farming tools, livestock and poultry and has given financial support for pesticides to control crop disease. It also encouraged the community to practice vegetable and fruits production and distributed seeds and fruit seedlings like banana, mango, and papaya. The organization also distributed cash crops to the community and encourage them to generate income through the sale of agricultural products over time and help the family and also support their children to attend school, have better medical treatment and to live better (Selam, 2001).

3.3.2 ENVIRONMENTAL REHABILITATION

Almost 55 percent of the Woreda is composed of a high land between 1,500-3000mt above sea level, which lies within the water shade of Broken River. Due to its physical feature and man intervention in clearing the vegetation cover for farming, fuel and construction the life support system such as land, water and air has been deteriorated in which land has been growing subject to sever degradation and excessive soil erosion which brings about a recurring drought in the area (Selam, 2001; WVE, 1999)

Following 1984/85 famines, World Vision intervened to restore the devastated environment-ecosystem through Agro forestation and Biodynamic farming where two million seed lings distributed to the community. Earth work, hill side terracing, farm terracing, cheek dams and other biodynamic farming activities also has been done through food for work to reduce soil erosion and improve the agro-ecological systems of the area. It also contributes financial and material support for natural resource conservation. This has enabled each household to produce better agricultural production to support its family.

3.3.3 CAPACITY BUILDING

The project conducts capacity building to community members to enhance their awareness and capacity to efficiently use their resources, carry out agricultural practices, environmental protection, and promote primary health care. The training includes local sector offices' staff, and project staff members. This program create a better awareness in the farmers and gives an opportunity to some poor families to be

food secured, generate income and support their children's education and medical treatment expense without financial support from World Vision.

3.4 FINANCIAL SOURCE

More than 80 percent of the budget to the project is coming through child sponsorship that is a relationship between one named sponsor in the supporting country and one named child in the project. The fund is intended to provide direct and indirect benefits to sponsored children and to the community as well. According to Table 1 a total of Birr 62,132,373.15 is raised in different developed/support countries and invested in the project area in the last 12 years in different activities like education health agriculture, and etc. Only 12.77 percent of the budget is raised through non-sponsorship/grant.

TABLE 1 - FINANCIAL SOURCE OF WORLD VISION-ANTSOKIA-GEMZA (1990-2001)

Year	Sponsorship Fund (Birr)	Non-Sponsorship-Grant (Birr)	Total (Birr)
1990	1,145,284.90	562,412.00	1,707,696.90
1991	1,367,330.00	756,231.00	2,123,561.00
1992	1,215,193.00	698,741.00	1,193,934.00
1993	4,056,596.00	768,594.00	4,825,190.00
1994	4,363,412.00	812,354.00	5,178,766.40
1995	4,617,766.00	810,234.80	5,428,000.80
1996	4,727,356.00	728,457.80	5,455,813.80
1997	5,003,774.00	689,121.25	5,692,895.25
1998	6,487,603.00	614,841.00	7,102,444.00
1999	6,193,564.00	632,314.00	6,825,878.00
2000	7,217,812.00	508,340.00	7,726,152.00
2001	7,804,772.00	347,269.00	8,152,041.00
Total	54,200,462.90	7,931,910.25	62,132,373.15

SOURCE: WVI-ANTSOKIA-GEMZA ADP FINANCE, 2002

In order to raise the fund, support offices use their marketing services to produce information on the heartbreaking situation of children and the activities curried out to the well-being of those children and reach sponsors and donors through different medias. In addition to these, there are grants that are non-sponsorship.

According to Table 2, the major supporting offices that raise fund to Antsokia-Gemza project are Germany that sponsor 6722 children and contributes 57.73 percent, U.S.A sponsor 2020 children and contributes 27.32 percent and the other three are Canada, Australia and United Kingdom that sponsor a total of 1353 children and contributes 17.73 percent of the total budget of the project for FY' 2001.

TABLE 2 - CIP, SUPPORT OFFICE AND BUDGET OF WORLD VISION-ANTSOKIA-GEMZA IN FY'2001

PA/PROJECT	CIP	SPONSORED CIP	SUPPORT OFFICE	BUDGET (BIRR)
Mekoy	500	442	Canada	569,239
M/A Amaba	265	272	Australia	168,403
Mesk	588	656	United Kingdom	646,124
Chancho	2020	1834	U.S.A	2,132,425
Gemeza	4000	3322	Germany	3,392,078
Albuko	22	--	Germany	---
Ephrata	2700	2114	Germany	896,503
Total	10095	8640		7,804,772

Source: Antsokia-Gemza WV, CSR- WV-A.AHO; 2002

3.5 ORGANIZATIONS AND MANAGEMENT OF THE PROJECT

The project has 17 employees out of which three, 18 percent, are female and the rest are male. The project is headed by an A/Manager and has his secretary. Following the A/Manager, there are program facilitators. The facilitators are in charge of Grant and Relief, MICAH, Agriculture, Social and Infrastructure. In addition, a Finance unit headed by an accountant is giving support to other units.

Regarding their educational background, 6 employees, which is 35 percent are with their first degree, 4, that is 24 percent are with diploma, and 1 with certificate out of the total staff and the rest are without any qualification. The Finance team is a supporting team, which is composed of an accountant, account clerk, cashier, and storekeeper.

3.6 MONITORING AND EVALUATION

The project is under the supervision of the DPPB and expected to submit a monthly report to Zonal and Regional sector offices and annual report is also submitted too. Timely report to WV regional office is also expected from the project. Regarding a quarterly report; the staff conducts a meeting as to how the monitoring process is going to be handled. Following their arrangement, a meeting will be conducted with community representatives, concerned line sector offices of the Woreda and project staff and review the accomplishments against set plans and goals, proper budget utilization, issues and concerns and move towards solution. Project staffs also conduct visits to households frequently and see the situation of sponsored children. During the visit, project workers are expected to write a note on "child visit card" on the status of

sponsored children. Regarding evaluation, the project is evaluated only two times in its lifetime.

3.7 WORLD VISION AND ITS RELATIONSHIP WITH THE LOCAL GOVERNMENT AND COMMUNITY

World Vision is a registered INGO that signed a general agreement with the central government-DPPC and with regional states that it intervenes too. World Vision Antsokia also signed agreement with the Amhara regional state for the last five years (1998-2001) and with concerned line sector offices. Regarding the relationship with the Woreda sector offices, they have been working together to accomplish the agreements signed and sometimes they work together in the time of epidemics and immunization, training, workshops, program evaluation and etc. However, the relationship with the MOA sector office is not in good terms due to program overlap. Its relationship with the community is good and they are working together in different activities. The community participates whenever World Vision prepares workshops, trainings and discussions like project evaluation and also they work together in the time of epidemics.

CHAPTER IV

FINDINGS AND DISCUSSION

As it is mentioned in the methodology, 169 household heads are taken from a total of 17051 Households. Those households are taken from six Kebeles, three from Kolla, two from Woina Dega and one from Dega Agro-ecological zones. Sponsored children survey also employed for 30 from 600 school-going sponsored children. The findings of data generated through household head survey, Interviews, target group discussion and secondary data are included and presented here below.

4.1 DEMOGRAPHIC AND EDUCATIONAL CHARACTERISTICS OF SURVEYED HOUSEHOLD HEADS IN ANTSOKIA-GEMZA WOREDA

As it is shown in Table 3, one can see the composition of household heads that have given their responses towards the impact of World Vision on the well-being of children in Antsokia-Gemeza Woreda. Their difference in sex, age and family status etc. may affect their attitude towards the activities carried out by World Vision due to cultural factors. Male and old people have more exposure, have a better knowledge to the situation of their area, and have experience to share their attitude than female groups. According to Table 3, about 82.84 percent of the household heads are male and 17.15 percent of them are women out of whom 66.26 are between the age of 20 and 49. Household heads with the age of below 20 and above 50 accounts for 33.70 percent of the total

HHHs. Out of the total household heads, 79.88 percent are married and 20.01 percent are widows, divorced and or single.

Regarding the education of household heads, only 40.82 percent are illiterate, 27 percent can read and write, 29 percent were in primary schools and 3 percent have been in secondary school.

TABLE 3 - DEMOGRAPHIC AND EDUCATIONAL CHARACTERISTICS OF HOUSEHOLD HEADS SURVEYED IN ANTSOKIA-GEMZA

CHARACTERISTICS	FREQUENCY	PERCENT
HHH	n=169	100
Male headed	140	82.84
Female headed	29	17.15
AGE	n=169	100
Below 20	17	10.05
20-29	18	10.65
30-39	48	28.40
40-49	46	27.21
50-59	23	13.60
Above 60	17	10.05
EDUCATIONAL STATUS	n=169	100
No Education	69	40.82
Read & Write	46	27.22
1-8	49	28.99
9-12	5	2.96

Source: - Own Survey, Antsokia-Gemeza, 2002

Generally, 59 percent of the HHH have the chance to go to school and their educational status has its own effect on their attitude towards the activities of World Vision. The status of parental education has also a strong influence on the household demand for education. Those parents who have better educational status used to send their children to school since they have a better knowledge about the advantage of education.

Regarding sponsored children, they are between the ages of 15-20 and 80 percent of them are male and 20 percent female. All who has completed the questionnaire are from Mekoy Elementary/High School whose grade is between 7-10, and 1 elementary school student. Their demographic characteristics and educational level may contribute to their attitude towards the intervention of World Vision and its impact on the well-being of school-going children and their contribution to the program as well.

4.2 ECONOMICAL STATUS OF HOUSEHOLDS SURVEYED IN ANTSOKIA-GEMZA WOREDA

The economical status of households is also considered in this survey since parents with better annual income have a better demand for education and covers their children's educational expense and other expenses too; but households with low income have less demand or no demand for schooling and do not send their children to school instead they use them at home to look after cattle, fetching water, gathering firewood and or work on their farm.

TABLE 4 - ECONOMICAL STATUS OF HOUSEHOLDS IN ANTSOKIA-GEMZA WOREDA

VARIABLE	FREQUENCY	PERCENT
Occupation	n=169	100
Farmer	152	89.94
Daily laborers	7	4.14
Pensioner	2	1.18
Small Trade	8	4.73
Annual Income	n=169	100
0-3000	117	69.23
3001and above	52	30.76
LAND	n=134	100
1-2hec	47	35.07
Less than 1heac	87	42.15

Source: - Own Survey, Antsokia-Gemeza, 2002

As indicated in Table 4, 89.94 percent of the household heads are farmers of whom 69.73 percent have an annual income of less than 3000 Birr, which is less than one dollar/day. Out of the total household heads 42.15 percent have less than one hectare of land, which is to small to produce enough for a family size of 5 and above. The focus group also mentioned about the problem that they face to produce enough for home consumption due to the small size of their plot of land and said " There is land but no enough plot of land is given to each household".

4.3. EDUCATION IN ANTSOKIA-GEMZA WOREDA BEFORE WORLD VISION

Since governments are responsible to the expansion of modern education in rural and urban areas, the former Ethiopian government also tried to plant schools in Antsokia-Gemeza Woreda. According to the report of the Woreda Educational sector office, until 1990, there were 11 government schools constructed out of wood and mud with poor or no facilities, that is, they have no clean water, latrine, library, classrooms, desks, and pedagogical center. They operate on shift system and almost 45 percent of them were non-functional. Since their classrooms were inadequate to that of the number of enrolled students, tree shades were used with stone seats. Educational books were not available as compared to the number of students and they share books or learn without books. The number of students was also small until 1990.

In order to see the situation of schools in the Woreda before 1990, there had been an assessment to have information and statistical data from Educational sector office but no data is available, instead interview is conducted to three elementary schools' directors.

When we consider the first school in the Woreda, Affesso Junior secondary school named after Antsokia until recently, was constructed by the government in 1958.The primary objective of Affssso school construction was to meet the interest of the then

governors and better people since their children were going far from home for schooling like to Dessie, Rabel, Kemmise, Ataye towns and etc. When the school starts in 1958, there were 199 Male and 1 female student, 3 government teachers, 1 voluntary priest teacher, 3 classrooms and 1 office. In 1967 there were only 60 male and 5 female students and in the same year only 6 students have taken grade 6 National Examination. In 1980 the school became junior secondary school and in the year 1982 there were 276 male and 108 female students. The number of teachers was 13 male, 6 female from TTI, 1 male, and 1 female with college Diploma. In 1987 the number of male students increased to 451 and female to 314, which is an increase of 63.4 percent for boys and 190.74 percent for female students, which means the number of female students coming to school was highly increased than before. In the same year, the number of teachers was 16 male, 8 female TTI, 1 male, and 1 female with diploma teachers and there were 13 classrooms. In 1992 the number of male students has fall down to 384 that is a decline in 14.85 percent but female students increased to 382 that is 21.65 percent increase. In the same year the number of teachers were 20 male, 9 female TTI, 2 male, and 1 female diploma teachers and there were 17 classrooms.

The second school is Mekdesa Elementary School. The school is started by MOE in 1977 with few students. In 1982 the school had 281 male, 149 female students, and 3 male and 1 female TTI teachers with 10 sections. But in 1987 the number of students declined to 136, which is 52 percent of male, and to 140, which is 6 percent of female students. In the year 1992 the enrollment of students increased to 244 for boy students and 273 for girl students, which is 76.47 and 95 percent respectively.

The third school is Mekoy Elementary/High School, which was started in 1982 with 113 male and 108 female students with 2 male TTI teachers and 2 classrooms by the government. In 1983 the number of students dropped to 41 male and 52 female with 2 male teachers and 3 classrooms and in the year 1987, the enrollment increased to 199 boy and 190 female students which is an increase of 385.36 percent and 265.38 percent for girls and in 1992 the number increased to 480 for boys and 442 for girls which is an increase of 141.20 percent and 132.63 percent respectively.

The above discussion shows that student enrollment in the three schools had no a smooth growth but there had been ups and downs until 1990-92.

The focus group discussion also points out that the awareness they had about education and their economical status did not permit them to send their children to school rather they expect them to work on their farm when they get physically strong. According to the discussion, only the well to do families and government officials were sending their children to school but the great majority of the community did not send and that is why the number of students was few until 1990.

TABLE 5 - EDUCATION IN ANTSOKIA-GEMZA BEFORE WORLD VISION (BEFORE 1990)

VARIABLES	FREQUENCY	PERCENT
Families had children	n=169	100
Yes	80	47.33
No	89	52.66
Families Send all their children to school	n=80	100
Yes	18	22.50
No	62	77.50
Location of School	n=18	100
Around the Woreda	7	38.88
Far from the Woreda	11	61.11
Reasons for not sending all children to school	n=62	100
Economic situation	8	12.90
School distance	2	3.22
Children were young	46	74.19
Help at home	4	6.45
Other	2	3.22
No. Of students who were going to school	n=169	100
Increase	111	65.68
Decrease	15	8.88
No change	2	1.18
I don't know	39	23.07

Source: - Own Survey, Antsokia-Gemeza, 2002

The result of the household survey in Table 5 shows that, 47.33 percent of the households had school age children of whom only 22.50 percent of them send all their children to school. From this 61.11 percent send out of the Woreda and 38.88 percent around the Woreda. However, 77.50 percent of the Households were not able to send

their children since 74.19 percent of the HHS' children were young. Around 12.90 percent of the HHs was economically weak and 6.45 percent of the households want them to work at home.

The Above discussion implies that most of the government schools were poor in their buildings and facilities and this had a contribution for poor student enrollment in addition to the economic, poor awareness of parents and school distance. Some parents were also sending their children far from the Woreda and they were expected to cover school and other expenses, which was unaffordable. Girl students were also few in numbers or no girl student at all in some schools. However, the number of students increased from time to time since government schools were expanding with better facilities.

4.4 EDUCATION IN ANTSOKIA-GEMZA WOREDA AFTER WORLD VISION (1991-2001)

Following the rehabilitation program of 1990, World Vision intervened in the area of education and creates awareness, and facilitates the community to send their children to school. According to the educational sector office, World Vision used to provide school materials like exercise book, pen, pencil, school fee, clothing and others to school going sponsored children. Due to this, many parents decided to send most of their children to school since they have noting to contribute on the educational expense of their children. For this reason, the number of students continued to increase from time to time. In order to look the progress, data for student enrollment has been considered but the Woerda educational sector office has only for the last five years. According to the data which is shown in Table 6, in the year 1997 primary schools'

enrollment in Antsokia-Gemeza Woreda was 4100, 52 percent, out of 7906 school age boy population and 3025, 38 percent, out of 7923 school age girl population. When we consider gender disparity, girls were less than boys in 1075, which is 26 percent.

TABLE 6 - PRIMARY (Grade1-8) SCHOLL AGE POPULATION AND ENROLLMENT IN ANTSOKIA-GEMZA (1997-2001)

SCHOOL AGE POPULATION				ENROLLMENT			
Year	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**	**Percent**
1997	7906	7923	15829	4100	3025	7125	45
1998	8071	8092	16613	4133	3487	7620	54
1999	8236	8261	16497	5125	4659	9784	59
2000	8376	8406	16782	5744	5141	10885	65
2001	8748	8762	17510	6248	5710	11958	68

SOURCE: - ANTSOKIA-GEMEZA EDUCATION SECTOR OFFICE, 2001

In 2001 the enrollment for boys was 6248, 71 percent from 8748 school age boy population and 5710 for girls, 65 percent from 8762 school age girl population were enrolled. The enrollment increased from 45 percent of 1997 to 68 percent in 2001. However, the percentage of student enrollment is declining from year to year.

The three school directors, whom I interviewed, also mentioned that World Vision has contributed to the growth of student enrollment in the Woreda through the provision of school materials.

According to Affeso Junior high school director, the number of students in Affesso has increased from time to time. In 1992 the number of boy students was 384 and girls was

382. In 1997 the number increased by 13.28 percent, become 435 for boys and by 36.38 percent, and become 521for girls. In 2001 the number for boys increased by 19.70 percent and girls by 2.30 percent and become 521 and 533 respectively.

Mekoy Elementary/high School's director also said that in the year 1992 the number reached to 480 for boy students and 442 for girls and in 1997 the number of boys increased by 43 percent and girls by 42 percent which is 615 and 626 respectively. In the year 2001 students of grade 1 to 4 moved to Mekoy elementary school and remain with grade 5 to 10 students and the number of students enrolled in that year was 610 for boys and 486 for girls.

According to Mekdesa Elementary School director, the number of boy students in 1992 was 244 for boys and 273 for girls and in 1997 the number increased by 0.8 percent for boys but girls decreased by 6 percent since school material provision is cut down by World Vision. In order to bring the students back to school, the school staff went home to home and facilitated parents to send their children back to school. If we take the number of students in 2001, boys increased by 33 percent and girls by 50 percent and become 327 and 384 respectively as compared to the number of student enrolled in 1997.

According to Selam Development Consultant, World Vision has provided educational materials like exercise book, pen, pencil, clothing, and medical assistance, registration

fees and secondary school student support. This has contributed to the growth of student enrollment in the Woreda (Selam, 2001).

According to Table 7, World Vision has covered the cost of educational materials and registration fee to about 7,156 additional students that amount a total of Birr 1,210, 621 that is 1.95 percent of the budget allocated to the project between 1990 and 2001.

TABLE 7: - PROVISION OF SCHOOL MATERIALS AND OTHER BENEFITS TO CHILDREN IN ANTSOKIA-GEMZA WOREDA (1990-2001)

PROVISION	BUDGET ALLOCATED		PERCENT OF TOTAL PROJECT BUDGET
	Birr	Cent	
Educational Material	1,030,406	00	1.66
Registration Fee	180,215	00	0.29
Total	1,210,621	00	1.95
Medical Expense	120,957	77	0.19
Clothing	2,434,504	38	3.92
TOTAL	2,555,462	15	4.11
Grand Total	3,766,083	15	6.06

SOURCE: -SELAM DEVELOPMENT CONSULTANT, 2001

World Vision also has covered medical expense and given clothing to sponsored and needy children that costs about birr 2,555,462.15 that is 4.11 percent of the budget allocated to the project for the last twelve years that is between 1990 and 2001. Regarding children support as a whole, the organization invested a total of Birr 3,766,083.15, which is 6.06 percent of the budget allocated to the project for the last twelve years.

The Focus group has also mentioned that World Vision has opened their eyes and they came to understand the advantage of education. Though they are economically weak

but they happen to send their children to school since World Vision has been providing school materials like exercise books, pen, pencil, clothing, registration fee and others to school attending children. The group continued and mentioned that World Vision has provided school materials to their children to start schooling nevertheless it does not continue to support them to finish. Currently, they are responsible to cover school expense since World Vision has blocked the provision of school materials to all sponsored children in which parents cannot afford.

TABLE 8 - EDUCATION IN ANTSOKIA-GEMZA AFTER WORLD VISION

VARIABLES	FREQUENCY	PERCENT
HH having School age children	n=169	100
Yes	133	78.69
No	36	21.30
HH who send all children to School	n=133	100
Yes	102	76.69
No	31	23.30
Reason for not sending all	n=31	100
Economic Situation	17	54.83
Too young	1	3.22
Help at Home	11	35.48
Health Problem	2	6.45
School Expense is covered	n=120	100
Parents	103	85.83
Relative	1	0.83
WV & Parents	16	13.33

Source: - Own Survey, Antsokia-Gemeza, 2002

The result of the household survey in Table 8 shows that 78.69 percent of the households have school age children out of which 76.69 percent send all their children

to school since World Vision has been providing school materials until recently. Due to this, student enrollment has increases by 48.19 percent as compared to that of World Vision intervention of 1990 (Table 5). However, 23.30 percent of the households do not send all due to their economical situation. Others want them to help at home in looking after cattle, fetching water, gathering firewood and help on farm. However, most of them are covering school expenses though their economical situation is worse, as it is shown in Table 4, where 89.94 percent of the households are farmers with an income of less than one dollar per day.

According to sponsored children survey, World Vision has facilitated and support most of the students in educational materials like exercise book, pen, pencils and clothing to join school since the organization is expected by sponsors to send sponsored children to school. According to Table 10, 90 percent of sponsored children responded that nowadays their parents and relatives are responsible to cover school and other expense.

TABLE 9 – SCHOOLING OF SPONSORED CHILDREN SURVEYED IN ANTSOKIA-GEMZA

VARIABLE	FREQUENCY	PERCENT
MISSING CLASS	n=30	100
Yes	19	63.33
No	11	36.66
REASON FOR MISSING	n=19	100
Economic	7	36.84
Health problem	3	15.78
Help at home	9	47.36
PART TIME WORK	n=30	100
Yes	10	33.33
No	20	66.66
SPONSORED CHILDREN DROPPED SCHOOLING	n=30	100
Yes	22	73.33
No	8	26.66
REASON FOR DROPPING	n=30	100
Economic	18	60.00
Health	1	3.33
Marriage	3	10.00
Unknown	8	26.66

Source: - Own Survey, Antsokia-Gemeza, 2002

Regarding sponsored children school attendance as it is shown in Table 9, 63.33 percent of them missed classes at different times of which 84.20 percent of them missed due to economic problem and work at home. About 73.33 percent responded that they might stop schooling out of which 95.45 percent have economical problem. However, 33.33 percent of them are working after class and on weekends in order to cover their school expense. According to the response of sponsored children about 73.33 percent have dropped schooling out of which 60 percent are due to economical problem.

As it is shown in Table 10, since World Vision has stopped the provision of school materials, parents are responsible to cover the expense. However, almost all children are asking World Vision to continue the provision of school materials and medical treatment until their parents become self-sufficient or the project phases out since their parents are economically weak to cover all household expenses.

TABLE 10 – SPONSORSHIP STATUS OF SURVEYED SPONSORED CHILDREN

VARIABLE	FREQUENCY	PERCENT
PRESENT ASSISTANCE TO SPONSORED CHILDREN	n=30	100
Clothing	2	6.66
Medical help	3	10.00
Educational material	2	6.66
No	23	76.66
EDUCATIONAL EXPENSE COVERED	n=30	100
Parents	24	80.00
World vision	3	10.00
Relative	3	10.00
SPONSORSHIP ASSISTANCE SHOULD CONTINUE UNTIL	n=30	100
Project phases out	12	40.00
Parents become self-sufficient	18	60.00

Source: - Own Survey, Antsokia-Gemeza, 2002

Hence the above discussion implies that the intervention of World Vision has opened a way to school age population and sponsored children in particular to go to school through the provision of school materials like exercise book, pen, pencil, registration fee, and clothing. World Vision also provided school facilities, books, and school materials that create a teaching-learning environment in schools. School distance also has reduced and creates a situation where children have time to help their family at home and also work to themselves so that they can cover their school expense. However, cutting of school materials to sponsored children turn out to be a hot issue in all the discussions and shows that sponsored children are still in need of assistance.

Due to the discontinuation of school materials, many sponsored children have drooped and will also drop school. If the organization fail to correct the situation through creating awareness in the community as Mekdessa school act upon to bring children back to school, almost all children will be dropping school.

4.5 SCHOOL CONSTRUCTION IN ANTSOKIA-GEMZA

As it is mentioned earlier that the number of school going children increased from time to time and demanded more new schools to be constructed and open opportunities for school age children to enroll in regular school program. Regarding school constructions, the Woreda Educational sector office said that World Vision has constructed 5 new schools, renovated 5 old schools, expanded 9 schools and upgraded 2 schools that is 1 junior high school and 1 secondary school. This has changed the number of schools from 12 to 23, which is a 91.67 percent growth, out of which Mekoy elementary and high school, Harbu Wolde, Addis Berhan, Aglana, Ankar Kobokob, are new. Addis Alem/HagereMariam, Mochera, Gojowuha, Kabsaramba and Ankar were non functional since they were old and renovated in 1994/95 by World Vision and all have been handed over to the Woreda Educational Sector office and started their function.

The Woreda's educational sector official said that the intervention of World Vision in education has contributed in new school buildings, expansion, renovating, upgrading, supplying furniture, educational materials, school facilities like latrine, libraries, and laboratories and has created a suitable teaching-learning environment.

According to Selam Development Consultant, World Vision has constructed new primary schools and also expands, renovates, upgrades the existing schools, and provides various educational materials, furniture and facilities too (Selam, 2001).

TABLE 11: - PRIMARY SCHOOL CONSTRUCTION, UPGRADING, EXPANSION AND RENOVATION IN ANTSOKIA-GEMEZA WOREDA (1991-2001)

CONSTRUCTION	NUMBER	BUDGET ALLOCATED		PERCENT FROM TOTAL BUDGET
		BIRR	Cent.	
NEW	5	2,058,641	36	3.32
EXPANSION	9	2,540,325	73	4.09
RENOVATION	5	1,500,061	00	2.42
UPGRADING	2	3,122,842	20	2.51
Total Birr		**9,221,869**	**29**	**12.34**

SOURCE: - SELAM DEVELOPMENT CONSULTANT, 2001

According to Table 11, World Vision has invested a total of Birr 9,221,869, which is 12.34 percent of the total budget allocated to the project in the last twelve years to construct 5 new schools, expand 9 old schools, renovate 5 non-functional elementary schools and upgrade 2 schools that is 1 elementary and 1 secondary school.

The development of schools resulted in the growth of classrooms from 79 to 190, which is 140 percent increment. The organization also has established 5 libraries in five different schools, donated books to the libraries, established laboratories to two different schools with laboratory equipments and also supplied furniture and educational materials to schools that cost Birr 2,100,186. In addition to these, a generator has been donated to Mekoy High/Elementary School that costs Birr 168,688 that helps the

laboratory of Mekoy School to be functional. It also becomes a means of income generation to the school through supplying light to Mekoy town. Latrines for schools are also constructed that cost Birr 12,846 and create a situation to bring more school age children to school. School construction, renovation expansion and provision of materials to schools costs a total of Birr 11,503,589 that is 18.53 percent of the total budget allocated to the project for the last 12 years.

Affesso Junior high school director also mentioned that the school had no enough classroom and its building was getting old and became out of use to accommodate all students. In order to solve this problem, World Vision has built 2 blocks with 6 rooms each and provided other facilities, like educational furniture, latrine and strengthen the school.

The interview that is conducted with Mekoy Elementary/High School director also shows that the intervention of World Vision has given a unique feature to the school in constructing additional buildings and upgrades the school to a high school level. The new school has well equipped laboratory, library, water and latrine. World Vision also has provided a generator to the school. The generator serves the school and Mekoy town as well and become a means of income generation.

The focus group mentioned that World Vision has constructed schools close to their home and this has contributed a lot to the early return of children to home and help on farm or any other work.

According to Table 12, the household survey carried out shows that 76.33 percent of the household head respond that World Vision has constructed schools and 23.66 percent respond that MOE and the Community has constructed schools in the Woreda.

TABLE 12 - SCHOOL CONSTRUCTION IN ANTSOKIA-GEMZA WOREDA

VARIABLES	FREQUENCY	PERCENT
WV CONSTRUCTS SCHOOL	n=169	100
Yes	129	76.33
No	40	23.66
COMMUNITY PARTICIPATION	n=169	100
Yes	142	84.02
No	27	15.97
COMMUNITY CONTRIBUTION	n=169	100
Material & Labor	25	14.79
Labor	113	66.86
Money	1	0.59
All	3	1.77
PRESENT SCHOOL DISTANCE	n=169	100
Far from home	5	2.95
Near to home	153	90.53
No change	11	6.50

Source: - Own Survey, Antsokia-Gemeza, 2002

Regarding the participation of the community in school construction, 84.02 percent of the household heads responded that they have participated in the construction out of which 66.86 percent contributed labor and 14.79 percent material, and labor and the rest contributed money. However, 15.97 percent of the household head did not participate due to health problem and some other reasons.

When we consider the spatial distribution of schools, 90.53 percent of the household head said that schools are close to their home, only 2.95 percent said that the schools

are far from home and they do not send their children rather they help their parents at home but 6.50 percent mentioned that no change than before.

However, there are about 23.30 percent of the household head that send their children to traditional schools like Ethiopian Orthodox Church and Korean schools due to their economical status and traditional beliefs; but 4.51 percent of the households send to both schools, traditional and modern schools.

The above discussions implies that World Vision has been promoting education in the past years through construction, renovation, expansion, and provision of school materials to schools and students. Creating access to education and the provision of educational materials has encouraged parents to send most of their children to school and student enrollment has increased from 11 percent to 59 percent and school dropouts is also minimized in the year 2001. Since more classrooms have been added, student-classroom has been improved. The number of teachers in 2001 reached to 220 and student-teacher ratio has improved and created conducive teaching-learning environment that brings efficiency and quality of teaching. Most of the students had been also traveling out from the Woreda for weeks but now schools are available within the Woreda at a short distance from home. This has given a chance to children to have time to help their parents at home, minimized educational cost that parents have been investing on the schooling of children and help them to send additional children and this has opened a way to many school age children to attend school. In this, the poorest of

the poor are benefited. Creating access to educational service is the way to raise individual living standard and a strategy to poverty reduction.

4.6 HEALTH IN ANTSOKIA-GEMZA WOREDA BEFORE WORLD VISION (Before 1990)

The Health sector office of Antsokia-Gemeza Woreda said that health accessibility in the Woreda was so poor that people were going out medical help. Until 1990 there were only three Clinics with out beds for a population of 58,290 in which the ratio was 1:19430 with four Nurses that is 1:14573, six Health Assistant that is 1:9715 and three Laboratory technician that is 1:19430 and 1 sanitarian for the Woreda. Even the existing Clinics were not well equipped, staffed, and organized to serve the community. According to the Health sector office, the people had a problem in the rainy season to go out from the Woreda to the near by health stations for treatment due to Borkena river and most of them passed away without any medical help.

Selam Development Consultant has explained the situation of health in the Woreda in its report that the Woreda had three clinics only. Health service coverage was 9 percent. Since Immunization coverage was nil infant mortality rate was 15 percent. Most of the people were suffering, particularly children from water borne disease (Selam, 2001)

The Focus Group also mentioned that health situation was worse and many people were suffering specially children from water borne diseases, malaria and many others. Their weak income earning capacity, as it shown in Table 4, and health stations

distance aggravated the problem and most of them were not able to take their children for medical treatment.

According to Table 13, 40.82 percent of the households had sick children out of whom 86.95 percent of them have taken their children to health stations for medical help. Out of these, 63.33 percent of them have taken out of the Woreda and others within the Woreda. About 78.34 percent of the households have taken one to three days for treatment but 21.66 percent of them have taken more than three days. According to the survey 95 percent of the households covered their children medical expense.

TABLE 13 - HEALTH IN ANTSOKIA-GEMZA WOREDA BEFORE WORLD VISION

VARIABLES	FREQUENCY	PERCENT
HH who had sick children	n=169	100
Yes	69	40.82
No	100	59.17
Children treated	n=69	100
Yes	60	86.95
No	9	13.04
Areas of Treatment	n=60	100
Out of the Woreda	38	63.33
Within the Woreda	22	36.66
Days Taken for Treatment	n=60	100
1-3 DAYS	47	78.33
More than 3 DAYS	11	18.33
1Month & above	2	3.33
Medical Expense Covered	N=60	100
Parents	57	95.00
Relative	3	5.00

Source: - Own Survey, Antsokia-Gemeza, 2002

The above discussion implies that since the previous governments had little attention to the development of health they had contributed little in the rural areas that results to have worse health situation in the Woreda. Due to this, health coverage in the Woreda

was so low that many people particularly children and women were not able to get medical treatment within the Woreda and have lost their life due to various diseases.

4.7 HEALTH IN ATSOKIA-GEMZA WOREDA AFTER WORLD VISION (1990-2001)

As it is mentioned in chapter 3 in this paper, World Vision intervention into the area due to 1984/85 famines require the organization to continue and involve in development activities to bring a change in the community. Health is one of the components of the activities that World Vision intervened.

According to the Woreda Health sector office, World Vision has constructed two health centers, one clinic and one health post, supplied medicines, and sophisticated equipments to all health stations.

The two health centers are active and serving about 89,100 people, in which the ratio is 1: 44550, that is 50 percent of the total population of the Woreda. The ratio is above the standard set by WHO and MOH (MOH, 2000). The two Health Centers have 6 beds each too with a ratio of 1:7452 that is 8.33 percent of the total population. The Clinics are severing the Woreda too. The ratio is 1:22,275 that is 25 percent of the total population. The health post is also serving the Woreda. The Health sector office mentioned that in 2001 alone a total of 21,562 patients that is 23.86 percent of the total population of the Woreda have taken medical treatment in all the health stations.

As it is shown in Table 14, in the year 2001 alone Immunization for BCG is 87 percent, DPT_3 89.4 percent; Measles 83 percent and 87 percent of the target population is fully immunized.

TABLE14:- IMMUNIZATION COVERAGE, TT_2 AND MATERNAL HEALTH SERVICE ACHIEVEMENT IN ANTSOKIA-GEMEZA WOREDA IN 2001.

SERVICE	TARGET POPULATION	ACHIEVED	COVERAGE
IMMUNIZATION			
BCG	2806	2441	87
DPT_3	2717	2426	89
MEASLES	2972	2467	83
FULLY	2832	2467	87
TT_2			
Pregnant	2798	1455	52
Non-pregnant	7858	7858	100
Antenatal care	1951	1678	86
Assisted delivery	785	471	60
Postnatal care	2074	1535	74
Family planning	4036	4036	100

SOURCE:- WOREDA HEALTH SECTOR OFFICE, 2001

Tetanus to pregnant women achieved is 52 percent and for non-pregnant women is 100 percent of the targeted population. Antenatal care and postnatal care achievement is 86 and 64 percent of the total targeted population respectively. Delivery is achieved 60 percent of the targeted population. Family planning is 100 percent achieved in the same year that is 2001.

The health sector office explained that the intervention of World Vision has contributed in improving the health coverage of the Woreda from 9 to 56 percent. Due to this, the leading causes of morbidity are getting minimized, infant mortality rate is also decreased from 15 to 8.4 percent and immunization coverage is grown from nil to 75 percent and most of school age children have better access of medical treatment and initiated them to attend schooling with out any health problem.

In collaboration with the Woreda health sector, World Vision provides basic health services like immunization and also participates in the time of epidemics to save the life of children and the community as well.

During the group discussion it is also mentioned that, nowadays they have a better access to health and some have a chance to be treated free of charge. They said that the community especially children were suffering from different diseases but now the problem is minimized. Deaths are also decreased and they do not go out of the Woreda for medical help. However, they strongly mentioned that malaria is getting worse in Kola and Woina-Dega zone and people are suffering unless measures are taken. Regarding the spread of malaria, the official from Malaria Eradication Service mentioned that the office is working to control the problem but the situation does not show any change due to D.D.T shortage.

Selam development Consultant also mentioned that the Health coverage grows from 9 percent to 56 percent and immunization is also grown from nil to 75 percent (Selam, 2001).

TABLE 15 - HEALTH IN ANTSOKIA-GEMZA WOREDA AFTER WORLD VISION

VARIABLES	FREQUENCY	PERCENT
HH HAD SICK CHILDREN	n=169	100
Yes	94	55.62
No	75	44.37
DISEASE	n=94	100
Malaria	43	45.74
Cough	19	20.21
Diarrhea	5	5.31
Injury	1	1.06
Other	26	27.65
MEDICAL HELP TAKEN	n=94	100
Yes	83	88.29
No	11	11.70
MEDICAL EXPENSE COVERED	n=83	100
Parents	80	96.38
Other	3	3.61

Source: - Own Survey, Antsokia-Gemeza, 2002

According to the survey shown in Table 15, 55.62 percent of the households had their children been sick of whom 72.32 percent were attacked with Malaria, Cough, Diarrhea, Injury, and 27.65 percent with different diseases. About 88.29 percent of the households have taken their children to health stations for medical treatment and 96.38 percent of the households covered medical expense but about 11.70 percent could not cover due to their economical problem.

As it shown in Table 16, 90 percent of the sponsored children had been sick out of which 70.37 percent were affected by malaria and 29.61 percent by various types of diseases. About 96.29 percent of them got medical treatment within the Woreda and

outside the Woreda health stations. Parents and relatives have covered medical expense for 65.38 percent and World Vision covers only for 34.61 percent of them.

TABLE 16:- HEALTH STATUS OF SPONSORED CHILDREN IN ANTSOKIA-GEMZA WOREDA

VARIABLE	FREQUENCY	PERCENT
HAD YOU BEEN SICK	n=30	100
Yes	27	90.00
No	3	10.00
DISEASE	n=27	100
Malaria	19	70.37
Diarrhea	1	3.70
Cough	2	7.40
Other	5	18.51
Medical treatment taken	n=27	100
Yes	26	96.29
No	1	3.70
MEDICAL EXPENSE COVERED	n=26	100
Parents	15	57.69
World Vision	9	34.61
Relative	2	7.69

Source: - Own Survey, Antsokia-Gemeza, 2002

The above discussion implies that the intervention of World Vision has changed the situation of health in the Woreda through strengthening the capacity of government health stations in planting additional health infrastructure, providing health supplies and materials. Accordingly public health, immunization, Antenatal coverage, number of facilities, human resource and health budget is developed and create the accessibility of health facilities to all community members within the Woreda and this has increased the time they invest on their farm rather than on trip for treatment. Though, the situation

allows many people to go for medical treatment but there are few people who are weak in their economy to help their family for further medical treatment. That is way many of them asked World Vision to continue in covering health expense to their children. Not only parents but children also are asking World Vision to cover their medical expense since their parents are economically weak to cover the cost. However, infant mortality rate and other diseases have decreased resulting in creating a better life expectancy and economically active labor force.

4.8 HEALTH INFRASTRUCTURE CONSTRUCTION IN ANTSOKIA-GEMZA WOREDA

Regarding health infrastructure, the Woreda health sector office reported that World Vision has constructed two Health Centers with delivery rooms, one Clinic and one Health Posts. If World Vision had not been intervened in health it would be a time taking for the state to have such health infrastructure in the Woreda.

Regarding the participation of the community in the area of health, the Woreda Health sector official said that the community has a good participation in different health services and mostly they participate in health infrastructure construction and contribute labor and material.

As it is shown in Table 17, Selam Development Consultants mentioned that World Vision has constructed two Health Centers, two Clinics and six Health posts and provide equipments and supplies to all health station with a total cost of Birr 4,789,199 which is 7.71 percent of the budget allocated to the project for the last twelve years. However,

two health centers, only one clinic, and one health post are recognized by the MOH (Selam, 2001).

TABLE 17:- HEALTH INFRASTRUCTURE CONSTRUCTION IN ANTSOKIA-GEMZA WOREDA (1991-2001)

HEALTH STATIONS	NEW	INVESTED	PERCENT TO TOTAL BUDGET
Health post with medical equipment and furniture	6	150,331	0.24
Clinic with Medical Equipment and furniture	2	224,000	0.36
Health center with medical equipment and future	2	4,414,868	7.11
Total Birr		**4,789,199**	**7.71**

SOURCE: -SELAM DEVELOPMENT CONSULTANT, 2001

The group discussion also mentioned that World Vision has constructed health stations in the Woreda and create better access to health services. The group continued and said that before the coming of World Vision, they were going out of the Woreda for three working days to have medical help. However, the coming of World Vision has minimized the distance they travel and the days they waste and enabled them to work on their plot.

According to the household survey shown in Table 18, 74.55 percent of the household heads responded that World Vision has constructed health stations and 25.44 percent replayed that community and MOH have constructed the health stations.

TABLE 18 - HEALTH INFRASTRUCTURE CONSTRUCTION IN ANTSOKIA-GEMZA WOREDA

VARIABLE	FREQUENCY	PERCENT
WV CONSTRUCTED HEALTH STATIONS	n=169	100
YES	126	74.55
NO	43	25.44
COMMUNITY PARTICIPATED	n=169	100
Yes	130	76.92
No	39	23.07
TYPES OF PARTICIPATION	n=130	100
Labor	125	96.15
Money	1	0.76
Material	4	3.07

Source: - Own Survey, Antsokia-Gemeza, 2002

Regarding the participation of the community, 76.92 percent of the Household head have participated in the construction out of which 96.15 percent contributed labor and the rest contributed money and material. But 23.07 percent of the household head did not participate due to Health and other problems.

The above discussion shows that World Vision has contributed a lot in building health stations, supplying medicines and materials and strengthening the existing government health stations. The community also has participated in the construction and contributed labor, material and money.

4.9 HEALTH TRAINING AND EDUCATION IN ANTSOKIA-GEMZA WOREDA

As part of community capacity building, World Vision has given health training since it is a part of health improvement programs. The organization has been using various methods and means to create awareness towards harmful diseases, family planning and HIV/AIDS and others.

The Woreda health sector office's official said that the organization has a strong dedication in training and in the formation of health clubs in schools.

Selam Development Consultants also mentioned in its report that World Vision has given training for more than 19,391 community members in the area of Trachoma, Family Planning, Epidemic control, Polio presentation, Environmental sanitation, STDs and AIDs prevention (Selam, 2001)

The Focus group also mentioned that World Vision has given health and health related training and education to the community but all the trainings encompass only some male groups over and over again.

According to Table 19, it is found out that only 13.01 percent of the households have a chance to take health training of which 72.72 percent are male. But 86.98 percent did not take. The training covered the areas of health, Nutrition family planning and HIV/AIDS.

TABLE 19: - COMMUNITY HEALTH TRAINING IN ANTSOKIA-GEMZA WOREDA

VARIABLE	FREQUENCY	PERCENT
HEALTH TRAINING IS GIVEN BY WV	n=169	100
YES	22	13.01
NO	147	86.98
PARTICIPANTS	n=22	100
Mother	6	27.27
Father	16	72.72

Source: - Own Survey, Antsokia-Gemeza, 2002

The above discussion implies that the community has taken training on health that will help to have better awareness towards harmful diseases, prevent him and children from communicable disease, and reduce the mortality rates of children.

4.10 CHILD MEAL PER DAY

When we consider child meal, about 63.94 percent of the households give meals to their children three times a day, 29.93 percent twice a day and 5.44 percent four times a day of whom, 81.63 percent of the households give unbalanced diet and 18.36 percent give balanced diet that is egg, milk, soup, vegetable, and others. According to the survey, most of the children seem to be exposed to malnutrition and in order to solve this problem World Vision has been providing supplementary food to an average of 3333 children until 1997. Currently, only 4.76 percent get supplementary food from World Vision and government organizations

According to sponsored children survey that is shown in Table 20, 66.66 percent of them responded that they have food shortage due to poor production and many other

factors. Due to this, 66.66 percent of sponsored children get meal once or twice the rest three to four times a day. However, almost all sponsored children do not have the chance to have balanced diet.

TABLE 20 - MEAL PER DAY OF SPONSORED CHILDREN IN ANTSOKIA-GEMZA WOREDA

CHARACTERISTICS	FREQUENCY	PERCENT
SHORTAGE OF FOOD	n=30	100
Yes	20	66.66
No	10	33.33
No Of meals/day	n=30	100
1	3	10.00
2	17	56.66
3	7	23.33
4	3	10.00

Source: - Own Survey, Antsokia-Gemeza, 2002

The above discussion implies that most of the children do not have the chance to have enough meal due to their parents' weak economical status. This has impact on their health status in which it will affect their schooling that is it will lessen their attention and learning capacity.

4.11 SANITATION AND WATER IN ANTSOKIA-GEMZA WOREDA

The development of water supply facilities can enable a community living within an area to have access to clean and potable water that constitutes an essential element to have a healthy life. Does the intervention of World Vision bring a change in this area?

When we take the Woreda, before the intervention of World Vision in water and sanitation program, people used river and wells for water and had been exposed to water borne diseases for a long period of time, As Selam Development Consultant mentioned in its report, soon after the famines, World Vision managed to provide clean water through springs, ponds, and hand dug wells, boreholes and big water supply schemes. Therefore, World Vision has done 56-spring capping, 55kms lying of water

TABLE 21: - WATER CONSTRUCTION AND SANITATION IN ANTSOKIA-GEMZA WOREDA (1992-2001)

Activity	Birr	Percent
Water construction (Springs, Pore holes, Water points, Shallow wells,	1,877,627	3.02
Pipe Line	158,814	0.26
Collection chambers	132,227	0.21
Hand dug wells	17, 754	0.03
TOTAL	**2,186,422**	**3.52**
Public showers	8,800	0.01
Pit latrine	711,750	1.15
TOTAL	**720,550**	**1.16**
GRAND TOTAL	**2,906,972**	**4.68**

Source: - SELAM DEVELOPMENT CONSULTANT, 2001

pipe, 26 collection chambers, 10 shallow wells and 4 hand dug wells in which almost 46,469 that is 52.15 percent of the population benefited throughout the year but 21.84 percent get seasonally due to water shortage at the source and low capacity of collection chambers. As it is shown in Table 21, to accomplish the work, World Vision has invested a total cost of Birr 2,186,422 that is 3.52 percent of the total budget allocated to the project for the last 12 years. In addition to that 2847-pit latrine and 5

public showers have been planted with a total cost of Birr 720,550, which is 1.16 percent of the budget allocated to the project.

The households survey conducted shows that about 40.82 percent of the households have latrine, especially those households in Mekoy and Majette but 59.17 percent of them do not have.

The Focus Group discussion also mentioned that the coming of World Vision has changed the accessibility of clean water. According to the group discussion prior to World vision they were using river and spring water and exposed to water borne disease specially children. In order to get water they were traveling a long distance too. They continued and explained that nowadays they have clean water near to their home or in their compound and it is not water but "Tsebel" medicated water that they serve to guests.

The household survey in Table 22 shows that almost 100 percent of the households were using river, well and spring water and to fetch water 62.13 percent of the households had been waking a long distance.

Currently, about 96.44 percent of the households use pipe and cupped spring water out of which 82.84 get water near to their home and 17.15 percent walk far from their home to fetch water.

TABLE 22 – ACCESS TO CLEAN WATER IN ANTSOKIA-GEMZA WOREDA BEFORE AND AFTER WORLD VISION INTERVENTION

VARIABLE	FREQUENCY	PERCENT
PRE WV HH GET WATER	n=169	100
River	89	52.66
Well	75	44.37
Spring	5	2.95
DISTANCE FROM HOME	n=169	100
Near to home	64	37.86
Away from home	105	62.13
AFTER WV HH GET WATER FROM	n=169	100
Spring (cuped)	85	50.29
Pipe	78	46.15
River	6	3.55
DISTANCE FROM HOME	n=169	100
Near Home	140	82.84
Far From Home	29	17.15

Source: - Own Survey, Antsokia-Gemeza, 2002

The above discussion implies that World Vision has improved access to potable water from nil to 74 percent and incidence of water borne diseases is also reduced to 51.1 percent and have created a better situation to children to attend school (Selam, 2001). A better situation is also created to parents to invest on the schooling of their children and on some other purpose instead of on the health of their children. The distance and time that women were taking to get drinking water has also minimized and create a situation to help the family at home and sometimes work on farm. Regarding the sanitation of the community, about 5 showers are planted in Mekoy, Majjetee, and other

towns and also 2847 households have access of using pit latrine that helps the community to protect himself from communicable diseases.

CHAPTER V
CONCLUSION AND RECOMMENDATIONS

5.1 CONCLUSION

The intervention of most NGOs is designed to bring a positive impact on the developmental status of a community in general and children in particular, in terms of its access to education, health, water and sanitation, agriculture facilities and other infrastructures. To implement their development program and transform the living condition of the poor of developing nations that gets deteriorated, the North introduces community development. The program, community development, has its own characteristics, objectives, indicators, theories, models, practices and methods of implementation in developing countries as well as in the North. However, scholars raise an alternative hypothesis and a new paradigm of community development in which child centered community development is one of the alternative where most NGOs advocate since children will be guaranteed by a development program carried on in an area. In a child-centered type of community development program, NGOs aimed to work to the well-being of children in a community from the poorest family so that children will have a better chance of survival and education and insure their well-being.

While children are relatively invisible in governments and international institutions, the effects of poverty pronounced among children in poverty situations, however there are a large number of NGOs having a diverse range of interests, actions and concerns to

alleviate poverty and promote human transformational development and create a better access to health and education among the poorest of the poor at grass root level in the developing world through community development program. During the implementation of their development program, children are considered among the most vulnerable of the poor, oppressed, and designed to improve children's health, education, meal/day and others in the context of sustainable development program. To implement these, most NGOs try to have smooth relationships with governments, donors, fundraisers and other organizations.

In regards to World Vision International, it starts its work in sponsoring a little needy Chine's girl in 1948 and continued to sponsor other children from China and then from other developing countries. However, the organization begun its work in Ethiopia in the year 1975 and entered to Antsokia-Gemeza Woreda in 1984/85 due to the then famine of the country since many lives has been affected by the famine in the country as a whole and Antsokia-Gemeza in particular. To address the need of people, World Vision has involved carrying out relief and rehabilitation program until 1990. In 1990/91 the organization has changed its activity and involved in community development program that focuses on child well-being. The main components of the program were agriculture, education, health, capacity building, environmental protection and etc. In regards to education, well-facilitated schools were constructed and created conducive environment for teaching-learning process and this has resulted in better educational coverage. School going children were supplied with school materials, this has encouraged many children from poor families to go to school, and student enrollment has been increasing

from year to year until 1997 that the provision of school materials to sponsored children is blocked. In the area of health, the coverage is improved and health facilities are accessible to most of the community within the Woreda. Sponsored children also had a better chance to be treated in the time of need until 1997. Immunization coverage is improved, the community developed a culture of using latrine and most of the community members have access to clean water. The development of health facilities has resulted in minimizing communicable and other diseases that lead to death. The government also working to control Malaria and World Vision is also involved in supplying Mosquito net to children under the age of 5 and pregnant women in the time of epidemic.

Even though, World Vision has brought a change in the well-being of children as a whole and sponsored children in particular through child centered community development in the area of education and health, but the economical status of the community is still so weak that it does not allow them to cover school and other expenses to their children. Still the community needs World Vision to stay in the area with its program.

5.2 RECOMMENDATION

1. Addressing poverty at household and community level is a way to meet child's need since most of the households are with low income to support their children educational and medical expense. Therefore, World Vision should reduce the root cause of poverty and strength HHs capacity of food production through agricultural extension, input provision, support on socio-economic infrastructure building,

livelihood skills and income generation programs and create a more stable economic base which will help to address child's need like improved number of meals per day, access to school and health services, thereby allowing the organization to gradually reduce the volume of its assistance and move to other development activities.

2. In a child-centered community development type of program, children in a community are the main target group to be benefited from the program. However, World Vision has given attention to those children from the poorest family through sponsorship program and provided assistances like educational material, medical care, nutritional support and others until recently since their families are less likely to be able to support and send them to school than the rest of the community. If World Vision has its target group, sponsored children, it should provide direct and indirect benefits like medical and educational support, during the initial period of the project and also continue until HHs get improved in its economical status and able to support their children. When families are self-sufficient, the provision should be restricted to the time of need and needy children only.

3. The construction of health and school infrastructure, the provision of school materials and medical supplies could create better accessibility to education and health services. However, it seems that World Vision has no clear agreement with respective sector offices when schools and health stations are constructed in the woreda since there are health stations that are not recognized by the health sector office. Regarding the provision of laboratory equipments and educational materials

to schools, medical equipments and supplies to health station, the organization should have clear information whether those materials are an immediate need to schools and health stations. This could help to minimize the wastage of money that would help to invest on other project activities. It should also ensure that all sponsored children are fully immunized and school going children are attending school.

4. World Vision should give equal chance to all HHs and sexes to participate in health and health related trainings and education to create awareness on health care and health status through preventing harmful diseases, family planning, and controlling of malaria so that most HHs will have a better chance to reach their entire family.

5. In monitoring child well-being, World Vision should include some indicators in its monitoring system. Home visit and asking school attendance by itself does not mean monitoring child's physical, spiritual and physiological safety. Therefore, in monitoring child well-being, there should be child health status follow-up, access to clean water and sanitation, social issues, HH food production and food security, change in income to support their children's education and medical treatment without financial support from World Vision.

6. In a gradual reduction of direct and indirect benefits, most of sponsored children and their families expected to receive throughout the lifetime of the project and disagree with the gradual reduction and transfer of benefits to development works. Therefore,

World Vision should develop a procedure of HH follow-up, reporting on the number of families opted for the reduction of benefits as a result of becoming economically strong and a family that should receive a particular benefit from the project, and the number of years that the project will provide benefits to sponsored children and their families and move to other project activities.

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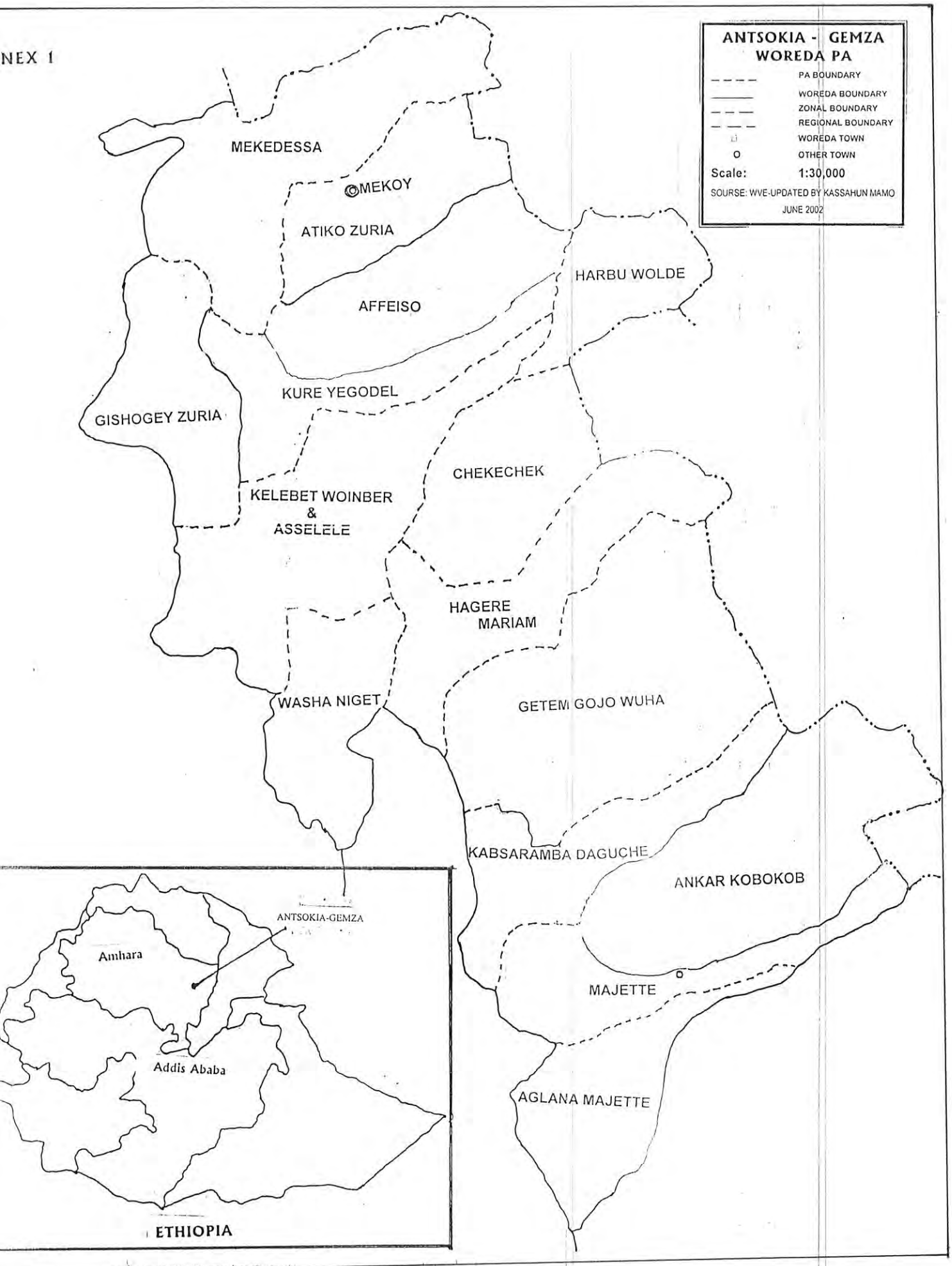
NEX 1


ANTSOKIA - GEMZA
WOREDA PA
PA BOUNDARY
WOREDA BOUNDARY
ZONAL BOUNDARY
REGIONAL BOUNDARY
WOREDA TOWN
OTHER TOWN
Scale: 1:30,000
SOURSE: WVE-UPDATED BY KASSAHUN MAMO
JUNE 2002
MEKEDESSA
MEKOY
ATIKO ZURIA
HARBU WOLDE
AFFEISO
KURE YEGODEL
GISHOGEY ZURIA
CHEKECHEK
KELEBET WOINBER
&
ASSELELE
HAGERE
MARIAM
WASHA NIGET
GETEM GOJO WUHA
KABSARAMBA DAGUCHE
ANKAR KOBOKOB
MAJETTE
AGLANA MAJETTE
ANTSOKIA-GEMZA
Amhara
Addis Ababa
ETHIOPIA

THE IMPACT OF NGOs ON CHILD WELL-BEING THROUGH CHILD-CENTERED COMMUNITY DEVELOPMENT IN ANTSOKIA-GEMEZA WOREDA (THE CASE OF WORLD VISION ETHIOPIA)

ASSESSMENT OF EDUCATION AND HEALTH SITUATION IN ANTSOKIA-GEMZA WOREDA, AMHARA REGION

Annex 2- HOUSEHOLD SURVEY QUESTIONNAIRE

INTRODUCTION

The aim of this questioner is to assess the impact of World vision Ethiopia in the well-being of children through child-Centered Community Development in the area of education and health in the Woreda.

Note: - Please do not write the name of the respondent;
- You can use the box or space provided against each number for your response;

I. IDENTIFICATION

Interviewer's Name: _____ Date _____

PA: _____ Village: _____

1. Rel. to HH _____ 2. Age: _____ 3. Sex: _____
4. Marital Status_____ 5. Education_____
6. Occupation_____

II. SOCIOECONOMIC INFORMATION

7. House hold annual income in Birr. _____
8. Source of Income _____
   1.Farming 2.Trade 3.Permanent Employment
   4.Day labor 5.Skilled Labor 6.Other, specify
9. Do you have a shortage of food currently? _____
   1. Yes 2. No
10. If Yes for Q3, for how long? _____
11. If yes, what survival mechanisms are used commonly? _____
    1.Food For Work 2.Going out for food 3. Wild foods
    4.Reducing meals 5.Other, Specify_____
12. Please list the types of crops you produced in the last harvest and their amount.

CROPS	AMOUNT = KUNTAL

13. Do you have livestock?
1. Yes 2. No

14 If Yes for Q5, Please complete the following Information on your Livestock

TYPE	OX	COW	GOAT	SHEEP	DONKEY	HORSE	MULE	HEN	OTHER
Owned Before WV (No)									
Owned After WV (No)									
Currently Owned (No)									
Total									

15. The size of your plot of land _____

III. EDUCATION INFORMATION

16. Are there schools in the Woreda at present?
1. Yes 2. No
17. Did you have Children?
1. Yes 2.No
18. If yes for Q17, before these schools, did you send all your children to School?
1.Yes 2.No
19. If yes for Q18, Where did you send your children?
1.Within the Woreda 2.Out of the Woreda
20. If No for Q18, how many children have you send?_____
21. If No for Q18, Why?
1.Economic situation 2.School is far
3.Children are young 4. Children help at home 5.Other_____
22. The number of students, who were going out for school were, _____
1.Increasing 2.Decreasing 3. No change 4. I don't know
23. Who covered school expense to your child?

	PARENTS	RELATIVE	WORLD V.	GUARDIAN	SELF	OTHER	NO
Transport							
Clothing							
Books							
Exe. Book							
Pen, Pencils							
Food							
House Rent							
School Fee							
Other							

If available put an X

24. Who constructed the present schools of the Woreda? _____
    1. MOE 2. Community 3. World Vision 4.WV & Community
25. Do you participate in school construction? _____
    1.Yes 2.No
26. If yes for Q6, what do you contribute? _____
    1.Materail 2.Labour 3.Money 4.Other, Specify_____
27. If No for Q7, Why?
    1.Economic Situation 2.Time 3.Othetr, specify_____
28. The distance of the present school as compared to that of the previous (Before WV)
    1.Increased 2.Decreased 3.No change
29. Do you have school age Child at Present?
    1.Yes 2. No
30. If Yes for Q 29; how many children do you have?_____
31. Do you send all your children to School?
    1. Yes 2.No
32. If no, how many of them do you send?
33. Why not you send all?
    1. Economic situation 2.Too young 3. Help at home 4.Health problem
34. Who is covering your Child's school expense?

	PARENTS	RELATIVE	WORLD V.	GUARDIAN	SELF	OTHER	NO
Transport							
Uniform							
Books							
Exe. Book							
Pen, Pencils							
Food							
House rent							
Fee							
Other							

    If available put an X
35. Do you know World Vision?
    1.Yes 2.No
36. If yes for Q35, for how long do you know? _____
37. If Yes for Q35, does it intervene in education? _____
38. If yes for Q35, In What? _____
    1.Construction 2. Facilities 3.Educational Materials 4.others,___
39. Is your child goes to school everyday?
    1.Yes 2.No
40. If no for Q39, why not?
    1. Parent's Economic Situation
    2. Looking after cattle
    3. Baby sitting
    4. Working on farm
    5. Other
41. Did your child miss class in the last six months?
    1.Yes 2.No
42. If yes for Q41, Why?
    1. Because of Sickness 2. Parent's Economic problem 3. Looking for job
    4. To help parents at home

43. Does your child ever detained in class?
1. Yes 2. No

44. If yes for Q43, why?

1. Did not study learning process. 2. Shortage of books 3. No good environment for teaching 4. Lack of teachers 5. Other

45. Is there any traditional school in your area?
1. Yes 2.No

46. The traditional school is
1. Orthodox Church School 2. Koran 3. Other _____

47. Is your child attending traditional schools?
1. Yes 2. No

48. Why not you send to modern schools? _____
_____

IV. HEALTH SECTION

49. Was there any child in the family who had been sick prior to WV?
1.Yes 2.No

50. If yes for Q49, did medical treatment is given?
1. Yes 2.No

51. If yes for Q50, where did you take him/her for treatment?
1. Health Stations 3.Traditional physicians
2.Village health workers 4.Other

52. If no to Q49, why not?
1. Economic Situation
2. Distance of health station
3. Don't believe in medicals
4. Other

53. Where did you go for medical treatment?
1. Out of the Woreda 2.Within the Woreda

54. If you go out of the Woreda, How many days did you take to complete the treatment?
1.1-3 days 2. More than 3 days 3. 1 month & above

55. Who covered the expense? Please complete by putting X .

EXPENSES	PARENTS	RELATIVE	GUARDIAN	SELF	OTHER	NO
Transport						
Hotel						
Examination						
Lab.						
Medicine						
Food						

56. Is there any health station in your area?
1. Yes 2. No

57. Who constructed the present health station?
1. Ministry of health 2. Community 3. World Vision
4. World Vision & Community 5. Other

58. Do you participate in the construction of the health station?
1.Yes 2.No
59. If yes for Q58, in what do you participate?
1.Labour 2.Money 3.Material 4.Other, Specify_____
60. If no Q58, Why?
1.Economic problem 2.Time 3.Other, Specify_____
61. Does World Vision intervene in health?
1.Yes 2.No
62. If yes for Q61, in what does it intervene?
1.Health Education 3.Construction
2.Suppliying medicine 4.Providing materials
63. How do you see the status of health facilities?
1.More Developed 2.Developed 3.No Change
64. How often do you go to the Health stations?
1. Sometimes 2. Always 3.I don't go
65. How do you see the hospitality of the Health stations?
1. Good 2. Fair 3. Average 4. Poor
66. The number of health stations compared to that of prior to World Vision intervention;
1.Increased 2. Reduced 3. No change
67. Is any member of the family has been sick in the last six months?
1.Yes 2.No
68. If yes for Q67, did you go to health stations of Gemza for medical help?
1. Yes 2. No
69. If yes for Q68, Who pays the medical expense?
.1.Parents 2. Other
70. If No for Q67, Why not?
1. Economic problem 3. Health institution is far
2. Do not believe 4. Other
71. If yes for Q67, what were the diseases that attack your family?
1.Malaria 2.Cough 3.Diarrhea 4. Injury 5.Measles 6.Other
72. Is there any family member who died in the last one year?
1.Yes 2.No
73. If yes for Q72, what was the reason for death?
1.Disease 2. Accident 3. Hunger 4. Other

4.1 Health Training and Education

74. Is there any health training and education conducted?
1. Yes 2. No
75. If yes for Q74, Is there any family member who participated the training?
1. Yes 2. No
76. If yes for Q75, who participated?
1. Mother 2. Father
77. What were the topics discussed in the training?
1. Health 2 Nutrition 3. Family planning 4. All 5. Other

78. Who arrange the training?
1. MOH 2. Community members 3. World Vision 4. Others

4.2 Immunization and Meal/Day

79. Does your child Immunized?
1.Yes 2.No

80. How many times do you feed your child within a day?
1. Once 2.Twice 3. Three times 4. Four times

81. Do you give your child all types of food?
1.Yes 2. No

82 If yes to Q81, Please mention the food that you feed your child in the last ten days,
1._____ 2._____ 3._____ 4._____

83. If no to Q81, do your child get supplementary food?
1.Yes 2.No

84. Who provide the supplementary food to your child?
1. World Vision 2. Other NGO 3. MOA

4.3 Sanitation and Water

85. Do you have latrine?
1. Yes 2.No

86. Where did you get drinking water before the coming World Vision?
1. River 2.Well 3.Spring

87. The time you need to get water
1.10min 2.30min 3.1hr. 4.More than 1hr.

88. What is your source of water in dry season?
1. Well 2. Spring 3. Pond 4. Other

89. How long do you travel to get water in dry season?
1. 30min 2. 1 hr. 3. 2hrs. 4. Other, Specify_____

90. What is your source of water during rainy season?
1. Rain 2. River 3. Tape 4. Other

91. How long do you travel to get water in rainy season?
1. 10min 2. 15min 3. 30min 4. Other, specify_____

92. Is there maternal death due to delivery problem?
1. Yes 2. No

93. Do the health stations have delivery rooms?
1. Yes 2. No

94. If no, where do women get help?
1.Local physician 2. Traditional Delivery attendant's 3.Other, Specify___

ANNEX 3 - SPONSORED CHILDREN QUESTIONNAIRES

INTRODUCTION

The aim of this questioner is to assess the impact of World vision Ethiopia in the well-being of sponsored children through child-Centered Community Development in the area of education and health in the Woreda.

Note: -Please do not write your name,
-You can use the box or space provided against each number for your response;

Sex _____
Age _____
School _____
Grade _____
Village _____

1. How do you start Schooling?
   1) Parents encourage me 2) Friends encourage me
   3) World Vision encourages me and supplies me school material.
2. Do you have brothers and sisters?
   1) Yes 2) NO
3. If yes for Q2; do they attend school?
   1) Yes 2) No
4. If yes for Q2; what is the number?
   1) Brothers_____ 2) Sisters _____
5. If no for Q2; why?
   1) Economic situation 2) Too Young 3) Health problem 4) School Distance
6. Who provide you school material?
   1) Parents 2) Relative 3) World Vision
7. Do you miss class in the last six months?
   1) Yes 2) No
8. If yes for Q7; why?
   1) Economic problem 2) Health problem 3) Help at home
9. Do you detained in class?
   1) Yes 2) No
10. If yes for Q9; why?
    1) Help at home 2) Health problem 3) Not study
11. Do you have a problem not to follow your schooling?
    1) Yes 2) No
12. If yes for Q11; what is you problem?
    1) Health 2) Economy 3) Help at home
13. Do you work par timework after class?
    1) Yes 2) No
14. If yes for Q13; what do you work? _____
15. How long had you been in sponsorship? _____
16. What did you benefit from sponsorship program?
    1) Clothing 2) Medical help 3) Educational material 4) Nol
17. Had you been sick?
    1) Yes 2) No
18. What was your sickness?
    1) Malaria 2) Diarrhea 3) Cough 4) Other

19. Did you take medical treatment?
    1) Yes 2) No
20. If yes for Q19, Who covered your medical expense?
    1) Parent 2) World Vision 3) Relative
21. Do you have a shortage food In your home?
    1) Yes 2) No
22. How many times do you eat in a day?
    1) 1 2) 2 3) 3 4) 4
23. Do you get balanced diet?
    1) Yes 2) No
24. Does World Vision ever supply you with supplementary food in the last 6 months?
    1) Yes 2) No
25. What are the major activities World Vision is doing?
26. What do you feel of World Vision development?
    1) Strongly agree 2) Agree 3) Don't agree
27. Does World Vision assist your parents?
    1) Yes 2) No
28. If Yes for Q27; in what?
    1) Tools 2) Seeds 3) Ox 4)
29. Do you know sponsored child who dropped schooling?
    1) Yes 2) No
30. If yes for Q29; what is the reason?
    1) Economic problem 2) Health problem
    3) Marriage 4) Job
31. Do World Vision stop supplying assistance to sponsored children?
    1) Yes 2) No
32. If yes for Q31, why?
    1) Budget problem 2) Development 3) Phasing out
33. Do you agree on the transfer of sponsorship budget to development work only?
    1) Yes 2) No
34. If yes for Q33; How should sponsorship budget managed?
    1) Use only for sponsorship 2) For Development 3) Both
35. For how long the provision of supplies to sponsored child should continue?
    1) Until project phase out 2) Until parents help themselves

ANNEX 4 - INTERVIEW TO SCHOOL DIRECTORS EDUCATION SECTOR OFFICE

Introduction.

The aim of this questioner is to assess the impact of World vision Ethiopia in the well-being of children through child focused community Development in the area of education and health in the Woreda.

1. When the school is started?
2. Who constructed the school? What was the reason for the establishment of the school,? How About School Facilities?
3. The number of students enrolled___ Male_____ Female_____
4. The number of classrooms
5. the number of teachers when the school begin__Male____Female___
6. What was the qualification of teachers?
7. Before schools opened in the Woreda, where did children go for schooling?
8. Do the present schools have facilities?
9. How is the enrollment of students in your area?
10. If it is poor, why?
11. If increasing, why?
12. Do World Vision contributed for better enrollment, how?
13. Is any change in classrooms over the last five years?
14. If classrooms expanded, who built it?
15. If not expanded, why?
16. Is there a school library?
17. Are there reference books available?
18. Who supplied books to your library?
19. Do school texts available? Do books distributed to each student or shared?
20. Is there a laboratory in your school? Is it well equipped?
21. Who supplied the equipment to the laboratory?

ANNEX 5 - INTERVIEW ON HEALTH

Introduction.

The aim of this questioner is to assess the impact of World Vision Ethiopia in the well-being of children through child focused community development in the area of education and health in the Woreda.

1. When this health station started its function?_____
2. How many staffs were there when the health station starts its function?
3. Who constructed the health station? Is there good facility?
4. Do the health stations have delivery rooms?
5. If there is no, where do women get delivery help?
6. Do Community participate in the area of health?
7. In what do the community Participate?
8. Do World Vision Participate in the area of Health?
9. In what It participates?
10. What is your attitude to wards the intervention of WV in the area of health?
11. Do the community benefit from the health stations?
12. How many people do come to the station for treatment in a day?
13. What are the common diseases that the community is attacked from?
14. Is the medical cost meet the economic situation of the community?
15. Do you give medical help to the poor in the community?
16. Is the number of health station Increasing?
17. Do children fully immunized? If not Why?
18. Do you get enough Health budget for the Woreda?

Annex 6 - FOCUS GROUPS DISCUSSION POINTS

PART 1- HEALTH

1. Do health facilities available in most PAs?
2. Is the health status of children improved? (Diarrhea, Respiratory problem)
3. Do children have access to health facilities, medicines/Immunization?
4. Do the distance of the health station reduced as compared with that of the distance prior to world vision intervention?
5. Is there any change in the medical expenses of the family as compared with that of prior to WV intervention?
6. Do families have health and health related training/education?
7. Do families use latrine?
8. Do families have access to drinking water for all and all the day and what are the major sources of water?
9. Do the distance to water reduced after the intervention of WV? For what purpose do families use it?
10. Do children have access to supplementary food? Who supply them?

PART 2 - EDUCATION

1. Do primary schools are available in all PAs?
2. Do too many students go for schooling?
3. Are there qualified teachers?
4. Is there a good environment for Learning-teaching Process?
   - Library, Laboratory, Student-teacher ratio, Student-Classroom ration
   Good Facilities (water, latrine)
5. Is the distance of schools reduced as compared to schools prior to WV Intervention?
6. Is there any literacy program/pre-school/kindergarten in the Woreda?
7. Where do children go after their completion of primary School?
8. Do parents have economical benefit for having schools in their area?
9. Is there any school assistance from WV to Children in there area of schooling?
10. Do you ever face a problem in sending your children to school?
11. Does World Vision participate in the area of education? In What? Does World Vision provide school materials to students? What do you agree or disagree with the provision?

DECLARATION

I declare that this thesis is my original work, and has not been presented for a degree in any other University; and all sources of material used for the thesis are duly acknowledged.

Name: Kassahun Mamo

Signature: 

Date: 15/11/03

Place: Addis Ababa