CHILD HEALTH NOW CAMPAIGN FINAL EVALUATION REPORT

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Abbreviations/Acronyms

AP	Area Program
ANC	Antenatal Care
CBO	Community Based Organization
CCCs	Community Care Coalitions
CHN	Child Health Now
CPO	Cluster Program Office
CSOs	Civil Societies Organizations
CVA	Citizen Voice and Action
DAC	Day of African Child
DME	Design, Monitoring and Evaluation
EDHS	Ethiopia Demographic and Health Survey
ENA	Emergency Nutrition Assessment
EWEC	Every Woman Every Child
FBOs	Faith Based Organizations
FMoH	Federal Ministry of Health
GTP	Growth and Transformation Plan
GWA	Global Week of Action
HC	Health Center
HDA	Health Development Army
HEW	Health Extension Worker
HF	Health Facility
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HSDP	Health Sector Development Program
IEC	Information, Education and Communication
IEOS	Integrated Emergency Obstetric and Surgery
IFHP	Integrated Family Health Program
IMNCI	Integrated Management of Newborn, Childhood illnesses
IMR	Infant Mortality Rate
KA	Kebele Administration
LLA	Local Level Advocacy
MDGs	Millennium Development Goals
MNCH	Maternal Newborn and Child Health
MOFED	Ministry Of Finance and Economic Development
OECD/DAC	Organization for Economic Cooperation and Development/Development Assistance Committee
PMNCH	Partnership for Maternal, Newborn and Child Health
SBA	Skilled Birth Attendance
SNNR	Southern Nations Nationalities Region
USAID	United States Aid for International Development
VCA	Vulnerable Child Advocacy
WaSH	Water, Sanitation and Hygiene
WCYA	Women, Children and Youth Affairs
WHO	World Health Organization
WVE	World Vision Ethiopia
WVI	World Vision International

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EXECUTIVE SUMMARY

Introduction

World Vision International (WVI) is a Christian relief, development and advocacy organization dedicated to working with children, families and communities to overcome poverty and injustice. Motivated by its Christian faith, World Vision is dedicated to working with the world's most vulnerable people, serving all people regardless of religion, race, ethnicity or gender. World Vision Ethiopia (WVE) has since 1971 been designing and implementing numerous relief, development and advocacy programs and projects for more than 45 years in Ethiopia. At present, WVE operates 59 Area Programs (APs) in five regional states, namely, Tigray, Amhara, Oromia, SNNPRS, Benishangul Gumuz, and one city administration – Addis Ababa, alongside running relief response operations in two more regional states, Ethio-Somali and Gambella Regions.

WVE commissioned FTS Management and Strategy Consulting towards the end of March 2017 to undertake the final evaluation of Child Health Now (CHN) Campaign Project in Banja and Humbo Woredas of Amhara and South Nations, Nationalities and Peoples (SNNP) Regions, respectively, where the project was piloted and implemented from October 2012 to September 2016. The goal of CHN Campaign Project was to contribute to the national effort in reducing maternal and newborn mortality in Ethiopia by 2016 while the expected outcomes were improved MNCH policy processes at the national and regional levels and increased awareness of MNCH related national commitments to global frameworks.

This is, therefore, the report of the final evaluation of the campaign project, based on the qualitative and quantitative data collected from April 10 to 28, 2017. The purpose of the terminal evaluation was to generate information to determine success factors, challenges and learning in the process of design, implementation and monitoring of the CHN Campaign Project, promote accountability and learning and forward recommendations for future policy advocacy campaigns.

Evaluation Methodology

The terminal evaluation adopted a mixed approach where both qualitative and quantitative methods were employed to meet the terminal evaluation objectives. Documents were reviewed; a participatory approach was adopted for data collection mainly through engaging focus group discussions and key informant interviews; site observations and household survey were conducted. In this respect, mothers, child parliamentarians, CCC members, health personnel, government officials (federal, region, zone and local levels), WVE staff (HO and AP levels), Save the Children and UNICEF, were engaged during data collection. The evaluation results obtained from the both qualitative and quantitative data were discussed and analyzed while comparisons were also made between baseline values and evaluation results for outcome level indicators of the project. The evaluation results were also analyzed against national level coverage data of MNCH services.

Key Evaluation Results

Relevance

After identifying low utilization of maternal health services, including skilled attendants at birth, as one of the major health challenges in 2010, the government has put the expansion of MNCH services high on its political agenda to reduce the preventable deaths of mothers and children. In its 2013-2015 national office strategy WVE has also identified health challenges of mothers and children and worked towards achieving maternal and child health outcomes by the end of the strategy period. The evaluation has revealed that the campaign project was designed,

implemented and monitored with the active participation of all relevant stakeholders, including the local government offices, CBOs, FBOs, beneficiary families and communities because the project was particularly relevant to government health policy and community problems. It is worth noting that the evaluation results have shown, among others, that the three delays approach, the research results, media engagement and community empowerment strategies proposed and implemented under the CHN Campaign Project, have complemented the efforts and contributions made by the government and non-state actors to reduce preventable maternal and child deaths across the country.

Effectiveness and Efficiency

The evaluation has shown that the project activities and their strategies were implemented in a satisfactory manner over the implementation period, producing results (outputs and outcomes) that have contributed effectively to the project's goal of reducing preventable deaths of mothers and children in target communities and beyond. Efforts were made to reduce the three delays (first delay: delay in making decision to seek health service, second delay: delay in reaching health facility, and third delay: delay in receiving health care), through effectively engaging partners and target communities. The campaign project has registered an impressive progress in addressing the first delay through effectively involving local faith leaders, which was effective. For instance, skilled birth attendance increased from 74.7% in September 2014 to 98.2% in April 2017 in Banja Woreda and from 53.5% to 88.1% in Humbo Woreda during the same periods. These are significant leaps forward compared to the national average of 28% in 2016 according to EDHS 2016 and 72.7% of the same based on Federal Ministry of Health's HMIS (health management information system), which is government's administrative data for 2015/2016.

The evaluation has also found out that the health policy processes and health programs of partners could have benefited more from implementation of the project had there been an adequate level of networking and reporting at regional level. The project had a planned budget of US$ 719,644, out of which US$ 543,444 or 76% was utilized up to the end of FY 2016. Even though there was a slow start due to the nature of the project, the budget utilization improved from year to year.

Impact and Sustainability

The campaign project, combined with government's and other MCH stakeholders' efforts, has empowered women to make appropriate decisions with regard to what to do and where to go for safe delivery. The involvement of the religious leaders has positively influenced the first delay, i.e. delay in making decision to seek health care, through inculcating positive behavioral and attitudinal changes in the families and communities regarding institutional delivery. The campaign project has contributed to the creation of social cohesion among community members in general and women in particular as they monitored pregnant women and encouraged each other to enhance the wellbeing and health of families in target communities.

The evaluation has revealed that the successful implementation and contribution of the campaign project in target communities, has fended off potential OVC psychosocial challenges and distresses that could have negative social and economic burdens to families and communities in particular and to the nation in general. The campaign project has also helped the government to focus on removing the barriers that cause the first delay through addressing community behavioral and attitudinal changes at the local level.

However short time it might be to see significant impacts, there are clear signs that popular awareness on and understanding of the need for institutional delivery have resulted in lasting

behavioral changes in rural families and communities. The evaluation has revealed that health facilities used to receive only deliveries with complications or obstructed deliveries, not normal deliveries, in most of the cases but now this situation has changed significantly. MNCH services expansion related projects like CHN Campaign Project, have already prompted the need on the part of the government to improve health sector planning and increase health budgets to meet the rising demand as a result of active community mobilization and sensitization on institutional delivery. The MNCH system and services are also expected to be resourced well in the future because the government has already started community based health insurance in 380 woredas in the country, where individual households pay 240 Birr (about USD 10) per annum, with the view to ensuring equitable access to and sustainability of MNCH services in the years ahead.

Conclusion

The campaign project has played a key role in triggering big demand for health services at the local level by emphasizing and promoting the need for skilled birth attendance to every childbirth in the target communities and beyond. Efforts were made to inspire the local government to increase its commitment to expand and improve institutional delivery. Most of the strategies adopted by the campaign project (like MNCH assessment, causes of low SBAs, public engagement through mass media, awareness creation and community mobilization on the need for MNCH services as well as engaging local government offices, child parliamentarians, CBOs, and FBOs) have been effective and constituted major steps forward in advancing the expansion, equity and quality of MCH services, particularly of SBA services, across project target communities and beyond. Nonetheless, there are still areas that need the attention of WVE and its partners as they continue collaborating on similar campaign projects in the future

Recommendations

Program Development and Coordination

- **Build organizational capacity:** WVE should focus on training and equipping its staff and reviewing its staffing level and organizational set up in order to continuously build its own organizational capacities for successful future engagements in advocacy work.
- **Developing key campaign/advocacy messages:** In the future, WVE needs to develop key campaign/advocacy messages that help effectively advance key issues with pertinent audiences at different levels and ensure that such advocacy messages are delivered with ease by various levels of organizational leadership and field staff.
- **Strengthen networking and partnership:** WVE should revisit its regional level organizational set up to include subject matter specialists or take any appropriate action to ensure consistent and continuous representation of the organization at relevant national and regional forums and technical working groups.

Policy and Strategy

- **Ensuring quality and equity of MNCH services:** The government needs to mobilize and work with international NGOs like WVE and multilaterals to strengthen the capacities of the health system and to improve the quality of MNCH services by consolidating best practices and models developed by its partners. The government also needs to improve road access to health facilities in the years ahead in order to ensure equity of MNCH services in hard to reach rural communities.
- **Ensuring sustainable MNCH financing:** The government needs to mobilize community participation at the local level expanding what it has already started as community based health insurance while continuously engaging its partners in the drive to

mobilize adequate financial resources with the view to sustaining and expanding achievements registered so far in MNCH services.

1. INTRODUCTION

1.1. Background

World Vision International (WVI) is a Christian relief, development and advocacy organization dedicated to working with children, families and communities to overcome poverty and injustice. Motivated by its Christian faith, World Vision is dedicated to working with the world's most vulnerable people, serving all people regardless of religion, race, ethnicity or gender. As an entity of this global organization, World Vision Ethiopia (WVE) has been designing and implementing numerous relief, development and advocacy programs and projects for more than 45 years since it began its operations in Ethiopia in 1971. At present, WVE implements 59 Area Programs (APs) in five regional states, namely, Tigray, Amhara, Oromia, SNNPRS, Benishangul Gumuz, and one city administration – Addis Ababa, alongside running relief response operations in two more regional states, Ethio-Somali and Gambella Regions.

WVE collaborates and partners with Ethiopian government offices, various donors, NGOs, bilateral and multilateral agencies and target communities with the view to creating synergy and sharing vital resources and capacities that help it effectively advance the causes of the poor, marginalized and underserved children, families and communities in its program target geographies and beyond. To this effect, WVE, in collaboration with its partners, designs and facilitates the implementation of food/livelihood security, water, sanitation and hygiene (WaSH), education and capacity building, child protection, and health and nutrition programs and projects, among others, by adopting and applying community empowerment approaches. The main goal of WVE's programs and projects is to contribute to the sustained wellbeing of children within families and communities, especially the most vulnerable groups.

In January 2013, WVE launched the Child Health Now (CHN) Campaign with government officials from both Amhara and SNNP Regions and other partners. Initially, the campaign project was expected to run until the end of September 2015. But the project was extended later by one more year up to the end of September 2016 due to the major organizational transition experienced by WVE that necessitated revision of the campaign project document in order to align it to the national health advocacy priorities and the Technical Approaches of World Vision Global. The campaign project was implemented in Humbo Woreda of Wolaita Zone, SNNPR, and Banja Woreda of Awi Zone, Amhara Region.

The main goal of the campaign project was to contribute towards the reduction of maternal and newborn mortality by the end of year 2016. There were two expected project outcomes, namely, improved maternal, newborn and child health (MNCH) policy processes at the national and regional levels and enhanced commitment to improve institutional delivery at the district level.

WVE planned to get CHN Campaign Project evaluated by hiring FTS Management and Strategy Consulting (FTS Consulting, for short) on a competitive basis. Accordingly, this final evaluation report was prepared and submitted to WVE in accordance with contract agreement signed between the organization and the consulting firm towards the end of March 2017.

This evaluation report covers purpose and objectives of the final evaluation, project description and its operating contexts, evaluation methodology, evaluation findings and discussions, conclusion and recommendations. References and annexes are also included at the end of the evaluation report.

1.2. Purpose and Objectives of the Final Evaluation

The purpose of the terminal evaluation is to generate information to determine success factors, challenges and learning in the process of design, implementation and monitoring of the CHN Campaign, promote accountability and learning and forward recommendations for future policy advocacy campaigns. The specific objectives of the terminal evaluation are:

i. To assess the extent to which the campaign achieved its goal and objectives,
ii. To determine the internal and external contributions of the campaign to WVE's work on child and maternal health,
iii. To determine the extent to which the campaign project has contributed to skilled birth attendance coverage and national health policy, and
iv. To assess the extent to which the project exhibited strengths and limitations and encountered problems and challenges while contributing to organizational learning.

2. CHN CAMPAIGN PROJECT DESCRIPTION AND ITS OPERATING CONTEXTS

2.1. Project Description

Project goal

The goal of the project was to contribute to the national effort in reducing maternal and newborn mortality in Ethiopia by 2016, through our Health and Nutrition and HIV response programs and through the CHN campaign.

Description of the project outcomes and outputs

In pursuit of the campaign project goal, WVE worked towards achieving the following two project outcomes: (1) improved MNCH policy processes at the national and regional levels and (2) enhanced commitment to improve institutional delivery at the district level. The campaign project was implemented in selected districts where WVE has been operational with more emphasis on Humbo and Banja ADPs.

Outcome 1: Improved MNCH policy processes at the national and regional levels

Improved health service delivery is contingent upon a number of factors that mainly include having adequate skilled health professionals working in the health system especially at the facility level, regular supply of drugs and commodities in health facilities and improved linkages between community needs and health systems priorities. The national and regional decision makers were targeted to respond the root causes of the three delays that cause difficulties in accessing skilled birth attendance.

In 2010, Ethiopia made commitment on EWEC for maternal and child health: to increase the number of midwives from 2050 to 8635, Skilled birth attendance from 16% to 60%, emergency obstetric care at all hospitals and at all health centers, reach measles coverage to 90%, 100% HIV/AIDS services, decrease MMR from 590 to 267 per 100,000 live births and reduce the under-five MR from 101 to 68 per 1,000 live births.

Outcome 2: Enhanced commitment to improve institutional delivery at the woreda level

This outcome was envisaged to be achieved by addressing immediate causes of the delays to make decisions that accelerate skilled birth attendance. It was also planned to target health system leaders at woreda and zonal level to show their commitment in delivering the essential services to mothers. The uptake of major maternal care services would improve and contribute for the reduction of child mortality. Community participation was planned to be emphasized in order to help improve service provision.

Output 1.1: Enhanced understanding of immediate and underlying causes of delays to skilled delivery

It was expected that this output was going to focus on conducting a formative research on skilled birth attendance to identify what prevents the women from going to health facilities to get health services. The assessment was expected to identify a number of issues that would lead the organization to do more on advocacy issues and messaging. The major activities expected to be implemented under this output included:

- Conducting an assessment on the factors and perceptions that impact on skilled birth deliveries in Ethiopia,
- Developing a policy brief to inform policy discussions on improving skilled birth deliveries,
- conducting a dissemination session of the assessment findings with critical decision makers,
- Generating advocacy messages targeting the community with the help of a communication consultant, and
- Production of advocacy materials to facilitate community sensitization and policy engagement (media packs, summary briefs and IEC materials).

Output 1.2: Increased awareness of MNCH related national commitments to global frameworks

A number of activities were planned to achieve this output:

- Conducting stakeholders sensitization forum on EWEC at the national and regional levels, Together with the government,
- Conducting a review of government progress in meeting the EWEC (every woman and every child) commitments,
- Participating in media talk shows to highlight EWEC commitments, the progress made and the challenges,
- Conducting annual follow up meeting with relevant stakeholders on EWEC, Production of easy to read IEC materials on EWEC and CHN messages for sharing with stakeholders.
- Supporting World Vision's national, regional and global advocacy efforts to improve child and maternal health (particularly the GWA in May 2014, WHA, UNGA and other important national events such as DAC, etc.) and
- Mobilize staff & RC to participate in Ethiopian Great Run to profile skilled delivery

Output 2.1: Increased community involvement in public health service delivery system:

WVE planned to make use of the existing community led care coalitions to plan and monitor the health service delivery systems. Prior to their involvement the coalitions would be trained on the standards of public health system delivery and common dialogue would be made with health facility level management. The other planned activities included:

- Conducting a mapping exercise of CCCs in the Campaign areas and their capacity gaps,
- Reviewing or customizing the local level (LLA) and civil voice and action (CVA) advocacy tools in line with the CCC capacity needs,
- Mobilizing and training CCC on public health standards and monitoring public health service delivery, and
- Organizing and facilitating sampled CCCs to pilot monitoring of health service delivery using the developed tools.

Output 2.2: Increased understanding among Woreda and Zonal level stakeholders of the importance of skilled delivery

The campaign planned to conduct various assessments and share the findings with the concerned stakeholders, focusing on the following activities:

- Conducting lobbying sessions based on developed policy briefs with woreda and zonal decision makers,
- Conducting training on the importance of skilled birth delivery for media editors at the woreda and zonal levels, and
- Working with the media (feature articles, field visits, talk shows, etc.) to sensitize communities on the importance of skilled birth delivery.

2.2. Global and National Contexts

In 2000, the United Nations (UN) set eight Millennium Development Goals (MDGs) to be achieved by 2015, where the targets of MDG 4 and 5 were to reduce under-five child mortality by two-thirds and maternal mortality by three-fourths, respectively. According to UN report, between 1990 and 2015, the number of deaths in children under five worldwide declined from 12.7 million to around 6 million, where the global under five mortality rate dropped from 90 to 43 deaths per 1,000 live births and declining by 52% eventually. The report notes further that every day in 2015, 16,000 children under five continued to die worldwide mostly from preventable causes.[1] WHO report has revealed also that there were estimated 532,000 deaths of mothers from complications related to pregnancy and childbirth in 1990 while these maternal deaths were reduced to about 289,000 by 2015, which was around 45% reduction globally, considerably short of expectations.[2]

Ethiopia has made significant progress in reducing maternal and child mortality rates over the past 15 years according to Ethiopia Demographic and Health Survey (EDHS) 2016. The maternal mortality ratio (MMR) has steadily declined from 871 deaths/100,000 live births in the 2000 EDHS, to 676 deaths/100,000 live births in the 2011 EDHs, to reach 412 deaths/100,000 live

[1] See United Nations Millennium Development Goals; http://www.UN.org/millenniumgoals/childhealth.shtml; Accessed on April 20, 2017.
[2] See http://www.who.int/topics/millennium_development_goals/maternal_/en/; accessed on April 20, 2017.

births in 2016 EDHS.[3] Ethiopia has also experienced steady declines in infant, child and under-five mortality rates over the last 16 years. More specifically, infant mortality dropped from 97 deaths/1,000 live births in 2000 to 48 deaths/1,000 live births in 2016. Child mortality rate also declined from 77 deaths/1,000 live births in 2000 to 20 deaths/1,000 live births. Similarly, under-five mortality rate declined from 166 deaths/1,000 live births to 67 deaths/1,000 live births during the same period.[4] In order to achieve these targets, the Government of Ethiopia has improved and expanded maternal, newborn and child health (MNCH) outreach services through deploying over 38,000 paid health extension workers (HEWs) and training about 10,000 health personnel in midwifery, and through investing in the health infrastructure throughout the country while working effectively with key stakeholders like international NGOs and bi-lateral and multi-lateral agencies.

3. EVALUATION METHODOLOGY

3.1. The Technical Approach and Methods

The terminal evaluation adopted a mixed approach where both qualitative and quantitative methods were employed to meet the terminal evaluation objectives. The qualitative data collection followed a participatory approach using focus group discussions, key informant interviews, and observation to generate the required information. A substantial amount of time was also invested in document review to find out progresses, problems and direction of the MNCH services in Ethiopia in general and in WVE operational areas in particular. In this regard, households (including mothers and children), local community officials and members, government officials (federal, region, zone and local levels), WVE technical staff (HO and AP levels), NGOs and multi-lateral institutions like Save the Children and UNICEF were engaged during data collection. The quantitative method involved mainly conducting household interviews with adult mothers who gave birth within the past 12 months before the survey, using survey questionnaires. Additional secondary data were also collected and analyzed to support and supplement the quantitative data.

Key evaluation questions, which addressed the objectives of the evaluation, were developed by FTS Consulting firm and approved by WVE to guide data collection.[5] Based on the key evaluation questions, specific evaluation questions or checklists were developed and used for the different categories of participants or interviewees who were engaged as part the evaluation process. Data collection was made from different sources using the methods as discussed below.

Kick-off Meeting and Desk Review

The evaluation team held a kick-off meeting with WVE's CHN Campaign Project Coordinator and received valuable briefing on the nature and achievements of the project focusing on the organization's expectations, priorities and methodology of data collection and analysis, among others. This meeting with the Coordinator has served as a springboard to clearly identify the client's needs, expectations and priorities in the terminal evaluation of the project. This initial meeting has also helped the consulting firm to secure the commitment and support required to

[3] Central Statistical Agency (CSA) [Ethiopia] and ICF. 2016. *Ethiopia Demographic and Health Survey 2016: Key Indicators Report*. Addis Ababa, Ethiopia, and Rockville, Maryland, USA. CSA and ICF, p. 46. Note that EDHS was conducted by Central Statistical Authority from January 18, 2016, to June 27, 2016.

[4] Ibid. p. 22.

[5] For details on tools see Annex 2.

effectively undertake the terminal evaluation both in and outside Addis Ababa throughout all the data and information gathering processes. The evaluation team has also reviewed all reports and documents relevant to CHN Campaign Project. In fact, the desk review continued to the end of the evaluation work to ensure findings were triangulated against different sources and reports.

Focus Group Discussions and Key Informant Interviews

Focus Group Discussions (FGDs) were held with different groups in Humbo and Banja Woredas and in three kebeles per woreda where the campaign project was implemented. FGDs were conducted with selected groups, which reflected a good mix of groups, gender, age, and role in community, including adult women and men, community care coalition (CCC) members, child parliament members, kebele leadership members, religious leaders and influential community members as well as health personnel, including community health extension workers (HEWs). A total of 12 FGDs with 93 participants, where 58% of them were female participants, were conducted with equal share between the two woredas.

Similarly, a total of 26 (female 38%) key informants participated in 20 KIIs as indicated. The key informants interviews (KIIs) were held with federal, regional, zone and woreda government officials that included key officials like FMoH MNCH Directorate Director, SNNP Region Health Bureau MCH & Nutrition Service Core Process Owner, deputy head of Zone Women, Children and Youth Affairs (WCYA) Department, zone MCH & Nutrition Service Process Coordinator as well as woreda level officials health, WCYA and finance and economic development offices of both pilot woredas. In the process UNICEF MNCH team leader and health specialist and one other specialist from Save the Children Ethiopia were contacted and interviewed. WVE's CHN Campaign Project Coordinator, two officials from health and nutrition program department, Cluster Program Office (CPO) management and AP management were also interviewed at their respective workplaces as part of the evaluation process.

Household Survey and Site Observations

A total of 168 women per woreda were interviewed using a comprehensive questionnaire developed during the baseline survey has been polished and used to ensure households were interviewed effectively in both woredas. The questionnaire has covered all the outcome level indicators in a way that ensures comparability with baseline values established towards the beginning of the campaign projects.

Field visits were paid to health centers in both woredas to observe the conditions of the facilities in the areas of delivery wards and whether or not they have access to such crucial services as water and electricity. The necessary secondary data, including the size and composition of their health personnel, were collected from seven health centers (five in Banja Woreda and two in Humbo Woreda). The data obtained from health facilities were summarized incorporated into this evaluation report.

3.2. Sampling Framework and Sample Size for Household Survey

The sample size and sampling framework followed the same procedures used during the baseline survey conducted in both Humbo and Banja Woredas. Accordingly, women who gave birth during the last 12 months before the survey were included in the sample regardless of their birth outcomes. The required sample size of eligible mothers for the study was determined using a formula to estimate a single population's proportion, $n = z^2\ p\ (1\text{-}p)/d2$. While calculating the sample size, the assumption was made that there was a 95 percent probability of obtaining the population proportion of mothers who gave birth at the HFs (z value) with 4 percent margin of

error (d2 value) and population of mothers who gave birth at health institutions was assumed to be 15 percent (p value). See table below for details.

Table 1. Sample Size

Woreda	Sample size	Remark
Banja	165	Same as baseline sample size but in actual terms 168 mothers each were interviewed in both woredas.
Humbo	165	
Eligible mothers to be visited per cluster	7	Considering one enumerator would interview 7 households per day based on the availability of mothers in the village with eligibility criteria
Total cluster per woreda	24	The number of clusters should have been above 22 normally
Number of training day	1 day	
Number of days for data collection	4 days	

Sampling procedure

A two stage cluster sampling method was used for this survey to interview women who gave birth within the last 12 months, regardless of their birth outcome. At stage one, a random selection of clusters (villages) was made while a random selection of households was conducted at the second stage. A scientific approach was employed in both procedures to follow a correct sampling procedure.

3.3. Data Collection, Compilation and Analysis

Training and Supervision of Enumerators

WVE hired and deployed 14 enumerators and two supervisors, shared eight each between the two woredas. The evaluation team statisticians gave training to, deployed and supervised data collectors on a daily basis.

Data Entry, Clearing and Tabulation

The senior statistician prepared appropriate data entry format using computer software and encoded the data himself to ensure data entry accuracy and completeness. The senior statistician then exported the data that was entered onto the computer into SPSS application software program and cleared and edited the data, tabulated and summarized the data.

Data Analysis

Qualitative data collection and analysis was the prime approach to evaluating the campaign project. The qualitative data collected from different sources, using the different data collection methods discussed earlier, was transcribed and analyzed interactively with data collection on a daily basis in a way that enhanced the evaluators' understanding of the real situations and experiences of the target communities. Then data reduction methods were used to classify collected data by themes and by units of analysis in order to identify and understand similarities and differences. Such content analysis was also employed with regard to the data collected from desk reviews. Probing questions were asked either on spot for more clarity or the next time FGDs or KIIs were conducted by a way of triangulation. To summarize, efforts were made to analyze the contents of the field notes and desk reviews to identify themes, categories (units of analysis) and patterns (opinions, views, feelings, reasoning, etc. of respondents) against

OECD/DAC's evaluation criteria with due consideration for the key evaluation objectives and questions.

Quantitative data collection and analysis were made using descriptive statistics in order to complement the qualitative approach in this evaluation work. Accordingly, the household survey report furnished the evaluation team mainly with the current state of skilled birth attendance coverage prevailing in the study communities. The evaluation results obtained from the household survey were discussed and analyzed against the baseline values of the outcome indicators of the project. The evaluation results were also analyzed against national level coverage data of MNCH services. The quantitative data analysis followed more of descriptive statistics with frequencies and proportions/percentages to show the magnitude of changes in the indicators since the baseline values were set. The data was checked for its consistency, completeness, accuracy, reliability and relevance while disaggregating the indicator values by woreda. In the end, the draft report was submitted to WVE's team for their validation in a feedback work setting and through written comments and suggestions to ensure that the report reflected the opinions, views and experiences of the target communities and key stakeholders to the campaign project.

3.4. Limitations

The timing of the evaluation fieldwork coincided with the eve of Eastern holiday across the country and community meeting arrangements were made under tight schedules. Right after the Easter holiday break the evaluation team made efforts to take appointments with WVE's key partners to engage them in key informant interviews. Unfortunately, this took more time than originally planned though the evaluation team managed to interview replacement staffs at UNICEF and Save the Children due staff turnover there. Even though there was no qualitative and quantitative data missed, in the future it would be important to consider big public holidays during project evaluation planning.

There is also a need for consideration of logistics (vehicles) planning for a smooth running of the evaluation fieldwork as it took extra effort to secure vehicles towards the beginning of data collection in both woredas. In fact, the project coordinator made strenuous efforts to solve the issue in consultation with WVE program teams in both woredas.

It is to be noted that campaign or advocacy project evaluation focuses much more on the implementation processes than the final goal or milestones expected to be reached or contributed to towards the end of the project period or beyond. WVE, like any other campaign running organization, has adjusted its focus in the middle of the project implementation period, particularly as early as 2014 when it started focusing on expanding SBA coverage. It is thus important to note such changes in the middle of the course as one reads through the findings and discussions of the report in the pages to follow.

4. EVALUATION FINDINGS AND DISCUSSION OF RESULTS

4.1. Project Relevance

4.1.1. Project Relevance to Government's Health Policy and WVEs NO Strategy

Based on document reviews, community discussions and key informant interviews made at various level, CHN Campaign Project has been very relevant to Ethiopia's 1993 health sector policy, which emphasizes the promotion of the participation of the private sector and nongovernmental organizations in health care as one of its core principles,[6] and the fourth health sector development program (HSDP IV)[7] as well as Road Map for Accelerating the Reduction of Maternal and Newborn Morbidity and Mortality in Ethiopia.[8] These policy and strategy documents have given sufficient attention to improving MCH services quality and delivery systems with the view to improving maternal and newborn health and survival in Ethiopia. When the project was started, maternal and neonatal morbidity and mortality was, and still is, high on government's agenda because maternal mortality rate (MMR) was estimated at 676/100,000 live births and neonatal and infant mortality rates were 37/1000 and 59/1000 live births, respectively, according to Ethiopia Demographic and Health Survey (EDHS) 2011.[9] The general objective of the MCH road map was to reduce MMR to 267/100,000 live births and newborn mortality rate to 15/1000 live births by the end of 2015.[10]

A joint report produced in 2015 by multi-stakeholders to MNCH in Ethiopia has identified key challenges to meeting MDGs for MMR and CMR as low utilization of maternal health services, including skilled attendants at birth; high unmet need for FP; adolescent and youth sexual and reproductive health; awareness of healthy behaviors; cultural barriers; inequities in health service utilization; and quality of care.[11] Indeed, the campaign project was quite relevant to the government's drive to achieve the MDGs 4 and 5 by the end of 2015.

In line with this, the campaign project developed implementation strategies and made significant efforts to address the three delays (first delay: delay in making decision to seek health care, second delay: delay in reaching or accessing health facilities and third delay: delay in receiving health care at health institutions), which cause maternal and newborn mortality in program target communities and beyond. The evaluation results have shown, among other things, that the three delays approach, the research results, media engagement and community empowerment strategies proposed and implemented under the CHN Campaign Project, have complemented the efforts and contributions made by the government and non-state actors to reduce preventable maternal and child deaths across the country. The project has been in line with and contributed

[6] See Health Policy of the Transitional Government of Ethiopia, 1993.
[7] See Federal Ministry of Health, Fourth Health Sector Development Program (HSDP IV) (2010/11 – 2014/15), which largely coincides with CHN Campaign Project in terms of design and implementation period.
[8] Federal Ministry of Health, Road Map for Accelerating the Reduction of Maternal and Newborn Morbidity and Mortality in Ethiopia (2012 – 2015), July 2012, p. 9ff.
[9] Central Statistical Agency [Ethiopia] and ICF International. Ethiopia Demographic and Health Survey 2011. Central Statistical Agency and ORC Macro. Addis Ababa, Ethiopia, and Calverton, Maryland, USA : 2012.
[10] Federal Ministry of Health, op. cit., p. 11.
[11] Ministry of Health Ethiopia, PMNCH, WHO, World Bank, AHPSR and participants in the Ethiopia multi-stakeholder policy review (2015). Success Factors for Women's and Children's Health: Ethiopia, p. 5.

to WVE's strategic objective of improving health and nutritional status of children and pregnant and lactating women as stipulated in the organization's three-year strategy that spanned from 2013 to 2015.[12]

4.1.2. Relevance to Community Problems

At the time when the campaign project was launched in 2013, the percentage of deliveries assisted by skilled health professionals (doctors, nurses and midwives) was only 10% and, no wonder, Ethiopia was experiencing very high MMR and newborn mortality rate as indicated in the foregoing sub-section. Antenatal and postnatal care services were also at their very low level, causing high morbidity and mortality rates among women and children in the country in general and in WVE operation areas in particular. In fact, of the three delays that caused MMR and newborn morbidity and mortality in Ethiopia, the first delay, i.e. lack of health care seeking behavior among families, particularly pregnant women, was a highly neglected behavioral and attitudinal problem that caused irreversible damages to the lives of innumerable women and children across the different regional states of Ethiopia.

The KIIs made with government officials and FGDs held with representatives of communities have revealed that the campaign project was designed, implemented and monitored with the active participation of all relevant stakeholders, including the local government offices, CBOs, FBOs, families and communities. Given the fact that the project aimed at reducing preventable deaths of mothers and children, there is no doubt with regard to the relevance of the project to the needs of the target communities.

4.1.3. Campaign Project Design

Even though the campaign project was launched officially in January 2013, WVE in due course of time shifted its campaign strategy in September 2013 by adopting a strategy document that emphasized "institutional delivery" as a major focus of the campaign project and subsequently conducted an extensive assessment that identified the major causes of low institutional delivery in selected seven woredas of Amhara, Oromia and SNNP regions where WVE operates. This has helped the organization to adjust its campaign focus and run evidence based campaign that has positively impacted the lives of many mothers and children, including households and communities, in changing internal and external environments.

The CHN Campaign Project was designed in such a way that it clearly shows project goal and its expected outcomes as well as the strategies to achieve project results from start to end of the project period. The project adopted such major strategies as employing the "three delays" approach, conducting policy analysis and research, disseminating standard research results and reports, engaging the media, networking and partnership building, empowering the community, and building staff capacity. In order to achieve its goal and objectives the project was designed to follow a participatory approach where key partners were identified though engaging them was limited much to government offices and communities, spanning from federal level to regional level and all the way down to the grassroots level.

Of all the sound implementation strategies and approaches adopted and put to use in the course of project implementation, the three delays approach and particularly the influence of the first delay stood out strongly in all discussions and meetings made with FGD participants and key

[12] World Vision Ethiopia, National Office Strategy (2013-2015), Addis Ababa, October 2012, p. 14.

informants. This was so particularly in the discussion the evaluation team made with the MCH Directorate Director of the Federal Ministry of Health. Of course, conducting researches and studies and disseminating their results, for example 'causes of low skilled birth attendance in seven selected woredas' and 'practicing faith', has proved to be a very good strategy in creating critical public awareness and in engaging policy makers, to a certain extent, on the need to remove barriers, including the "three delays", to effective MCHs services that would help avoid preventable deaths of mothers and children.

The evaluation team understood from the discussions and meetings held at various levels that in the implementation processes the campaign project exhibited very good standing at the grassroots level as it created critical public awareness on the need for expanding SBA coverage, showing that WVE's longstanding reputation for service delivery programs/projects at the local level has positively impacted the organization's grassroots advocacy campaign. The evaluation team has also witnessed that, however a small stint that might be compared to the organization's stature, the campaign project was relatively well positioned at the federal level to contribute to policy dialogues that address the "first delay" – delay in making decision to seek health care, as compared to the regional level where WVE has not been represented at MNCH technical working groups.

Although measuring success of such campaign or advocacy projects is not an easy task, WVE has designed both qualitative and quantitative (e.g., baseline survey) approaches to gauge success at the end of the day. The evaluation has shown that WVE designed and implemented multiple activities and outputs that involved documenting and accounting for their contributions to outcomes and then to project goal ultimately. The evaluation team has reviewed the project's sustainability and transition plan and found out that WVE's efforts to train and equip local CBOs (CCCs in particular) and FBOs for effective implementation of project components and a gradual shift of roles from the organization towards these community institutions have proved to be a success to a larger degree in both Humbo and Banja Woredas, which were the pilot woredas. The CCCs, based on their past experiences working with WVE, have become staunch supporters and promoters of the expansion and continuity of institutional delivery in the local context. However, the numbers of CCCs and FBOs to be mobilized were not clearly targeted in project documents. Even then the intentional involvement, of faith leaders in the implementation process has prompted optimism among government officials for an enduring behavioral and attitudinal changes in favor of institutional delivery in the years to come.

The evaluation team has made efforts to review the critical assumptions made and the risks identified and their management strategy which were stipulated in project design document. Programmatic risks, project management risks due to loose structure and absence of project ownership at lower echelon of the organization, and institutional risks like loss of organizational reputation due to misunderstanding and misconception about campaign projects that tilt towards community empowerment and advocacy work, were not identified as risks in the project document. More importantly, the project strategy document did not capture the closure of ADPs before completion of the project as one risk factor. Humbo ADP, for instance, phased out before project completion and this has also created information gaps between WVE and past target communities and local government offices for smooth operation of the project.

Finally, it is important to note that the project has been and will remain to be consistent with and supportive of the policies and programmatic priorities of both the Government of Ethiopia and

WVE. It is also observed that project objectives and strategies are aimed at addressing the priority needs of mothers, newborns and children under-five in program target areas and beyond.

4.2. Project Effectiveness

In this evaluation effectiveness of the project includes the assessment of project benefits to mothers, children and their families in the campaign project area communities. The goal of the project was to contribute to the national effort in reducing maternal and newborn mortality in Ethiopia by 2016 through achieving two expected outcomes, each having two outputs over the project period, as supported by the household survey conducted in Humbo and Banja Woredas in April 2016 as part of the terminal evaluation work.

4.2.1. Efforts Made towards Achieving Project Goal

Outcome 1: Improved MNCH policy processes at the national and regional levels

WVE's CHN Campaign Project envisaged to engage federal and regional decision makers to address the root causes of the three delays that affect the expansion of skilled birth attendance coverage at national and regional levels in general and in project target communities in particular.

Output 1.1 Enhanced understanding of immediate and underlying causes of delays to skilled delivery

Conducted a formative assessment on the causes of low skilled birth attendance

WVE conducted the initial MNCH situation assessment in 2012 and then officially launched the campaign project in January 2013. After narrowing down the focus and scope of the campaign project to expanding skilled birth attendance, WVE conducted a formative assessment on the causes of low skilled birth attendance in seven woredas of Amhara, Oromia and SNNP regions in September 2014. The dissemination of the results of this research took place in 2015 and 2016 to various categories of audience in a workshop or conference setting and has helped trigger health policy implementation reviews at national and regional levels with the involvement of key government officials like FMoH representatives, Amhara and SNNP regions Health Bureau officials as well as zone and woreda government officials and experts who had the responsibilities to either run or oversee health policy implementation and reviews.

Even though WVE has published two important research/study results that focused on 'causes of low skilled-birth attendance coverage' in selected woredas and 'engaging faith leaders for advancing MNCH services', and disseminated assessment results through Amhara and SNNP regional radio programs, the organization's key partners in both government and multilaterals such as UNICEF have limited knowledge about the publications. This means the campaign project could not adequately seize the opportunity such research results present to promote change in health policy processes at both regional and federal levels. However, the evaluation team believes that the research results have been effective in enabling WVE to conduct grassroots level campaign in its drive to contribute to the reduction of preventable deaths of mothers and children in target communities and beyond.

Output 1.2: Increased awareness of MNCH related national commitments to global frameworks

Conducting a review of government progress in meeting the EWEC commitments

WVE conducted annual meetings to review government's progress towards meeting the 'every woman every child' strategy requirements set by the United Nations,[13] to which the implementation of which the Ethiopian Government has committed itself. The meetings were conducted on annual basis with CCCs, HDAs, CHEWs, and adult men and women over a period of three years from 2014 to 2016. The document reviews have also confirmed that in 2015 Amhara Region Health Bureau, in collaboration with Awi Zone Health Department, Banja woreda Health and WCYA Offices, conducted stakeholders sensitization forum on EWEC at all levels with woreda health and other sectors officials and staffs, school and community WASH participants as well as community lead mothers selected from various woredas.

The effects of such community mobilization and sensitization on the need for implementing nationally adopted requirements and standards for antenatal, delivery and post-natal care, was witnessed by the evaluation team in both pilot woredas. In the community FGDs with CCCs members it was learnt that lead mothers, CCCs, HDAs and HEWs take joint actions to identify, register and follow up on the health of pregnant women, and this effect local ambulance arrangement and referral systems quietly improved as a result of the sensitization and mobilization of the community.

Awareness creation during Global Week of Action (GWA) to enhance understanding on MNCH

The campaign project supported World Vision's national, regional and global advocacy efforts to improve child and maternal health by helping WVE staff and communities to observe the Global Week of Action (GWA) every year from 2012 to 2015. During the GWA, the following major activities were conducted:

- ***WVE used the popular mobilization events*** to sensitize and mobilize more than 10,000 people to take at least one or more actions in support of child and maternal health issues, in collaboration with partners such as the woreda health and other local government sector offices, students and the wider community.
- ***Organized panel discussions*** on major causes of maternal and children under-five mortality and used the sessions to underscore and sensitize communities on the importance of immunization, supplementary feeding using locally available foods and the importance of institutionally delivery in reducing child and maternal mortality.
- **Organized roadside exhibition** (May 9 and 10, 2014) where WVE displayed its institutional delivery model to hundreds of Hawassa city residents who visited the tent and conveyed CHN advocacy messages.
- ***Key CHN messages*** were conveyed to over 4,000 runners of the Hawassa Great Run & tens of thousands of Hawassa residents who gathered to attend the event, and WVE National Director presented award to winners of the race.
- ***Sponsoring Great Ethiopian Run and rewarding winners:*** WVE sponsored the Hawassa Great Run themed " Saving the Lives of Newborn Babies" in collaboration with Save the Children and the Ethiopian Great Run in 2014 and finally, WVE also sponsored

[13] https://www.everywomaneverychild.org/global-strategy/; http://www.everywomaneverychild.org/wp-content/uploads/2016/06/EWEC_GS_BROCHURE_ENG_WEB_newlogo_v02.pdf

Ethiopian Great Run in Addis Ababa in 2015 where staff from WVE from HO, CPO and from APs joined the team from WV US and actively participated in the event wearing T-shirts with campaign messages.

Experience Sharing and Scale up meeting with relevant stakeholders (Religious Leaders and CCC) on EWEC

Youth to Youth Experience Sharing Visits: In 2016, youth experience sharing forum was organized in Enjibara town on EWEC and MNCH services. A group of three young men, who have got best experiences in EWEC and MNCH services at both national and international levels, were invited from Addis Ababa to Banja area to share their experiences with 88 young people drawn from 26 kebele administrations (KAs) of Banja Woreda. The experience sharing forum was successful in that it could inspire the local youth groups to take actions by organizing themselves as volunteers in their communities. The youth volunteers have started serving as traditional porters who carry pregnant women on traditional stretchers from their homes to health facilities where the roads are inaccessible for ambulances.

Picture 1. Partial view of Ethiopian Great Run participants from WVE and WV US
Photo: Courtesy of WVE

Creation and scaling up of home delivery free communities: In 2016, WVE ran experience sharing and scale up meetings with 196 religious leaders from Ethiopian Orthodox Church, CCCs, community leaders and volunteers from different kebeles of Banja ADP of Awi Zone in Amhara Region and conducted training on the EWEC and MNCH Commitments which were integrated with WV's Sponsorship Basics. The main objectives of the meeting was to share best practices of the Kessa KA religious leaders and CCC vital roles in changing the Home Delivery Dominant community in to Home Delivery Free (HDF) with the intention of scaling up HDF practices to other KAs of Banja Woreda. The meeting and training sessions created opportunities for networking among the religious leaders, CCCs, HDAs and HEWs with regard

to the need for awareness creation of the advantage of institutional delivery and following up of the pregnant mothers before and after delivery.

As a result, consensus was reached among these local community actors to replicate good practices of Kessa KA religious leaders and CCCs to other KAs in Banja Woreda KAs and the trainees, including husbands, made promises to empower mothers during pregnancy to attend health facilities for ANC, delivery and post-natal care services. Following the consensus reached and promises made, a total of 125 (female 53) CCCs, youth groups, representatives of child parliaments and other community members staged marches on the prime market day of the district and chanted slogans like "home delivery free community" in order to positively influence community attitude and practice regarding skilled-birth attendance and institutional delivery.

In general, all community FGDs and key informants in both woredas and zones have witnessed that there were strong community mobilization and sensitization activities ongoing under the campaign project work with regard to the need for institutional delivery and completing ANC and PNC services to ensure good health for mothers and children. All categories of evaluation participants have indicated that the community mobilization and sensitization activities effectively brought about attitudinal and behavioral changes in target communities and beyond.

Picture 2. Priests from Banja Woreda participating in EWEC meeting, 2015
Photo: Courtesy of WVE.

Outcome 2: Enhanced commitment to improve institutional delivery at the district level

Output 2.1: Increased community involvement in public health service delivery system:

In 2014, the campaign project conducted CCCs mapping exercises in both Banja and Humbo Woredas in order to identify their capacity gaps and customize the local level advocacy (LLA) and citizen voice and action (CVA) tools and to effectively run advocacy activities in the target

communities. Accordingly, the campaign project, in collaboration with woreda government offices, mobilized and trained CCCs (one committee per kebele in all kebeles of each woreda; e.g. in 41 kebeles for Humbo Woreda) and deployed them for ANC, delivery and PNC services monitoring in target communities. The campaign project, in collaboration with local WCYAs offices in both woredas, trained CCCs, religious leaders and CBOs (iddir members) on health services standards and monitoring.

During field work the evaluation team conducted FGDs with CCC members in both pilot woredas and captured the views and opinions of these CCCs as follows:

- Currently, there is no mother who gives birth at home in traditional ways,
- There are no mothers and children dying from birth complications at present
- Currently, there are no maternal and child deaths reported or heard in the communities
- Pregnant mothers used to give birth at home and suffer complications (over bleeding or suffocations) and either die themselves or lose their infants but now no such problems, and
- Mothers and children now enjoy good health because of the increased awareness and enhanced understanding among pregnant women, their families and the communities at large.
- As a result of the training and sensitization activities, community CCCs have started playing active role from planning to monitoring government's health care system at the local level which is found to be encouraging.

The evaluation team observed that the CCC FGDs were inspirational and motivated to serve their communities as their monitoring activities, which focused on identifying and encouraging pregnant mothers to visit health facilities before, during and after delivery. Thus, it can be judged that the results of the campaign project and WVE's other health projects implemented in the pilot woredas, have been effective in contributing to project goal.

Output 2.2: Increased understanding among Woreda and Zonal level stakeholders of the importance of skilled delivery

Engaging youth delegates and using mass media in MNCH advocacy activities

The review of project annual reports and discussions made with child parliamentarians and youth groups have revealed that the campaign project

- has effectively conducted lobbying sessions with woreda and zonal decision makers, based on developed policy briefs,
- Trained media editors on the importance of skilled birth delivery and worked with the media and (feature articles, field visits and talk shows) to sensitize communities on the importance of skilled birth delivery in 2016.

The campaign project mobilized young delegates and engaged them in MNCH advocacy activities using the following five key messages:

- "Let us keep our promises to save mothers and children from dying"
- "Let every woman in the world and in Ethiopia give birth with the help of skilled birth attendants"
- "Let us envision safe motherhood and the newborn health"
- "Together we can end preventable deaths!"

- "Let us stop child marriage; the duty of a girl is to go to school!"

The advocacy activities involved appealing to government offices to keep their promises both in terms of increased budgets and increased commitments towards implementing national and international standards and initiatives to address MNCH issues, on one hand, and educating and encouraging the public to bring about behavioral and attitudinal changes regarding institutional delivery and early child marriage, on the other.

The young advocates conveyed these messages to different target groups including government officials, school communities mainly the youth and staff of World Vision Ethiopia itself through speeches, poems, music and dramas shown at various events. The evaluation team believes that the campaign project was effective in engaging the use and in using the mass media for MNCH advocacy in SNNP and Amhara Regions as witnessed also by zone and woreda sector offices heads and experts as well as by Soddo CPO which appreciated the media coverage in their areas. However, it is believed also that there is much to improve with regard to campaign messaging as the slogans are many and key messages are not available in a summarized way.

Picture 3. Young advocates raising at work in Humbo Woreda

Photo: Courtesy of WVE

Experience sharing visits

World Vision Ethiopia sent the campaign coordinator with a youth group to Recife in Brazil for participation on a global WV campaign event on MNCH in 2014. The team delivered child wellbeing messages to global leaders and decision makers to take action on untimely deaths of children from preventable causes. In the course of the event, the delegates gathered in Recife shared experiences, discussed issues such as violence, child labor and sexual exploitation during workshops, presentations and group discussions. The evaluation team consider this good for

advancing the causes of mothers and children. However, the evaluation team also believes also that such technical staff experience sharing visits and capacity building trainings have been limited.

Campaign management and sustainability training conducted at Gojam and Awi CPO

As part of the campaign sustainability strategy, three days long training was organized from April 12-14, 2016 in Bahirdar for 14 WVE field staff selected from Gojam and Awi CPO APs namely Banja AP (AP supervisor and WASH specialist), Gojam CPO (CPO manager and DME officer), Yilmana Densa AP (AP supervisor and Child and WaSH Specialist), Jabi Tehnan AP (AP supervisor, Child and WASH specialist). The objectives of the training were to:

- Build field level capacity for the advocacy campaign management and sustainability of the Campaign initiatives in other CPOs,
- Provide basic skills on WV's advocacy approaches, Birth Registration and Child Marriage prevention, and
- Share the best practices and achievements of CHN consolidated from its national, regional and woreda level activities and results.

Although the campaign management side was late in terms of timing, the training given on how to sustain campaign results are believed to have positive effects going forward. Such management and sustainability training could have also been arranged for government offices and community FBOs and CBOs in Awi Zone of Amhara Region.

4.2.2. Quantitative Findings and Discussions

In both Banja and Humbo Woredas, household survey was conducted to interview 168 women per woreda in the same approach followed during the baseline survey conducted in 2014, so that comparison would be possible between baseline values and evaluation results for selected indicators. Survey findings are presented and discussed by woreda as follows.

4.2.2.1 Banja Woreda Results

Antenatal care

The end line household survey revealed 99.4 % of women attended at least one or more ANC appointments during their pregnancy. 5.4% of women attended only one ANC appointment, 71.3% of women attended 2-3 times and 23.4% percent said they had four or more visits. 65.3% of women said they completed their first visit within the first four to six months of pregnancy and 30.5 % started ANC during the first trimester with only 4.2% percent waiting until the final three months of pregnancy.

Table 2. Comparison of baseline and end line results of ANC visit in last pregnancy

	Baseline result	End line result
ANC visited in last pregnancy	96%	99.4 %
Attended one ANC visit	8%	5.4%
Attended 2-3 Time ANC visit		71.3%
Attended 4 and above ANC visit	22%	23.4%
Started ANC in first 3 months	20%	30.5%
Started ANC 4-6 months	61%	65.3%

Started ANC in last 3 pregnancy months	11.9%	4.2%

Overall, end line results have shown improvements when compared with the baseline results for women's health facility visits for ANC services. There is an improvement in starting of ANC visit during the first trimester by 10.5%. The observed difference might be due to the attention given to it by community CBOs and FBOs at the local level, which in turn was a result of intensive sensitization and mobilization activities of the campaign project.

Delivery care

98.2% of women reported that their deliveries were assisted by skilled birth attendants in the 12 months preceding the survey. 81.5% of interviewed women gave birth at health centers, where 99.3 % were assisted by a nurse or a midwife, followed by 0.7% by health officer. When end line results are compared with the baseline, it shows a near zero proportion of deliveries at home, which means there is an improvement in the number of deliveries at health facilities as a result of sensitization and mobilization activities discussed above.

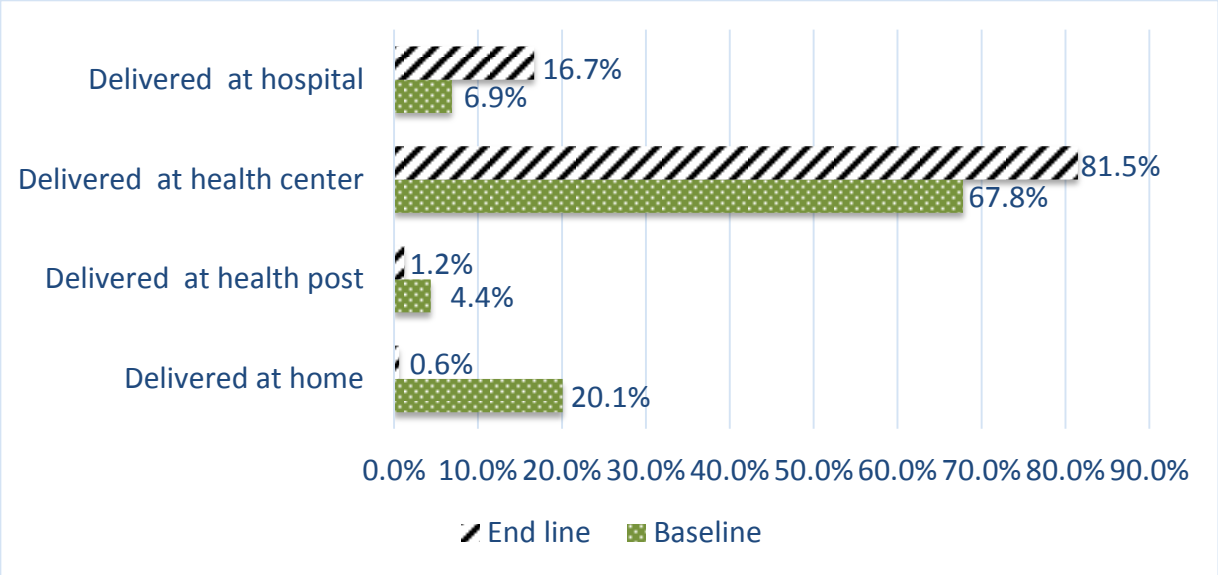

Figure 1. Last place of delivery

94.6% of deliveries attended by nurse or midwife, 1.8% were health officers, 1.2% of births were attended by HEW and 0.6% by doctor because of the capacities (manpower in particular) created at health centers. Only 0.6% were delivered by caesarean sections because majority of majority of the deliveries took place at health centers where trained health officers/midwives were handling such deliveries.

Table 3. Comparison of baseline result to end line result for SBA

	Baseline result	End line result
SBA deliveries 12 months preceding survey	74.7%	98.2%
Medical doctor	6.0%	0.6%
Health officer		1.8%

Nurse/Midwifery nurse		94.6%
Health extension worker	4.0%	1.2%

The end line result for SBA has markedly shown improvement when compared to the baseline value of 74.7% in 2014.

89.8% of study participants who reported giving birth in a health facility affirmed that their health was checked immediately after giving birth. Subsequently, 16.7 % of mothers delivered at HF were follow up at home after delivery of which 53.6% were checked by HEWs. 53.6% of mothers who delivered 12 months preceding survey were visits health facility of which 45.5 were visits executed by Midwife/nurse, 35.5% by health officer and 17.3% by HEWs.

First delay: delay in making decision to seek health care

Of the women who attended follow-up ANC appointments, 71.4% were advised about birth preparedness. Of the women who received preparedness advice, 76.2 % got ready by saving money, buying or preparing clothes for the baby, etc. About 58.9% of women were confident in their knowledge of pregnancy danger indicators, 82.7% of whom said they were informed of possible symptoms during an ANC visit, and were able to identify the warning signs. 53.2% recognized severe headaches and 42.5% vaginal bleeding as a potential crisis, 49.6% identified severe abdominal pain as being a possible issue, 23.7% knew that Discharge of amniotic fluid could indicate a problem, and 25.9% understood that blurred vision could be hazardous. Other risks they were informed of during routine ANC visits included Swelling.

29.8% women reported experiencing a health problem during a recent pregnancy and all sought care from HFs to address the issue. Around 1.2%complained of vaginal bleeding, 12.5% percent felt abdominal pain, 20.2% suffered from severe headaches, 1.2 % felt blurred vision and 0.6% percent mentioned difficulties with ruptured membranes and others symptoms 6.5%

Table 4. Pregnancy complication symptoms experience in last pregnancy

Pregnancy complication	% of women with symptom	% of women with symptom from experienced
Vaginal bleeding	1.2%	4.0%
Rapture of amniotic fluid	0.6%	2.0%
Severe headache	20.2%	68.0%
Abdominal pain	12.5%	42.0%
Blurred vision	1.2%	4%
Others (swelling of leg,)	6.5%	22%

Nearly 83.9% of women reported that the decision of where to give birth was made jointly by themselves and their husbands, 7.7% making the decision by husbands and 6.5% by parents.

The majority (85.7%) of delivery location choices were made during the course of the pregnancy with only 14.3% waiting until they were in labor to make a decision.

Second delay: delay in reaching or accessing health facilities

According to the household survey, approximately 51.8% of the participants' homes were with 30 minutes radius, 38.7% were between 30 minutes to one hour away and 9.5% were 1hour and above away from a HF. 51.2% of the women received community support in the form of transportation assistance either to the HF or to a site where an ambulance could reach them and accompanied. Of those who were able to reach the HF, 45.8% were transported on foot, 32.1% were brought by public transport, and 65% were brought by ambulance and 8.9% on stretchers.

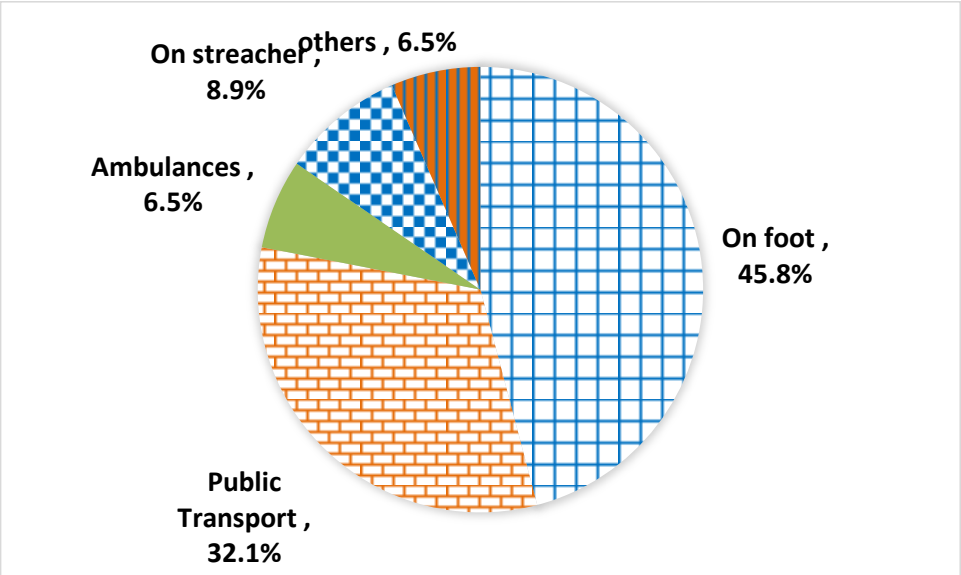

Figure 2. Means of transport to health facility for delivery

Third delay: delay in receiving health care at health institutions

Banja Woreda has five health centers, namely Kessa, Danegeya Surita, Kidamaga and Dinkara which can provide BEmOC during deliveries. There is at least one staff in all facility who was trained in BEmOC and all health centers have national guidelines on management of pregnancies and childbirth available in the facilities as well as job aids and/or checklists around the delivery room. Non-emergency maternity services (ANC, delivery care and PNC) are available 24 hours a day, seven days a week, including weekends and public holidays at all health centers in order to encourage institutional deliveries and improve SBA.

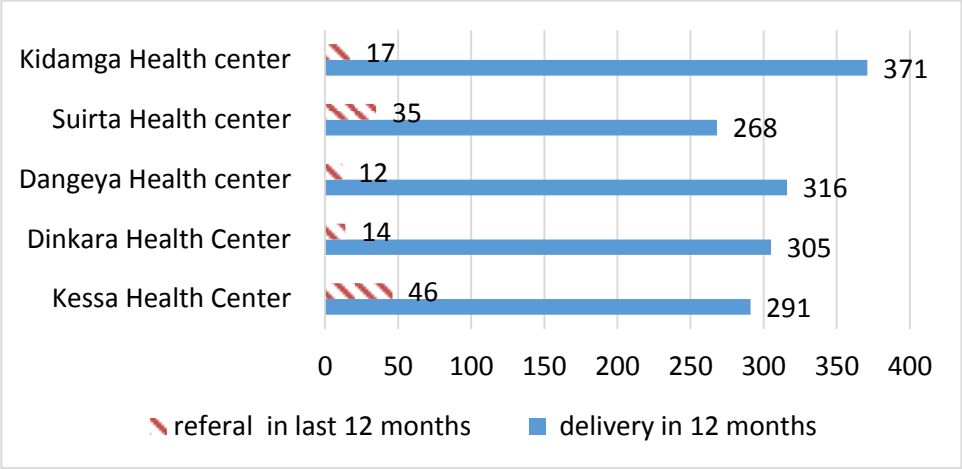

Figure 3. Number of deliveries and referrals in the last 12 months in five health centers

Kessa Health Center has six nurses, two health officers and two midwives. 306 deliveries at the facility in the past reporting year (2015/16, 214 delivered and 35 referrals in the past 9 months in the health facility and ANC-1 coverage were 75%. The facility refers to Enjibara Hospital which is 9 km from the health center. Kesaa HC health worker who received training on newborn resuscitation were leaved the facility. One midwife were trained in BEmOC in the past one year. The health center has four beds reserved for maternity, access to public tap water, it has wireless phone and electricity even if there is frequent and prolonged interruption in the past seven days prior to the survey.

The health center had a relatively good supply of medicines and most essential drugs including antibiotics, oxytocin, anticonvulsant and emergency drugs but drugs like Hydralazine, Labetalol and methyldopa which used as anti-hypertensive were not available at health center at the time of the assessment. The health center had almost all of the necessary basic equipment except shortage of disposable latex glove.

Dinkara HC has four nurses, two health officer and two midwives. 253 deliveries at the facility in the past reporting year (2015/16, after that 214 delivered and 12 referrals in the past 9 months in the health facility and ANC-1 coverage 98%. The facility refers to Enjibara Hospital which is 25 km from the health center. Dinkara health center has health worker who received training on newborn resuscitation and BEmOC. The health center has three beds reserved for maternity, access to public tap water, and electricity even if there is frequent and prolonged interruption in the past seven days prior to the survey but did not have telephone landline.

The health center had had a relatively good supply of medicines and most essential drugs including antibiotics, oxytocin, anticonvulsant, anti-hypertensive and emergency drugs. The health center had almost all of the necessary basic equipment except examination light and manual vacuum extractor.

Surita HC has four nurses, two health officer and two midwives. The health center handled 300 deliveries last year (in 2015/16), and then 216 women delivered and 32 referrals were made in the past 9 months in the health facility where ANC-1 coverage was 80%. The facility refers to Enjibara Hospital which is 51 km from the health center and the road to Surita health center is not easily accessible to vehicles and it far health center of the woreda to refer patents the Ambulance service will get after 2 hour for referral. Surita health center has health worker who

received training on newborn resuscitation and BEmOC. Suirta health center did have telephone landline, electricity and mobile network strong enough to depend on it even if the generator is not working at the time of the assessment. The health center has two beds reserved for maternity and access to Hand pump water. The health center had a relatively good supply of medicines and most essential drugs including antibiotics, oxytocin, anticonvulsant and emergency drugs but drugs like Hydralazine and Labetalol which are used as anti-hypertensive were not available at health center at the time of the assessment. The health center had almost all of the necessary basic equipment except examination light and incubator.

Dangeya HC has four nurses, two health officers and two midwives with the catchment population of 18,360.The farthest distance within the catchments is 15km. The health facility reported 638 deliveries during the past reporting year (2015/16) while it handled 228 deliveries and 10 referrals in the past 9 months along with ANC-1 coverage of 71.6%. The facility refers to Enjibara Hospital which is 10 km from the health center. Dangeya health center has health worker who received training on BEmOC but not newborn resuscitation due to staff turnover. The health center has four beds reserved for maternity, access to public tap water, electricity even if there is frequent and prolonged interruption in the past seven days prior to the survey but did have telephone landline. The health center had a relatively good supply of medicines and most essential drugs including antibiotics, oxytocin, anticonvulsant, anti-hypertensive and emergency drugs. The health center had the necessary basic equipment.

Kidamaga HC has four nurses, two health officers and two midwives with the catchment population of 13,173 of which the farthest distance within the catchments is 9km. 375 deliveries at the facility in the past reporting year (2015/16), after that 280 delivered and 15 referrals in the past 9 months in the health facility and ANC-1 coverage 143% which is above planned. The facility refers to Enjibara Hospital which is 34 km from the health center. Dangeya health center has health worker who received training on BEmOC but not newborn resuscitation currently on duty due to one staff is in maternity leave and the other one went back to school. The health center has three beds reserved for maternity, access to electricity even if there is frequent and prolonged interruption in the past seven days prior to the survey and have telephone landline. Kidamaga health center use rainwater harvest for some months their shortage water in the facility in dry seasons. The health center had a relatively good supply of medicines and most essential drugs including antibiotics, oxytocin, anticonvulsant, anti-hypertensive and emergency drugs. The health center had almost all of the necessary basic equipment except incubator.

Table 5. Treatment of mothers during delivery at health facilities in Banja Woreda

Condition of treatment confirmed by the respondent	Baseline result	End line result
Health workers happy to see you and provide care	94.4%	97.0%
Introduce themselves	59.5%	54.8%
Respectful and caring	95.2%	94.0%
Explain the procedure	65.1%	64.7%
Accompanied by relatives in the delivery room	81.7%	69.5%
workers in the delivery room treat you unfairly	7.1%	21.0%

Study participants provided feedback about their treatment at the facilities during their delivery, with the questions and their responses reflected in the above table. The majority said that the

health workers were pleasant, introduced themselves, allowed family members to accompany them into the delivery room and took precautions with their health. However, due to a relatively higher level of awareness on their rights while at the health facilities, the proportion of women reporting unfair treatment increased substantially from the baseline time when any treatment by health personnel could be considered as normal for them.

Discussions made with health officers of visited health centers have revealed that pregnant women might oftentimes stay in waiting rooms at health centers for about two weeks prior to delivery. In such instances the health facilities create home-like atmosphere for pregnant women offering them food and refreshment covering all associated expenses themselves. As it was reported that the health facilities would not cover costs of accompanying family members, the proportion of women accompanied at the facilities has decreased. In fact, the health personnel indicated also that they were making efforts to mobilize resources at the local level in the form of firewood contribution.

4.2.2.2 Humbo Woreda

Antenatal care

99.4% of the women went for ANC visits. 41.3% visited the facilities 2-3 times, 48.5% attending 4 or more visits and only 10.2 % went to just one appointment. 13.8% of the mothers started the ANC in their first three months of pregnancy. Over 75.4% of women began ANC during their second trimester, and about 10.8% not seeking care until their final few months of pregnancy.

Delivery care

88.1% of women reported that they were assisted by skilled birth attendants at their deliveries in the 12 months preceding the survey, 70.2% they gave birth in HCs of which 65.5% were assisted by a nurse or midwife followed by 14.9% assisted by medical doctor and 7.7% by health officers.

A substantial number of mothers still deliver at home with TBAs for a variety of reasons; 38.9% thought it was due not allowed by husband and family, 22.2 said it was uncommon for women in their community to utilize HFs for deliveries and 38.9% gave other reasons such as delivering when prepared to go to health center. As can be seen from Table below, still one in ten mothers are found to give birth at home in 46 kebeles of Humbo Woreda. Discussions with CCC members and child parliament members have revealed that most of the remote kebeles of the woreda were not accessible during rainy seasons. The problem of inaccessibility of some remote kebeles is often exacerbated by heavy rains which sometimes wash away local bridges and erode feeder roads that connect kebeles to kebeles for the most part. The increase in hospital deliveries is related to the closeness of Soddo Hospital which is within a range of 20 km for some kebeles although it is possible that a heightened level of awareness has also contributed for the surge of demand for hospital services.

Table 6. Comparison of SBA result of baseline and end line surveys in Humbo Woreda

	Baseline	End line
SBA deliveries 12 months preceding survey	53.5%	88.1%
Delivered at home	46.5%	10.7%
Delivered at health post		1.8%
Delivered at health center	48.3%	70.2%
Delivered at hospital	4.1%	17.3%
Other	1.2%	

When evaluation results are compared with the baseline there is a decrease in number of deliveries at home by 35.8% which means there is an improvement in number of deliveries in health facility. Similarly result reveled there is an improvement in proportion of SBA mothers by 34.6% compared to the baseline result.

Postnatal care

68.7, who gave birth at a HF reported having their health status checked immediately after delivery. 12.7% percent were checked after leaving the HF. 12.7%of women had someone visit them at home with a month of giving birth; 55 percent of those visits were conducted by health-

care providers with the remaining 45 percent visited by HEWs. 27.3% percent of the mothers travelled to a HF for PNC sometime during the month post-delivery.77.5% of mothers were checked by health –care providers and the remaining 20% checked by HEW.

First delay: delay in making decision to seek health care

Of the women who attended follow-up ANC appointments, 23.8% were advised about birth preparedness. 76.2 % women's were got ready by saving money, buying or preparing clothes for the baby, etc. 44.6 % received support from the community.

Of the women who had ANC, 41.9%of them were told about pregnancy warning signs. 39.3% of women were confident in their knowledge of pregnancy danger signs. The most recognized complications were vaginal bleeding 66.7%, Anemia 37.9% and severe headache 42.4%; swelling, increased blood pressure and quivering were also mentioned.

Table 7. Knowledge of pregnancy complications reported by interviewed mothers in Humbo Woreda

Pregnancy complication	Baseline result	End line result
Vaginal bleeding	63.1 %	66.7%
Rapture of amniotic fluid	25.4%	37.9%
Severe headache	23.8%	42.4%
Blurred vision	17.2%	55.6%
Others	5.7%	11.1%

In most cases, 88.7% of the time, the decision of where to give birth was made jointly with the women and their husbands. Husbands decide by themselves the place of birth for the women that accounts for 2.4% of the study participants. 73.7% decision were made during pregnancy followed by 25.7% during labor.

Second delay: delay in reaching or accessing health facilities

49.4%women reported that living less than 30 minutes away, 24.4% living 30 minutes away from their home, 22.6% living betewn30 minutes and hour and 3.6% between 1hour and 2 hours. About 61.3% of women utilized the ambulance service to reach a HF before they delivered and 22.6 percent used walked and 13.7 used other means like mother and Bajaj.

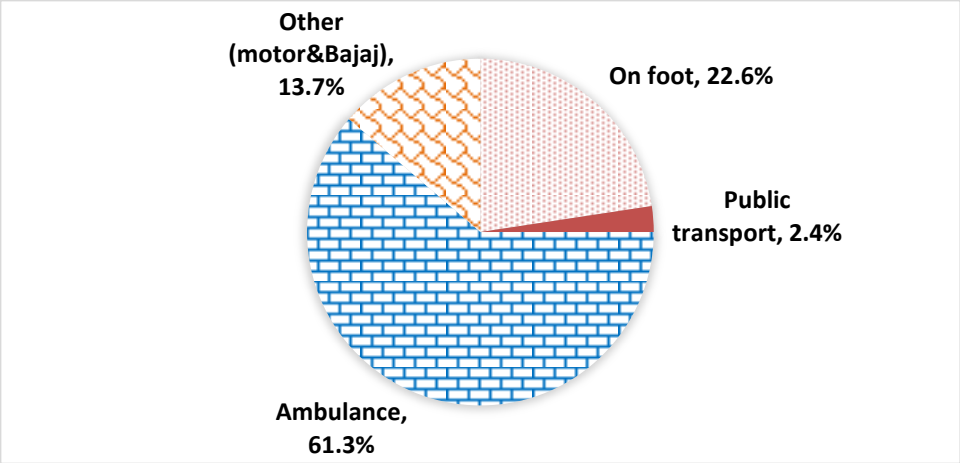

Figure 4. Means of transport to health facilities

95.8% of pregnant mothers preferred travelling to a HF as soon as labor began, but 14.9 percent waited until they faced prolonged labor.

Third delay: delay in receiving health care at health institutions

Tebela Health Center has 20 nurses, 3 health officer and 3 midwives and handled 1406 deliveries in the past reporting year (2015/16), with the catchment population of 41, 583, and an ANC-1 coverage of 76.6%. The facility refers to Soddo Hospital which is 22 km from the health center. The health center does not have any health worker who received training on newborn resuscitation and BEmOC. Tebela health center has got access to electric power and piped water but it did not have landline telephone. The health center has six beds reserved for maternity. The health center had a relatively good supply of medicines and most essential drugs including antibiotics, oxytocin, anticonvulsant and emergency drugs but drugs like Methyldopa and Labetalol which were used as anti-hypertensive were not available at health center at the time of the assessment. The health center had almost all of the necessary basic equipment except examination light and incubator.

Abella Faricho HC has 7 nurses, 3 health officers and 1 midwives and handled 1,116 deliveries during the past reporting year (2015/16), with the catchment population of 31,602 and nine health posts. The health center's ANC-1 coverage was 87%. The facility refers complicated pregnancies to Soddo Hospital which is located at a distance of 32 km. The health center has a health worker who received training on newborn resuscitation and BEmOC. Abella health center did not have landline telephone but it has access to electric power and piped water. The health center had some supply of medicines like most essential drugs including antibiotics, oxytocin, and emergency drugs but drugs which used as anti-hypertensive and anticonvulsant were not available at the time of the assessment. The health center had almost all of the necessary basic equipment except examination light and incubator.

Treatment of mothers during delivery

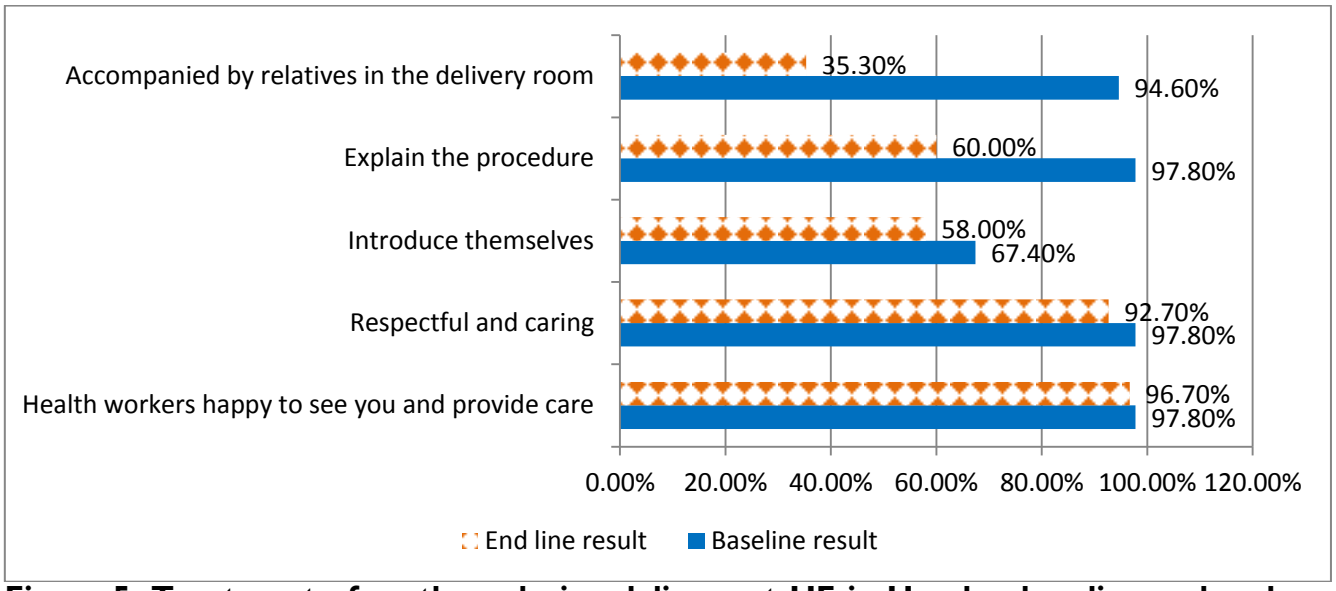

Figure 5. Treatment of mothers during delivery at HF in Humbo: baseline and end line results

In summary, the contribution of the project outputs and outcomes have been effective particularly with regard to expanding SBA coverage in target woredas because the end result shows that SBA is 98.2% in Banja Woreda and 88.1% in Humbo Woreda as compared to national average of 28% in 2016 according to EDHS 2016 and 72.7% based on FMoH's HMIS (health management information system), which is government's administrative data for 2008 EFY or 2015/2016.

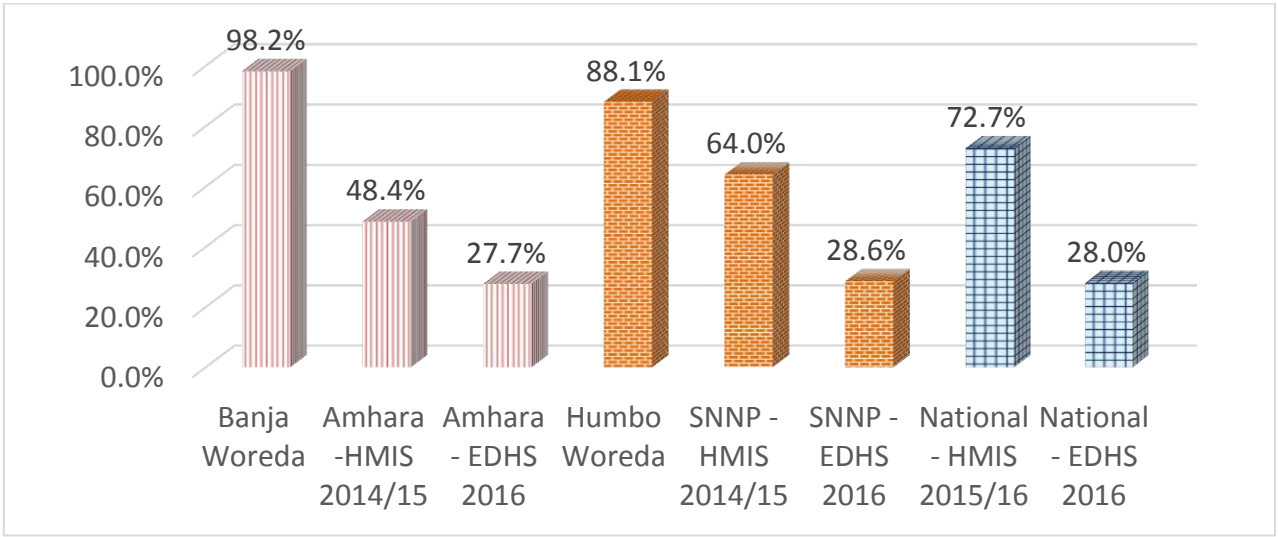

Figure 6. SBA achievements: evaluation results versus regional and national coverage, April 2017

Sources: April 2017 evaluation results for Humbo and Banja Woredas; HMIS 2007 and 2008 EC for national data[14]

4.2.3. Problems and Challenges Encountered

The discussions held with local government offices, target community representatives, members of child parliaments and WVE's field team on the ground there are still problems and challenges that constrain pregnant women's access to quality maternal health services, mainly at two stages: second and third delays.

- **Poor road conditions and existence of remote and inaccessible rural kebeles:** In both Humbo and Banja Woredas there are remote and inaccessible kebeles which have posed challenges to mothers during pregnancy, antenatal care, delivery and postnatal care where access to health services provided by skilled and professional health personnel, plays a vital role in the efforts to reduce preventable deaths of mothers and children. The problem is that ambulances were not able to pick pregnant mothers from remote kebeles/villages due to poor road conditions.
- The problem of inaccessibility of some remote kebeles is often exacerbated by heavy rains which sometimes wash away local bridges and erode feeder roads that connect kebeles to kebeles for the most part. Road maintenance has not been an easy task for the local government which operates under budget constraints due to competing ends. In some kebeles of Banja Woreda the youth were organized to serve as porters carrying pregnant women on traditional stretchers until they reach either a health institution or a place where ambulances can reach to pick them.
- **Poor quality of services provided:** The quality of MNCH services provided in health facilities has been affected by lack of access to potable water and electricity. Even if there is access to public tap water, wireless phone and electricity, there has been frequent breakdown of these services. The shortage of skilled birth attendants in health facilities also badly affect the quality of delivery services and antenatal and postnatal care services. These problems and challenges were reported from the health centers visited during the evaluation fieldwork. At present, there is more pressure on existing health facilities as the numbers of health services seeking mothers have increased in both pilot woredas and beyond.
- **Shortage of ambulances:** FGD discussions and key informant interviews have revealed there is a rising demand for additional ambulances in both woredas though there are two ambulances per woreda at present. Efforts are being made by different groups of people to purchase the third ambulance which is seen as an encouraging sign of community ownership of the development process at the local level.
- **Shortage of essential drugs at health facilities:** women and newborn babies often face shortage of essential drugs in health centers where childbirth takes place. When drug supplies are low at public health institutions, poor families suffer the most as they cannot afford to buy from private drug stores or drug stores sometimes may not be accessible readily due to distances.
- **Frequent changes in local leadership:** Local kebele level leadership changes often resulted in schedule delays or plan revisions and affected the pace of project

[14] See Federal Ministry of Health, Health and Health Related Indicators (2007 EC). Policy Planning Directorate, Addis Ababa. October 2015, p. 18; Federal Ministry of Health, HEALTH Sector Transformation Plan I Annual Performance Report, EFY 2008 (2015/16).

implementation, including that of the CHN Campaign Project. This often required the campaign project team to made extra efforts to bring new kebele leadership and CCC members onboard so that smooth project operation would take place at the local level.

4.3. Project Efficiency

The efficiency evaluation criterion deals with how well project results have been achieved at reasonable cost, i.e. it helps assess how well project inputs have been converted into project activities in terms of quality, quantity and time, and the quality of the results achieved. In this regard, actual project results are assessed to highlight progresses, achievements and problems to draw lessons for future programming. The efficiency of project campaign processes are also assessed for their efficiency.

4.3.1. Implementation Arrangements and Project Integration

WVE Head Office team[15] indicated that the health and nutrition programs department of the organization had regularly participated in national technical working groups led by FMoH such as Safe Motherhood Technical Working Group and Child Survival Technical Working Group and often sharing MNCH related best practices, research results and CHN Campaign Project messages to members of the technical working groups. Such efforts by the health and nutrition programs department point to the fact that the campaign project was integrated into main programs of the organization. The discussion with WVE HO team has also revealed that WVE has actively engaged in and contributed to the development of national newborn child health care strategy and family planning guidelines. However, WVE's key partners have also indicated that the organization did not have regular and consistent representation in MNCH technical working groups at national level where health policy processes took place in the past.

WVE, through the campaign project coordination and the health programs department, has worked effectively with Christian faith followers (Ethiopian Orthodox, evangelical Protestants, and Catholic) and Muslims to create critical public awareness on the magnitude and nature of preventable deaths of mothers and children at childbirth and the role each one of them could play through positively influencing their followers and through bring about behavioral and attitudinal changes in their respective followers and communities. According to a separate discussion with the representative of FMoH the government is planning to consider faith leaders to be part of the national MNCH technical working group as a result of WVE's earlier successful work with the groups. In this regard, WVE's effort is set to bear fruits in the near future as the organization pushes forward to bring about behavioral and attitudinal changes in the families and communities with the involvement of faith leaders.[16]

The project had outcome and outputs that needed to be achieved at regional state level but the organizational set up of WVE has not been conducive for this. Even though it is represented at regional state level by regional offices, WVE has not been participating in MNCH technical working groups that summons every quarter under the auspices of the Regional Health Bureaus to discuss progresses, issues and problems related to MNCH programs and projects run by international NGOs in the regions. WVE could have taken the chance to make presentations on its campaign messages, research outputs and best practices on MCH in general and on SBA in

[15] See Annex 2 for details.
[16] See World Vision Ethiopia, Practicing Faith - Four Stories from Ethiopia: Enhancing Faith Leaders for Better Maternal Health, 2014.

particular. However, this could not be realized due to the absence of its representation by technical staff at such regional forums.

A discussion held with WVE HO senior managers has disclosed that WVE does not have health programs technical staff (subject matter specialists) who represent the organization at regional forums or regional technical working groups. It was learnt also that it was not possible to draw heath technical staff from Area Programs or Cluster Program Offices because they are located at long distances and their scope of networking has been limited to woreda and zone levels, on one hand, and because they could not afford to release staff for regular and continuous representation at regional technical working groups, on the other. This situation has led to a loss of opportunities for WVE to effectively influence both health policy processes of regional governments and programming and services of international NGOs running MNCH programs/projects in project target regions.

4.3.2. Project Management Structure

WVE set up a project management structure in the head office with the oversight of the senior leadership and technical support of the "Campaign Secretariat" composed of Health, Nutrition, MNCH, HIV/AIDS, and cross-cutting Departments where the advocacy specialist and the campaign coordinator were tasked with role of getting the project implemented through pertinent CPOs and pilot ADPs.

Even though it was supposed to steer the campaign project processes, the "Campaign Secretariat" was not engaged actively to discharge its responsibilities as expected. At the CPOs and pilot APs the project was considered simply as one of their portfolios though it lacked proper resourcing (staffing and budgeting) for implementation and follow up. It was learnt during evaluation fieldwork that most of the project's implementation processes were shouldered mainly by the project coordinator who of course indicated he had been receiving considerable leadership backing all through the project lifetime. It is in fact important for WVE to strengthen the management of such important projects by putting in place a proper project management structure in the future.

4.3.3. Financial Management

In project design strategy document WVE envisaged to obtain a total of USD 442,640 for three years with the annual breakdown of USD 144,906 for 2014, USD 147,464 for 2015, and USD 150,270 for 2016. In fact, the strategy document was prepared after the project started officially in 2012. The project was funded Word Vision Hong Kong over the lifetime of the project and the actual funding and expenditures of the project are presented in the table below.

Table 8. WVE CHN Campaign Project budget and expenditure, 2013-2016

Fiscal Year	Annual Budget	Budget Allocation Trend (%)	Annual Expenditure	Unutilized Budget	Annual Budget Utiliz. (%)	% of Unutilized Annual Budget
2012	100,000	14%	72.233	2,7767	72%	28%
2013	107,767	15%	30,658	77,109	28%	72%
2014	156,254	22%	124,168	32,086	79%	21%
2015	179,550	25%	153,747	25,803	86%	14%

2016	176,073	24%	162,637	13,436	92%	8%
Total	719,644		543,444	176,200	76%	24%

Source: WVE CHN Campaign Project annual financial reports from 2012 to 2016.

The total project budget for five years, as indicated in Table 9 above, was US$ 719,644, out of which US$ 543,444 or 76% was utilized up to the end of FY 2016. The budget allocation over the project period was good while budget utilization rate improved from year to year though the overall picture of budget utilization was not to the expected level as a huge amount of budget remained unutilized overtime. Given the nature of the campaign project and the improvement seen in terms of burn rate over years, it is possible to judge that the budget utilization was moderately satisfactory. See Figure 7 below for details.

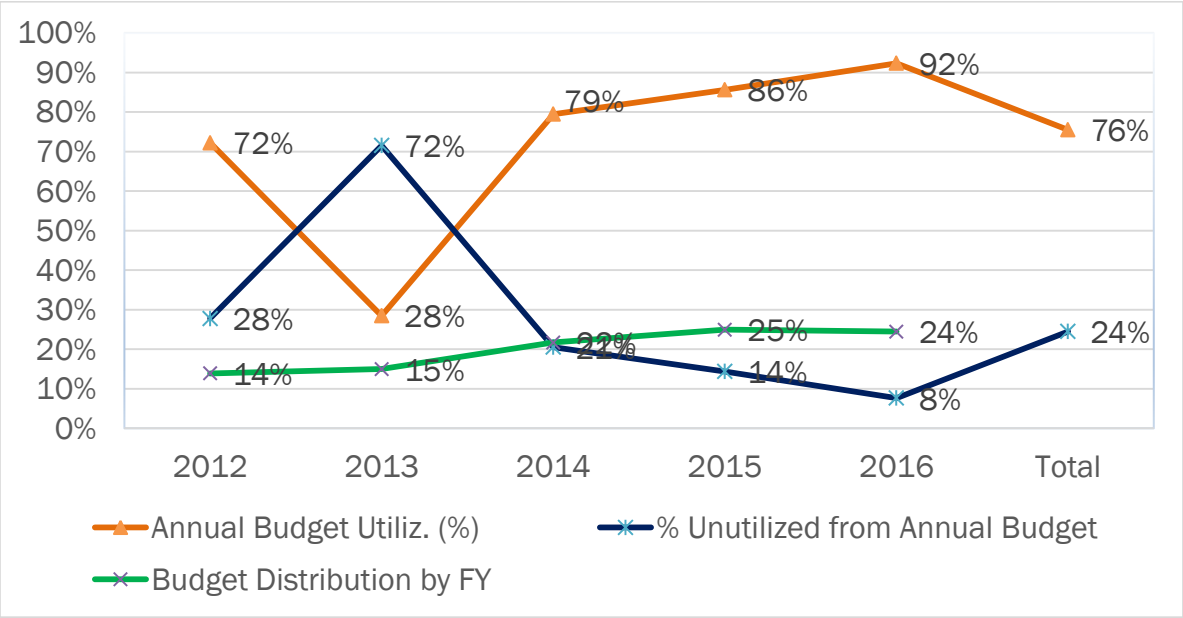

Figure 7. Budget allocation and utilization trends by fiscal year
Source: Table 4.

4.3.4. Project Reporting

CHN Campaign Project was one of many WVE's projects operating in Amhara and SNNP Regions expected to submit reports to regions, zones and woredas where projects are implemented. As consolidated project reports have been prepared at the national office level in Addis Ababa and there is no structure responsible for preparing the project's reports at either CPOs or APs level, zone co-signatory offices (health, WCYA and finance & economic development departments) and their woreda level structures have not been receiving reports on a regular basis though they were part of the implementation processes themselves. The regional bureaus have also claimed not to have received reports or updates on a regular basis. In this regard, there is a room for improvements in terms of submitting regular reports to co-signatory offices while installing feedback mechanism to ensure reporting quality and timeliness. However, the project coordination unit in Addis Ababa was preparing and submitting regular reports to higher officials within WV's system.

4.4. Project Impact

The main purpose of any project evaluation, including the campaign project which alludes much to advocacy than to service delivery projects, is to assess whether the designed project achieved its goal and met its objectives. This evaluation emphasizes the qualitative changes in the lives of the target women and children their families and communities. Impacts are concerned with changes in the qualitative and quantitative achievements of goal and objectives of the project as indicated in the project document. The changes could be either direct or indirect and/or positive or negative. A mix of indicators are used to assess the impact of the project.

Discussions held with the local government offices revealed that MNCH systems and services have been strengthened through deployment of 38,000 HEWs and provision of ambulances (two for Humbo and one for Banja), and budgets allocated intentionally within the government's resource capacity. Moreover, accountability has been upheld for effective and quality services and efforts have also been made to achieve equity between rural and urban poor and among different wealth categories. Shifts in policy and resource allocation are thus being made in favor of the poor and vulnerable families as the government currently provides subsidies to increase SBA coverage across the vast areas of the country, including CHN campaign project target communities. All these positive changes, to which WVE has significantly contributed, have been possible with popular participation at grassroots level that emanated from community empowerment activities over the past few years.

Community FGDs and interviews with local government officials have also brought to light the fact that the campaign project, combined with government's and other MCH stakeholders' efforts, has empowered pregnant women to make appropriate decisions with regard to what to do and where to go for safe delivery. Woreda and zone government health offices have indicated that the campaign project has contributed a lot in promoting health seeking behaviors in target communities in general and among childbearing age women and their husbands in particular. This is an encouraging achievement that needs to be enhanced and sustained over the long-term.

WVE actively engaged religious leaders in its campaign efforts to increase SBA coverage in rural communities. The involvement of the religious leaders drawn from four faith institutions has cultivated and resulted in overcoming the first delay, i.e. delay in making decision to seek health care, through inculcating positive behavioral and attitudinal changes in the families and communities regarding institutional delivery. Subsequent to this development, currently religious groups have got the chance to become active members of MNCH technical working groups at both regional and national levels. This was an unintended but positive outcome in the making as a result of the CHN Campaign Project. In short, the first delay was brought into government focus due to WVE's project's campaign activities and local government's level of commitment to removing the barriers to the first delay has improved ever since in both Humbo and Banja Woredas which were pilot woredas of the project.

Discussions with zone and woreda WCYA offices revealed that reduction in preventable deaths of pregnant mothers has in effect minimized the chances of their children becoming orphans and vulnerable children (OVCs) who might be forced to grow under poor grandmothers or stepmothers or who just might not get the care and support they need as children to experience a healthy life. The evaluation team believes that the successful implementation and contribution of the campaign project in target communities, has fended off potential OVC psychosocial challenges and distresses that could have negative social and economic burdens to families and communities, and even to the nation ultimately.

Community FGD participants and key informants at various levels stressed the fact that the CHN Campaign Project has empowered women in many ways. They argued that the project has tangibly empowered rural women to decide where to give birth and to demand for better services from health facilities and that it has contributed to the creation of social cohesion among community members in general and women in particular as they, monitored pregnant women and encouraged each other to enhance family health and wellbeing are improved. The project has also contributed to women's social positions in their communities and organizations and Wzo. Alemitu Lencha, Deputy Head of Wolaita Soddo Zone WCYA Department, could be a typical example for this. She recognizes that her active involvement in the implementation processes of CHN Campaign Project and other projects positively impacted her leadership skills and capacities, which led to the effectiveness and visibility of her office when she was working as head of Humbo Woreda WCYA. She says this situation has eventually resulted in her promotion to Wolaita Zone as deputy head of Zone WCYA.

In the end, it is worth noting that progresses have been achieved in the provision and expansion of MCH services in Ethiopia in general and in WVE's CHH Campaign Project catchment areas in particular. All FGD participants and key informants have agreed that the results achieved with regard to MCH services over the past three to five years have been the fruits of the coordinated efforts of multiple stakeholders, including government, NGOs, bilateral and multilateral agencies, FBOs, CBOs and communities. Many have argued and the evaluation team appreciates the fact that attributing the results to a certain agency or a group of actors is very difficult though majority of them still agree that all of the stakeholders, including international NGOs like WVE have made their respective contributions to bring about positive changes in the coverage of skilled birth attendance over the past few years.

4.5. Sustainability

The sustainability of project results and benefits is dependent on the institutional, technical capacity and feasibility, financial and project ownership by local communities and pertinent government offices after the termination of the projects or external assistance. WVE, through its CHN Campaign Project, has therefore made efforts in collaboration with its partners to prepare grounds for role shift eventually to the local government offices and beneficiary communities.

In spite of constraints and challenges often faced by rural communities, particularly those living in remote and inaccessible kebeles or villages, participants of community FGDs and local government KIIs have indicated that it has become a popular belief that no woman should die while giving life, which is in line with the direction set by the government in this regard. The CHN campaign project has mobilized and ensured an active participation of the younger generation currently in primary and secondary schools as well as colleges who have not only advocated for safe motherhood and childhood in their communities but also learnt a lesson for life which is expected to be adhered to in the years ahead as they will become mature adults themselves. There are clear signs that popular awareness on and understanding of the need for institutional delivery have resulted in lasting behavioral changes in rural families and communities.

Community Care Coalition (CCC) members, where religious leaders are active members, have indicated in Humbo Woreda that faith leaders and health personnel are now on one side supporting institutional delivery of pregnancies unlike the time before the implementation of the Child Health Now Campaign Project when local faith leaders were not active supporters of institutional deliveries. Furthermore, they used to receive only deliveries with complications or obstructed deliveries, not normal deliveries, in most of the cases. Apart from religious leaders

and pregnant mothers, woreda health officials and HEWs engaged in discussions indicated also that the health personnel have experienced significant changes in their attitudes towards covering all deliveries, whether normal or complicated, at health institutions.

CHN Campaign Project combined training with practice; project activities have been supported with training and capacity building efforts made by the organization; the project emphasized community empowerment approaches in the designing and implementation processes which not only helped communities to realize their potentials but also co-signatory offices like WCYA office stretch their efforts to address the issues and problems of women and children with little or no resources to their side.

As a matter of fact, still there is a need for the government to continue providing free delivery services for pregnant mothers; or else poor women in particular would be forced to resort back to home delivery which has already proved to be dangerous for the health and wellbeing of both mothers and children. Achieving equity and affordability in maternal and child health services should therefore continue to be major areas of government focus in the future.

In the drive for expanding SBA coverage the government and NGOs like WVE have worked together effectively. However, discussions made with government officials at both regional and federal levels have indicated that such MNCH services expansion related projects as the CHN Campaign Project, have already prompted the need on the part of the government to improve health sector planning and increase health budgets to meet the rising demand for health services triggered by active community mobilization and sensitization on institutional delivery at all levels. According to the discussion made with FMoH and woreda level health officials, the government covers all health care costs and accommodation and meal expenses of every pregnant mother during their stay in waiting rooms of the health facilities. Although these officials have also indicated that the government has already started community based health insurance in 380 woredas in the country, where individual households pay 240 Birr (about USD 10) per annum, the burden financing such huge MNCH services across the country will not be simple as government embarks on ensuring equity and quality of health services in the years ahead.

4.6. Overall Assessment of Project Performance

4.6.1. Strengths

Aligning campaign strategy to changing contexts: Even though the campaign project was launched officially in January 2013, WVE in due course shifted its campaign strategy in September 2013 by adopting a strategy document that emphasized "institutional delivery" as a major focus of the campaign project and subsequently conducted an extensive assessment that identified the major causes of low institutional delivery in selected seven woredas of Amhara, Oromia and SNNP regions where WVE operates. This has helped the organization to adjust its campaign focus and run evidence based campaign that has positively impacted the lives of many mothers and children, including households and communities, in changing internal and external contexts.

Evidence based campaign: The practice of conducting situation assessment and field research has been one of WVE's strengths in the design and implementation of Child Health Now Campaign project as this made it possible to make evidence based campaign. Issues were identified and vision was cast as to what success would look like at the end of the project. WVE has published on its official website research results entitled "Practicing Faith - Four Stories from Ethiopia: Enhancing Faith Leaders for Better Maternal Health" "Causes of Low Skilled-Birth

Attendance Coverage: In Selected Woredas of Amhara, Oromia and SNNP Regions," which are downloadable and open for public access to them.[17] 'Practicing Faith' was prepared and published by WVE with the involvement of religious leaders from Ethiopian Orthodox Church, Evangelical Protestant Churches, Moslems and Catholic Church. This practice needs to be strengthened as WVE seeks to pursue running evidence based social change campaign projects in the future.

Integration and consolidation of MCH projects: Before implementation of CHN Campaign Project was started, WVE used to implement small and fragmented MCH projects here and there. Such MCH projects did not have the required synergy and complementarity that would help WVE to effectively coordinate and address health issues of target households and communities across the country. Now the implementation of the CHN Campaign Project has inspired the health and nutrition department to design and implement integrated and measurable health and nutrition outcomes in the best interest of mothers and children in target communities.

Commendable project coordination efforts: Even though the setup of the project was not conducive enough for a smooth implementation across the board, the project coordination unit in Addis Ababa was able to reach out effectively to local and zone level government offices over the project implementation period. In this regard, the project coordination unit, led by the project coordinator and supported by his colleagues, was acknowledged by government officials and WVE field teams for the commitment, hard work and effective facilitation put into project implementation with the view to encouraging local government officials, health personnel, faith leaders and community representatives to take appropriate actions towards achieving the goal of reducing preventable maternal and child deaths in their respective communities. Implementing APs and CPOs indicated also that they have benefited a lot from the coordination unit which effectively supported them in the campaign project implementation and management processes. Even if it has not gone forward with its full strength as an advocacy organization due to the restrictive regulatory environment, WVE has laid the basis for developing organizational capability and confidence at both technical staff and leadership levels to effectively design and run advocacy campaign programs aimed at bringing about social changes in favor of the poor and underserved.

4.6.2. Growth Areas

Even though strengths outweigh the growth areas of the campaign project here are a few points that need to be considered in the programming of such campaign projects in future.

- The campaign has got multiple slogans on different occasions that emphasized the need for institutional delivery with the assistance of professional health personnel (MDs, health officers nurses and midwives); as such the project key message development or a central theme that could have been shared by various levels of organizational leadership and field staff appear to be not stated in clear and concrete terms; campaign messages were printed on T-shirts which disappear fast compared to billboards which were not used by the campaign project. Messages on billboards could relatively be seen by many more people and that could last longer than T-shirts.
- Local government offices raised the fact that the campaign project was paying daily per Diem to community members when they were called for trainings and community meetings. Some of the local government offices claimed that whenever the government called for community meetings for its own agenda, they were not motivated enough

[17] See World Vision Ethiopia Website: http://www.wvi.org/ethiopia/publications. Visited in May 2017.

because per diem was not paid in such instances and that this has affected their activities somehow according to the discussions the evaluation team had with the offices.

- Some of the project activities or outputs, for instance formation of CCCs and HDF kebeles did not have planned targets. Inadequate participation of WVE in existing MNCH networks at both federal and regional levels, has been raised at various levels of KIIs in the evaluation process. There was also no staffing at the CPO or RO level to link the project to the regional health policy processes (related to MCH).
- Limited visibility of WVE when seen in terms of contribution that needed to be made at both the national and regional levels through the CHN Campaign Project.

4.6.3. Lessons Learnt

Over years WVE has built good reputation for running successful relief and development programs and projects across the different regions of Ethiopia; this has given it a leverage to be an authoritative voice as its campaign messages were well received at the grassroots level. WVE's campaign coordination unit efforts have pointed to the fact it is possible to bring about any sizeable social changes in the best interest of the poor and vulnerable community groups in collaboration with different levels of government – local, state and federal levels.

Before WVE launched the campaign project, the focus of the government at all federal and regional levels was limited to overcoming the second and third delays, i.e. the supply constraints and challenges affecting institutional delivery. However, the campaign project's success in generating popular demand for institutional delivery at local level through bringing about behavioral and attitudinal changes, has also helped the government to focus on removing the barriers that cause the first delay through addressing community behavioral and attitudinal changes at the local level. This was confirmed during the key informant interviews made separately with WVE HO team and FMoH representative.

WVE HO team members indicated during the meeting held with them that WVE has now identified MNCH as one of the top health and nutrition program priorities because of the positive effect CHN Campaign Project has had on health and nutrition programming in the organization. Furthermore, it was revealed during the discussion with same team that WVE has learnt a lesson that could be a good basis for leaning more towards campaign or advocacy, which focuses on community empowerment approach, than service delivery mode to implementing effective health and nutrition programs and projects in the future.

The discussion held with FMoH official revealed that the Ministry engages religious leaders to help influence family planning matters; UNICEF Ethiopia works with religious leaders to change feeding practices of pregnant mothers during fasting seasons, the major one being the season that leads up to Eastern holiday every year[18] while WVE's work with the religious leaders has already started bearing fruits in the drive to improve the health conditions of pregnant mothers and their children. The involvement of religious groups is expected to inform and positively influence government's MNCH and family planning related policies, strategies, guidelines and services in the near future as FMoH is considering to engage religious leaders to be part of the national MNCH technical working group, which is a potential success area for WVE in this regard.

[18] According to Orthodox Christianity tradition all believers, including pregnant mothers, are expected not to eat meat, egg and butter, and drink milk during the 55 days before Easter holiday and during other days in a year as designated by the church.

Media messages on SBA were strong enough to rally pregnant women, their husbands and the larger community for change. Messages disseminated through IEC materials have created critical public awareness and a sense of regret when the families and communities knew what it would have taken to save the lives of many pregnant women and their children was just sending the women to health institutions on time.

The role played by CHEWs and health development armies (HDAs) has been of immense importance in breaking behavioral and attitudinal barriers through tackling the root causes of the first delay (women lacking care seeking behavior) which came about through continuous identification and monitoring of pregnant mothers, health education, persuasion, as well as making and following up with ambulance arrangements.

Last but not least, child parliament members in both woredas indicated that they were involved in sensitizing and urging families and communities on the need for skilled delivery and many times monitored and challenged cases of negligence at family level, particularly when husbands did not do enough to support their pregnant wives. It is believed in this case that the seed of standing for the rights and wellbeing of others has been sown among the children and it is expected this could be a lifelong learning for the children themselves.

5. CONCLUSIONS AND RECOMMENDATIONS

5.1. Conclusions

A synthesis and analysis of the data and information gathered through this evaluation work indicate that WVE has successfully designed and implemented its CHN Campaign Project, which had the goal of contributing to the reduction of preventable deaths of mothers and children through its operation areas and beyond. In general terms, many lives have already been saved; so many family breakdowns have been prevented from happening and the potential for children to be orphaned have also been minimized as a result the contributions made by WVE through implementing this CHN Campaign Project.

The campaign project has played a key role in triggering big demand for health services at the local level by emphasizing and promoting the need for skilled birth attendance to every childbirth in the target communities and beyond. Efforts were also made to inspire the local government to increase its commitment to expand and improve institutional delivery. All these can be taken as substantial achievements that have triggered changes in the living conditions of women, infants and young children under five years old in the communities as there is no better achievement than saving human lives, particularly of women and children who are always more vulnerable to preventable diseases and malnutrition, on one hand, and empowering the communities to take charge of their development destiny in the philanthropy world, on the other.

It is important to note that government's and its partners' commitments to the issues of safe motherhood and childhood is clear both at policy level and in practice as various health development programs have recently taken up the issue so loudly and widely across the different levels of the government. This has hugely contributed to the campaign project's success in the past three to five years of it implementation period.

The assessments made on MNCH situations, the research conducted on barriers to skilled birth attendance, public engagement through mass media, the production and dissemination of documentary films on MNCH situations, the campaign messages developed and disseminated with

the involvement of religious leaders, child parliamentarians, the youth and key government officials, the active roles played by local institutions like CCCs in community mobilization, have all constituted the major steps forward in advancing the expansion, equity and quality of MNCH services, particularly of SBA services, across project target communities and beyond. The assessments and research results obviously serve as evidences and help inform health policy dialogues and shape health sector programs elsewhere in some positive ways.

Community attitudes and practices have got causes for sound changes while the thoughts and ideas of many health personnel have also been shaped up to bring about measurable changes in the lives of mothers and children in their catchment areas and beyond. It is worth noting that WVE's approach to addressing the first delays (decisional delays experienced by pregnant mothers in seeking health services) has been unconventional as it involved religious leaders so effectively and could be considered a social innovation which has been more efficient than and expected to be sustained better than any other approaches tried so far by other actors working on the first delays. Indeed, these achievements have been enormous and remarkable because the campaign project has positively impacted the lives of tens of thousands, if not millions, of mothers and children as well as their families and communities and in fact the pace set by this project will require WVE and its partners to embark on more and more innovative initiatives that help transform the lives of many poor and vulnerable families and communities, to whom WVE is highly committed.

The project has proved that WVE has the opportunity to gain an authoritative voice and legitimacy for effective campaigns from the well of its longstanding commitment and reputation for service delivery programs that have positively impacted the lives of many poor, vulnerable and underserved communities across the different regions of the country. The project has shown a good sign of progress in grassroots advocacy while campaign for improving policy processes needs more attentions in the future. It is true that the campaign project evaluation is different from service delivery project evaluation as the latter most often focuses on outputs and outcomes that are easily amenable for measurement. It is therefore important to set realistic and high level expectations from such campaign projects in the future.

5.2. Recommendations

Evaluation recommendations are forwarded in the following categories: program development and coordination, local level decision makers and implementers, and policy and strategy.

5.2.1. Program Development and Coordination

- **Build organizational capacity:** WVE should focus on training and equipping its staff and reviewing its staffing level and organizational set up in order to continuously build its own organizational capacities for successful future engagements in advocacy work.
- **Developing key campaign/advocacy messages:** In the future, WVE needs to develop key campaign/advocacy messages that help effectively advance key issues with pertinent audiences at different levels and ensure that such advocacy messages are delivered with ease by various levels of organizational leadership and field staff.
- **Strengthen networking and partnership:** WVE should revisit its regional level organizational set up to include subject matter specialists or take any appropriate action to ensure consistent and continuous representation of the organization at relevant national and regional forums and technical working groups.

- **Sequencing of project activities:** WVE gave campaign management and sustainability training towards the end of the project. Even though the importance of the training is not questionable, such trainings should be given far in advance in the future in order to ensure project communities make adequate preparations to own, manage and run project implementation processes and attendant benefits and outcomes after projects phase out eventually.
- **Work towards better visibility:** As successful advocacy campaigns often yield big and far reaching results, WVE may need to improve its campaign visibility for instance through regular and continuous public media engagement, effective and regular networking with and appropriate representation at forums and networks organized and run by government, likeminded NGOs, as well as multilateral organizations.

5.2.2. Local Level Decision Makers and Implementers

- **Focusing more on community empowerment: CBOs (such as CCCs) and FBOs need** to be more and more empowered to own, manage and sustain community development services and benefits through focusing on building their institutional and technical capacities in the future.
- **Establishing and maintaining post-transition connections:** WVE Humbo AP phased out of Humbo Woreda a few years back and there is still a fresh memory of the organization among local government offices and ex-target communities. WVE may need to have a mechanism to stay connected to ex-target communities and local government offices to listen to them, learn from its past programs/projects and ensure organizational reputation remains intact in the face of changing local contexts.

5.2.3. Policy and Strategy

- **Ensuring quality and equity of MNCH services:** The government needs to mobilize and work with international NGOs like WVE and multilaterals to strengthen the capacities of the health system and to improve the quality of MNCH services by consolidating best practices and models developed by its partners. The government also needs to improve road access to health facilities in the years ahead in order to ensure equity of MNCH services in hard to reach rural communities.
- **Ensuring sustainable MNCH financing**: The government needs to mobilize community participation at the local level expanding what it has already started as community based health insurance while also working hard to ensure sustainability of MNCH achievements in general and skilled birth attendance coverage in particular through raising adequate financial resources.
- **Providing guidance and technical supports to health researches:** As an international NGO, WVE, in collaboration with FMoH and other partners, should continue developing and implementing research based MNCH campaign projects that will focus on safe motherhood and child survival in order to effectively complement government's and non-state actors' development efforts in Ethiopia. The government may need to provide guidance and standards to NGOs like WVE as they embark on health researches.

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ANNEXES

Annex 1. Evaluation ToR

World Vision Ethiopia

CHILD HEALTH NOW CAMPAIGN

Final Evaluation Terms of Reference

Prepared by Tsegaab Tadesse, CHN Coordinator

Approved by:

Beyene Geleta Date January 12, 2017

1. Evaluation Summary

Program	World Vision Child Health Now Campaign E196979
Program Phase	Period being covered by the evaluation. (from January 1, 2012 to September 30, 2016)
Evaluation Type	End of project evaluation
Evaluation Purpose	The purpose of the evaluation will be to see the whether the project goals and indicators are achieved and also to get feedback on the process of campaigning in WVE
Evaluation Methodologies	The methods the evaluation will use to answer the key questions. It must be practical as well as capable of providing meaningful answers to the questions.
Scope of evaluation	It will be done at Humbo and Banja woredas of WVE operation areas
Evaluation Start and end dates	January 20, 2017 to February 28, 2017
Anticipated Evaluation Report release date	March 1, 2017

2. Description of Programme or Project Being Evaluated

Ethiopia achieved MDG target on reducing the child mortality by two thirds in late 2013. However, the progress on maternal mortality and neonatal mortality rates is very slow. Saving the lives of women and children requires equitable access to an integrated package of quality essential interventions and services delivered by functioning health systems that extend to the household and community level. A strong health system must be adequately financed and have enough skilled and motivated health workers, in the right place at the right time, with the necessary infrastructure, drugs and supporting policies.

The government of Ethiopia has been preparing and implemented a five years Development and Transformation Plan one that is from 2011 to 2015 and now started the Health Sector Transformation Plan. The transformation plan envisages ambitious targets regarding health sector in particular on reducing maternal and child mortality rates. In view of the prevailing political good will and government's commitment to child and maternal health, WVE intends to further support the country's quest to improve maternal and child health through this study that seeks to benchmark skilled birth attendance and related practices and, to review the state of implementation and impact of existing national health policies linked to Skilled Birth Attendance. The identified policy gaps will inform not only the response of the government of Ethiopia to maternal and child health issues but also the response of other partner organizations and stakeholders.

The research questions are categorized under three major CHN focus areas of delays in achieving skilled delivery. The first is delay in deciding where to give birth by every woman; the second, delay in reaching health services timely; and delay in receiving adequate care at health services.
In addition the final evaluation of the project will aim at providing detailed account of the project achievements, effectiveness, efficiency, feasibility, and affordability. Using standard evaluation methodology comes up with the recommendations for further intervention in programming and advocacy campaigning approaches.

3. Evaluation Target Audiences

The assessment will be conducted at five woredas of SNNPR, and Amhara regions located in different zones. It will be disseminated to all the stakeholders and the donor of the campaign will use the evaluation report.

S/No	Woreda	Zone and Region	Remarks
1	Banja	Awi Zone, Amhara Region	CHN pilot ADP
2	Humbo	Wolaita zone, SNNPR	CHN pilot ADP
3		Amhara Regional Health Bureau	
4		SNNP Regional Health Bureau	

In addition to this it is important to include the audiences as per the table below.

Group	Partners concerns that should be considered in the evaluation	What partners expect to be reflected in the evaluation report
Community care coalitions (CCC) in the woreda	The level of involvement of CCC in the woreda health service monitoring, The coverage of Skilled Birth attendance in the woredas The level of community empowerment	Federal ministry of health, regional health bureaus, ministry of women and children's affairs at all levels, woreda and zonal administrations
Child parliament members	The level of child participation in the process of campaign activities	School child parliament members
Health workers	The availability and commitment of health workers that are assigned at all levels of health service	Health workers and officials of woreda health office

4. Evaluation Type

It is final evaluation to see the effectiveness of the campaign in the operation areas.

5. Evaluation Purpose and Objectives

The overall goal of this study is to benchmark skilled birth attendance, to review the state of implementation and impact of existing policies and identify major bottlenecks in reaching universal coverage of institutional delivery.

Specific Objectives

- Conduct a policy review on the state of implementation and the impact of national health policies that impact Skilled Birth Attendance (SBA) and identify and explain policy gaps that impede SBA in the country
- Provide the detailed account of the relation between improving SBA trend verses increasing primary health care continuum in the study areas
- To assess the performance of the campaign strategy achievement in terms of key parameters: efficiency, impact, effectiveness, equity and sustainability of the campaign interventions.

Evaluation objectives

World Vision Ethiopia (WVE) wishes to conduct an end term evaluation of the campaign as it reached the end of its final year of formal funding in September 30, 2015. The evaluation is meant to enable WVE:

- Assess the extent to which it achieved the Campaign goal and most importantly,

- Build our accountability not only to our community partners but also local and international stakeholders who supported the Campaign.

- It is hoped that this evaluation will also enable the organization to learn about its strengths and

- Limitations and adjust accordingly in future advocacy campaigns.

The objectives of this end term evaluation assignment are to:

1. Understand the extent to which the campaign achieved its objectives
2. Determine the internal and external contributions of the campaign to WVEs work on child and maternal health
3. Determine the campaign's contribution to health policy and the implications to improvements in SBA in the country
4. Establish whether the campaign has been implemented according to plan (efficiency) and its effectiveness

RESEARCH QUESTIONS

In view of the foregoing, this study attempts to address the following questions:

- Conduct a policy review on the state of implementation and the impact of national health policies that impacted SBA coverage
- Benchmark key SBA indicators in the country (or projects sites)
- Provide the detailed account of the relation between improving SBA trend verses increasing primary health care continuum in the study areas
- Conduct the final evaluation of the CHN campaign project in the project areas
- How has Ethiopia progressed in implementing national health policies that impact SBA and what is the impact of these policies so far?

In view of the above, the consultant(s) is/are required to refer to the below table that contains identified indicators for the respective outcomes and outputs. It is important to note that these indicators are global indicators for the Campaign in different countries and all of them may not be applicable to Ethiopia. This necessitates the need for the consultant to orient him/herself well with the Campaign activities and to conduct a comprehensive analysis of the data gathered.

Key indicators to be measured

CWBO	Children and their caregivers access essential health services
Indicator	Proportion of health facilities providing basic and/or comprehensive Emergency Obstetric Care (EmOC)
Indicator	Proportion of mothers/caregivers of children aged 0-59 months who paid a fee for essential services at point of access for MCHN health services.
Indicator	Number of new commitments made in favor of international initiatives on MNCH (EWEC, SUN, WHO led initiative, etc.)
Indicator	Number of health facilities per 10,000 populations.
Indicator	Proportion of population having access to a PHC facility within 10 Km of their place of residence.
Indicator	Proportion of Primary health centers meeting the national standards on health workforce.
Indicator	Proportion of the overall national budget allocated to the MoH.
Indicator	Proportion of EWEC commitments fulfilled.
CWBO	Children celebrated and registered at birth
Indicator	Percent of children aged 0–59 months whose birth was registered with the local authorities as reported by the parent or caregiver

Limitations

The evaluation has limitations because we have implemented at different leves and hence some of the indicators such as the level of policy influence on MNCH, may not be directly associated with the campaign implementation only. The government's commitment vary from region to region may indicate difference in the evaluation process that may include it may be challenging to identify previous technical and administration bodies because of turn over.

Authority and Responsibility

Role of WV Ethiopia

- Supervision and support the consultant at every level data collection processes,
- Writes official letter for the pertinent government and other agencies as deemed
- Provides technical comments from relevant experts in the organization.
- WVE will provide vehicle for field work, recruit the enumerators or study supervisors
- The supply chain department will ensure all the accomplishments of the assessment as per the terms and takes appropriate corrective measures.

Role of the Consultant/Researcher

Tools development

- The consultant shall prepare separate list of research questions for the different groups to be interviewed. The tools should be prepared both in English and Amharic languages
- The consultant shall submit the list of questions to World Vision Ethiopia for review and receive comments within five working days from formal agreement date
- The consultant shall produce final version of list of questions to World Vision Ethiopia incorporating the comments given, if any

Field Research

The consultant shall go to the Federal Ministry of Health and to selected sites for the research in the Amhara, and SNNRP Regional Health bureaus, Zonal Health Departments, woreda health offices, and other relevant offices, and collect data using the prepared and agreed up on research tools

- All the work should be in compliance with the nationally accepted professional and ethical research standards. The quality of data collection, input and analysis will be checked using the appropriate procedures.
- The consultant is expected to recruit, train and supervise enumerators
- The consultant shall provide all logistics and transportation for the overall research activities
- The consultant will make thorough review of plans, reports, and briefs of the campaign implementation in WVE in last five years and also interview key staffs that have been engaged in the implementation processes.
- At the end of the study, the study team will debrief concerned woreda level offices and respective WVE area programs
- The first draft report shall be submitted to World Vision Ethiopia in two printed copies and a soft copy with the two copies of the raw data (transcribed verbatim with audio cassettes)
- Transcribe (verbatim) and analyze Qualitative data using appropriate qualitative data analysis packages
- The consultant needs to respect all WVE code of conducts including child protection policy

Time of the research

- Research will be finalized within one month duration from the commencement of the formal agreement with the consultant.
- The consultant will submit the first draft five copies after 15 days data analysis and report writing
- The consultant will submit final report five copies of hard copy and soft copy within 10 days after all the comments are given by WVE.

DELIVERABLES

An experienced researcher with a MA/MSc level of education in Public Health will lead the research team. The firm is required to facilitate ethical clearance for this particular assessment from Ethiopian Science and Technology institute. Experience in conducting similar studies with at least two published health paper will be an advantage. The team will be accountable for the following deliverables: Comprehensive report of a final end term evaluation report at the target woredas and recommendation in policy and practices regarding MNCH services. The report excluding annexes shall not exceed 40 pages. The report shall be sectioned into executive summary, methodology, research findings (result), recommendation and conclusion, references and annexes.

The consultant will submit

1. Inception report,
2. First & second draft evaluation reports and final report per the ToR and agreement.
3. Raw data in SPSS or any format in which the analysis is being done

Reporting Template

Executive Summary
Provide an executive summary of the research in no more than 2 pages. Provide a brief background, methodology, summary of the conclusion and recommendations

Methodology

Provide a brief summary of the methodology including sampling methodology, method of document reviews, methods for any qualitative data collection.

Research Findings

Provide results of research as it relates to the research questions.

Conclusion

Provide conclusion based on the findings and analysis.

Recommendation

Based on the findings of the research the researcher is expected to provide no more than 10 recommendations that will inform the government of Ethiopia and WVE in its endeavor to be campaigning organization.

References

A consistent referencing system should be used throughout the report. A Harvard referencing style is recommended.

Annexes

1. Insert copies of key policy documents, strategy documents used to inform findings of the research. Tables and charts for analyzing findings of the research can also be added as part of annex

2. A publishable research paper

3. The development of a WV national key facts paper based on the data collected and the areas prioritized for progress.

GUIDING PRINCIPLES

World Vision is a Christ centered, child focused, community based organization. We pay high regard to child protection principles. We require the consultant to sign the child protection policy and live up to the standard through the process.

KEY STAKEHOLDERS

The communities we work in, the children we work for and the government bodies we support are key stakeholders in this work. Other partners in development including nongovernmental organizations, faith based agencies and community based organizations are all stakeholders in this work.

KEY 'SIDE PRODUCTS' TO CONSIDER

TIMELINE

	January				February				March			
	Wk 1	Wk2	Wk3	Wk 4	Wk 1	Wk 2	Wk 3	Wk 4	Wk 1	Wk2	Wk 3	Wk 4
Initial meetings and orientation			X									
Literature review and stakeholder consultations			X									
Analysis of WV programming and national policy framework			X									
Inception report submission including draft tools to WVE			X									
Data collection tool reviewed by WVE			X									
Data collection and analysis period		X	X	X								
Consultant submits first draft to WVE					X XX X							
WVE provides feedback on first draft						XX						
Final report submitted to WVE								X				
Draft public report and exec summary drafting									X			
Draft report sent for initial formatting									X			
Child health policy team feedback										X		
Final text report										X		
Report sent for formatting											X	
Final product review and sign off											X	
Publishing/Printing												X

Annex 2. List of Key Informants

No.	Name	Organization	Position
1	Shimelis Wangoro Debole,	SNNP Region Health Bureau	MCH & Nutrition Service Core Process Owner
2	Haile Bekele	Wolaita Zone Health Department	MCH & Nutrition Service Process Coordinator
3	Melkamu Dera	Humbo Woreda Health Office	Office Head
4	Eshetu Tolcha	Humbo Woreda Health Office	Deputy Office Head
5	Belta Bashe	Humbo Woreda Finance and Economic Development Office	Office Head
6	Samuel Shanka,	Humbo Woreda Finance and Economic Development Office	Deputy Office Head
7	Alemitu Lencha	SNNPR, Wolaita Zone Women, Children and Youth Affairs Desk	Deputy Office Head
8		Humbo WoredaWomen, Children and Youth Affairs Office	
9	Eyasu Anja	Humbo WoredaWomen, Children and Youth Affairs Office	Coordinator for Gender and Child Protection Mainstreaming and Development Benefits Assurance Core Process
10	Seyum	Humbo WoredaWomen, Children and Youth Affairs Office	Education and Training officer
11	**Tegegn Worku**	Banja Woreda Health Office	MCH Expert
12	**Meseret Gizachew**	WVE Banja AP	AP Supervisor
13	Samuel Buticho	WVE Soddo CPO	CPO Program Manager
14	Tesfahun Eyuel	WVE Soddo CPO	Carbon Credit Project Officer
15	Mr. Tsegaab Tadesse	World Vision Ethiopia Head Office	CHN Campaign Project Coordinator
16	Dr. Yohannes Chanyalew	World Vision Ethiopia Head Office	
17	Tigist Mamo	World Vision Ethiopia Head Office	
18	**Dessie Genet**	**Hawi Zone WCYA Department**	**Children Affairs Work Process Owner**
19	**Hiwot Emishaw**	**Save the Children**	**Communications Director**
20	Dr. Ephrem Tekle	Federal Ministry of Health	Director, MNCH Directorate
21	Mariame Sylla	UNICEF	MNCH Cluster Team Leader
22	Bizuhan Gelaw Birhanu	UNICEF	Health Specialist;

No.	Name	Organization	Position
23	Desta Mota	Ex-WVE Staff in Humbo	

Annex 3. FGDs and KIIs Checklists

Proposed Checklist for Community FGDs

No.	Evaluation Objectives with Key Evaluation Questions
1	*To assess the extent to which the campaign achieved its goal and objectives*
	• Are you aware of WVE's CHN Campaign Project? If yes, how do you describe the project goal and do you think it has been achieved? • What was your role in the design and implementation of the project? • Which of the project outputs/actions were effective and why? Which were not and why not? • Has the project achieved any results not intended, whether positive or negative?
2	*To determine the internal and external contributions of the campaign to WVE's work on child and maternal health*
	• What were the CHN Campaign Project messages to respective advocacy audiences, including your community, to raise their attention to preventable deaths of mothers and children? • How effective were the messages and their delivery mechanism (profiles of messengers, events and media of delivery)? Any roles you played? • What efforts has WVE made to share the progresses or outcomes of the campaign project? • What has happened elsewhere because of the Child Health Now Campaign? Inspired to initiate other campaigns?
3	*To determine the extent to which the campaign project has contributed to skilled birth attendance coverage and national health policy*
	• To what extent do you think the campaign project has contributed to skilled birth attendance coverage in your communities? • Do you think some projects in your communities have benefited from the implementation of CHN Campaign Project? Give explanations on actual (or potential) changes occurred (or expected).
4	• *To assess the extent to which the project exhibited strengths and limitations and encountered problems and challenges while contributing to organizational learning*
	• What have been the major strengths and weaknesses of the CHN Campaign Project? • What were the challenges or barriers in implementing the project and in achieving its objectives? How were these challenges or barriers addressed? • What do you want to advise WVE to focus on as it seeks to continue designing and implementing campaign projects in the future?

Checklist for Government Offices (various levels)

No.	Evaluation Objectives with Key Evaluation Questions
1	*To assess the extent to which the campaign achieved its goal and objectives*
	• Are you aware of WVE's CHN Campaign Project and its goal (*reduction of maternal and newborn mortality by the end of year 2016*)? • If yes, what has been the campaign project's contribution in the following areas? a. Health policy processes at national and regional levels, b. Enhancing commitment to institutional delivery at woreda level and

No.	Evaluation Objectives with Key Evaluation Questions
	c. Creating critical public/community awareness on the need to expand SBA coverage at the local level? • Which of the project outputs/actions were effective and why? Which were not and why not? • Has the project achieved any results not intended, whether positive or negative? • To what extent has WVE managed to organize coalitions, networks or communities around raising public awareness and support for expanding SBA coverage?
2	*To determine the internal and external contributions of the campaign to WVE's work on child and maternal health*
	• What were the CHN Campaign Project messages to respective advocacy audiences, including your office, to raise their attention to preventable deaths of mothers and children? • How effective were the messages and their delivery mechanism (profiles of messengers, events and media of delivery)? • What efforts has WVE made to share the progresses or outcomes of the campaign project with likeminded organizations and institutions which strong and wider presence in different parts of the country? • What has happened elsewhere because of the Child Health Now Campaign? Inspired by the initiative?
3	*To determine the extent to which the campaign project has contributed to skilled birth attendance coverage and national health policy*
	• To what extent has the project impacted health policy, management structures/systems and the capacities of WVE and other likeminded organizations? • How do you assess the visibility and influence of the project at various levels of engagement (FMoH, networks/partnerships, NGOs, multi-lateral agencies, local government offices, communities, etc.)? • To what extent do you think the campaign project has contributed to skilled birth attendance coverage? • Do you think some of aspects of the national health policy (policy review, policy implementation, etc.) have benefited from the implementation of CHN Campaign Project? Give explanations on actual (or potential) changes occurred (or expected).
4	• *To assess the extent to which the project exhibited strengths and limitations and encountered problems and challenges while contributing to organizational learning*
	• What have been the major strengths and weaknesses of the CHN Campaign Project? • What were the challenges or barriers in implementing the project and in achieving its objectives? How were these challenges or barriers addressed? • What do you want to advise WVE to focus on as it seeks to continue designing and implementing campaign projects in the future?

Checklist for KIIs with NGOs and Multi-lateral Agencies

No.	Evaluation Objectives with Key Evaluation Questions
1	*To assess the extent to which the campaign achieved its goal and objectives*
	• Are you aware of WVE's CHN Campaign Project and its goal (*reduction of maternal and newborn mortality by the end of year 2016*)? • If yes, what has been the campaign project's contribution in the following areas? a. Health policy processes at national and regional levels, b. Enhancing commitment to institutional delivery at woreda level and c. Creating critical public/community awareness on the need to expand SBA coverage at the local level?

No.	Evaluation Objectives with Key Evaluation Questions
	• How do you describe the level of collaboration/partnership between your organization and WVE, particularly on advancing MNCH initiatives? • To what extent has WVE managed to organize/participate in coalitions, networks or communities around raising public awareness and support for expanding SBA coverage?
2	*To determine the internal and external contributions of the campaign to WVE's work on child and maternal health*
	• Are you aware of WVE's CHN Campaign Project? If yes, to what do you think WVE's campaign project has contributed and in what areas (national health policy implementation, creation of critical public/community awareness on the need to expand SBA coverage, etc.)? • What were the CHN Campaign Project messages you or your organization received to that raised your attention to preventable deaths of mothers and children? • How effective were the messages and their delivery mechanism (profiles of messengers, events and media of delivery)? • Did you receive any updates/reports on the progresses or outcomes of the campaign project? If yes, describe the importance of the updates/reports to your organization. • What has happened elsewhere because of the Child Health Now Campaign? Inspired by the initiative?
3	*To determine the extent to which the campaign project has contributed to skilled birth attendance coverage and national health policy*
	• To what extent has the project impacted health policy, management structures/systems and the capacities of WVE and other likeminded organizations? • To what extent do you think the campaign project has contributed to skilled birth attendance coverage? • Do you think some of aspects of the national health policy (policy review, policy implementation, etc.) have benefited from the implementation of CHN Campaign Project? Give explanations on actual (or potential) changes occurred (or expected).
4	• *To assess the extent to which the project exhibited strengths and limitations and encountered problems and challenges while contributing to organizational learning*
	• What capacities do you think WVE has as an organization campaigning for social changes? • What have been the major strengths and weaknesses of the CHN Campaign Project? • What do you want to advise WVE to focus on as it seeks to continue designing and implementing campaign projects in the future?

Checklist for FDG/KII with World Vision Ethiopia (HO and Field Staff)

No.	Evaluation Objectives with Key Evaluation Questions
1	*To assess the extent to which the campaign achieved its goal and objectives*
	• To what extent has the project achieved its goal and stated objectives? • Which of the project outputs/actions were effective and why? Which were not and why not? • To what extent has WVE managed to organize coalitions, networks or communities around raising public awareness and support for expanding SBA coverage? • Has the project achieved any results not intended, whether positive or negative?
2	*To determine the internal and external contributions of the campaign to WVE's work on child and maternal health*
	• To what extent has the campaign project helped to mobilize external resources for WVE's programs and projects? • What were the CHN Campaign Project messages to respective advocacy audiences to raise their attention to preventable deaths of mothers and children?

No.	Evaluation Objectives with Key Evaluation Questions
	• How effective were the messages and their delivery mechanism (profiles of messengers, events and media of delivery)? • What efforts has WVE made to share the progresses or outcomes of the campaign project with likeminded organizations and institutions which strong and wider presence in different parts of the country? • What has happened elsewhere because of the success in the Child Health Now Campaign?
3	*To determine the extent to which the campaign project has contributed to skilled birth attendance coverage and national health policy*
	• To what extent has the project impacted health policy, management structures/systems and the capacities of WVE and other likeminded organizations? • How do you assess the visibility and influence of the project at various levels of engagement (FMoH, networks/partnerships, NGOs, multi-lateral agencies, local government offices, communities, etc.)? • Do you think some of aspects of the national health policy (policy review, policy implementation, etc.) have benefited from the implementation of CHN Campaign Project? Give explanations on actual (or potential) changes occurred (or expected).
4	• *To assess the extent to which the project exhibited strengths and limitations and encountered problems and challenges while contributing to organizational learning*
	• What capacities has WVE developed as a result of the implementation of the campaign project? Has the organization taken on any new campaign initiatives as a result of the campaign project? • What have been the major strengths and weaknesses of the CHN Campaign Project? What does WVE celebrate now the project has come to its end? • What were the challenges or barriers in implementing the project and in achieving its objectives? How were these challenges or barriers addressed? • How accurate were the risk assessment and assumptions made at the start of the project? • Looking back at the project's design and implementation processes, what do you think could have been done differently? What do you think should continue to be done? What should be discontinued in the future? • What lessons can be drawn from this campaign project for similar actions in the future? What next steps do you suggest for WVE to embark on?