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Final Evaluation Report World Vision Zambia **Child Health Now project**

October 2016

An independent evaluation of the WVUS-funded Child Health Now campaign project in Zambia, 2012-2016

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Consultation with Safe Motherhood Action Group members (SMAGs), Mbala, September 2016

Acronyms:

ANC:	Ante-natal care
CSO:	Civil Society Organisation
CVA:	Citizen Voice and Action
DNCC:	District Nutrition Coordinating Committee
IEC:	Information, Education and Communication (materials)
MDGs:	Millennium Development Goals
MNCH:	Maternal, Newborn and Child Health
PNC:	Post-natal care
SAMNeCH:	Southern Africa Maternal Newborn and Child Health (WV Australia funded project in Zambia)
SDGs:	Sustainable Development Goals
SMAG:	Safe Motherhood Action Group (member)
SUN:	Scaling Up Nutrition
TBA:	Traditional birth attendant
WHA:	World Health Assembly
WNCC:	Ward Nutrition Coordinating Committee

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EXECUTIVE SUMMARY

BETWEEN OCTOBER 2011 AND SEPTEMBER 2016, WORLD VISION ZAMBIA'S CHILD HEALTH NOW CAMPAIGN USED ADVOCACY AND BEHAVIOUR CHANGE APPROACHES TO SUPPORT MATERNAL AND CHILD SURVIVAL OUTCOMES AT LOCAL, DISTRICT AND NATIONAL LEVELS.

PROJECT GOAL	Contribute to reduced maternal, newborn and child mortality in targeted communities in Zambia
OUTCOME GOALS	1: Improved maternal and child health practices and behaviours 2: Increased access to quality health services 3: Project effectively managed
DONOR	World Vision US, through private non-sponsorship funds
DURATION	Five years (October 2011 – September 2016)
COST	US\$321,000



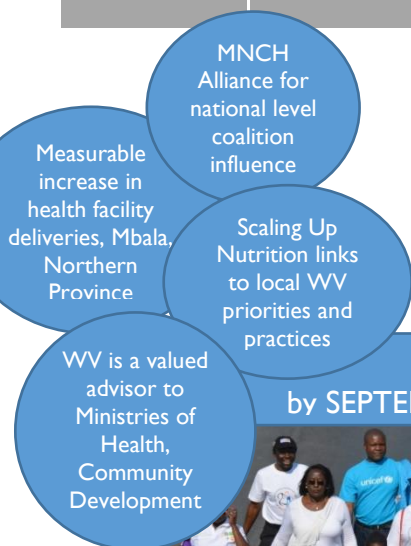
CHALLENGES CONTRIBUTING TO HIGH MATERNAL AND CHILD DEATHS IN ZAMBIA, 2011

- High fertility rates and extreme poverty
- Under-resourced services, particularly in rural areas
- Shortfalls against government policies for health centres and outreach services
- Gender inequality and low household priority on MNCH, especially as a woman ages
- Uncertainty of decentralisation intent, with budget on health held at national level
- Inadequate skills and equipment to respond to birth complications for mother and child
- Limited knowledge of danger signs in pregnancy, newborns and under-five illnesses

The Child Health Now campaign aimed to address these root causes by increasing demand and accountability for effective community-based health systems in Zambia. The campaign was included in four World Vision local programmes as well as working nationally with government and health partners.

CAMPAIGN APPROACHES

- **At local level**, the Child Health Now coordinator worked with ADP managers and their health staff to create awareness and demand for health services. While ADPs worked across a diverse and holistic set of maternal and child health and nutrition issues, the main policy platforms for Child Health Now at this level were assisted delivery and appropriate maternal and newborn care.
- **At national level**, Child Health Now developed relationships with a number of health stakeholders within government and the UN/NGO sector. This included collaboration with the SUN Civil Society Alliance and foundational support to Zambia's new MNCH Alliance. In 2016, the Child Health Now coordinator was invited to be part of the Zambian government delegation to the World Health Assembly.
- **At global level**, particularly in the first three years, WV Zambia joined over 70 World Vision offices for global mobilisation on accountabilities to maternal and child survival, while the Child Health Now coordinator lobbied appropriate ministries to take decisions in line with these accountabilities.



RESULTS by SEPTEMBER 2016



The Urban Mothers' Walk, in August 2015, used local evidence from World Vision's programmes to highlight the access challenges for pregnant women in rural areas of Zambia. It was organised through the MNCH Alliance jointly with the national Ministry of Health.

By the end of the campaign in September 2016, Child Health Now's activities were mainly at the national level, particularly in ongoing secretariat support to the MNCH Alliance. Campaign results were emerging; however, the final year included an election period which placed some policy decisions on hold, and there is now more work needed to convert relationships into actions within relevant government ministries.

ABOUT THE EVALUATION

World Vision contracted an independent consultant to conduct the evaluation. She has applied realist theory-building to identify campaign contributions and their causal mechanisms. Triangulated analysis validated theories of how change took place at local and national levels, by testing case studies built by staff and implementing partners against monitoring records, community feedback and government/NGO perspectives.

Methodology process:

1. Implementing partners construct contribution claims.
2. Document review and stakeholder interviews with staff, government, partner NGOs and health workers validate and add perspective to the contribution claims.
3. Process tracing logic confirms or denies contribution claims.
4. Stakeholder interviews also provide qualitative insight into OECD-DAC programme quality principles

THE EVALUATION FOUND

- Child Health Now was campaigning mainly at the national level, in coalition through the newly established MNCH. Alliance as well as directly with the Ministry of Health and the Ministry of Community Development.
- Child Health Now had supported effective advocacy with traditional leaders (chiefs) in World Vision programme areas.
- The campaign's support to globally coordinated advocacy and mobilisation was significant, including regular direct lobbying in advance of global governance meetings.
- WV Zambia sourced insight and inspiration from the campaign, with health rights and inequities becoming part of dialogue between World Vision and community.
- Child Health Now's outcomes are unfinished; more is needed to maintain the momentum built in the first five years.

ENABLING FACTORS:

- The campaign's emphasis on health rights.
- Engaging traditional leaders and customary law.
- Relationships with partners, building bridges between World Vision as a programmer and as an advocate.

LIMITING FACTORS:

- Less campaign visibility than anticipated.
- Generic guidelines and insufficient technical support delayed campaign startup and targeting of specific health policies.

OECD-DAC CONCLUSIONS

RELEVANCE Child Health Now was found to be highlighting the urgent priorities for Zambia in line with World Vision's health strategy, the government's promises and intentions, and global mandates for MNCH. Relevance in local programmes reduced over the campaign's lifetime, with the most important contribution at this level seen as the IEC materials and conversations in early days.

IMPACT Two examples of impact were successfully tested using process tracing: building the MNCH Alliance and influencing a traditional leader in Mbala to pass and enforce a bylaw on giving birth in health facilities (see case studies, following page). It was generally agreed that the campaign had not yet finished its momentum and that more results were likely in years to come.

EFFECTIVENESS Simply having a campaign, with internal communication, staff reflection and community discussion, has broadened health rights concepts among community members of both genders, while sharing examples of good leadership on health among traditional leaders has set precedents for others to follow. CHN information and mobilisation was found to be an effective enabler for World Vision's local accountability model, Citizen Voice and Action (CVA).

EFFICIENCY The campaign's generic design at first challenged efficiency, as activities often seemed unrelated. Underspend was also a problem in early years. Efficiency increased as the campaign began to work out its own strategies based on emerging opportunities. By the end, most 'loose ends' had started to meet up to create pathways for change.

SUSTAINABILITY Sustainability is possible, but care needs to be taken that the 'end of campaign' is not understood as the end of health advocacy for WV Zambia. Certain activities should continue at all levels, funded directly by ADPs or national office budgets. While the MNCH Alliance is sustainable, an ongoing primary role in the alliance represents strong advantages for World Vision as an organisation in meeting health strategy.

NATIONAL CASE STUDY: ESTABLISHING THE NATIONAL MNCH ALLIANCE

Responding to UNICEF's call for partners in 'A Promised Renewed' campaign, Child Health Now encouraged the newly forming alliance to think more broadly about long-term MNCH engagement. With its own identity, outcome goals and a fully funded workplan to the end of 2017, the resulting MNCH Alliance fills a gap in coordinated action on maternal and child survival.

CONTEXT:

- **-ve:** Little coordination between NGOs on public health campaigning
- **+ve:** Zambian government commitments to A Promise Renewed, Scaling Up Nutrition

MECHANISMS:

- UNICEF calls for campaign partners
- Child Health Now leads conversation on MOU
- Child Health Now coordinator takes secretariat role
- Partners attend PATH-funded training
- Alliance manages successful funding proposals

OUTCOME:

- MNCH Alliance releases its four-pillar strategy for working with government
- Inaugural Urban Mothers' Walk proves coordination capacity

SUMMARY OF LESSONS

- Campaigns lose time by being generic.
- Policy analysis technical skills are essential.
- 'Go-to' activists in church and youth groups were a missed opportunity.
- Campaigning required greater organisational redefinition than anticipated.
- Traditional leaders are key, especially for steering community-led 'zero' campaigns.
- Alliance work can overcome organisational limitations.
- Local to national data linkage works - and is needed.

RECOMMENDATIONS for World Vision's ongoing health advocacy:

- Add World Vision's voice to relevant national policy pushes: the reinstatement of the Breastmilk Substitute Code, the completion of the National Food and Nutrition Commission Act and the roadmap for 2016 WHA ratifications.
- Set annual organisational KPIs for local to national data transfer and health reporting; create systems for regular aggregation and analysis of health data to share with government and partners.
- Consider networking with other offices who work with dual laws and governance to enhance advocacy approaches to traditional leaders.

LOCAL CASE STUDY: TRADITIONAL LEADER ACTION ON MATERNAL SERVICES

In Mbala, after planning meetings with local programme teams and Child Health Now, traditional Chief Nsokolo passed a bylaw enforcing the national policy for women to give birth in health facilities. This, combined with a strengthened role in '1000 Days' preventive health advice from community health workers, has seen the rate of assisted facility births rise from two or three per week in 2013 to around five per day in 2016.

CONTEXT:

- **-ve:** Maternal health and delivery services considered sub-standard; women frightened to attend health posts
- **+ve:** Partnership between World Vision and Ministry of Health to roll out training to Safe Motherhood Action Group members (SMAGs)

MECHANISMS:

- Meetings between Mbala ADP staff, Child Health Now and local chief Nsokolo
- Child Health Now and Citizen Voice and Action teams organise inter-provincial chiefs' forum
- Chief Nsokolo gains access to monitor health indicators in his district

OUTCOMES:

- Nsokolo passes bylaw specific to maternal delivery
- Health centre delivery in Mbala now universal (>95%)

RECOMMENDATIONS for World Vision's next campaign:

- Select issues and goals with maximum potential for audience reach and interest.
- Use national situation analysis to build influential coalitions and working groups.
- Include government and partners in the design workshop.
- Ensure plentiful, reader-friendly IEC materials are available for staff and community in ADPs.
- Invest leadership time in necessary organisational change for shared ownership of the campaign; ensure CEO-level networks exist for collaboration and shared voice.

RECOMMENDATIONS for Zambian government and partners:

- Discuss data and research requirements with World Vision.
- Within the Alliance, continue to work on health budget support on behalf of the Ministry of Health.
- Raise the possibility of M&E practices within the MNCH Alliance to demonstrate its long-term value.
- Through the MNCH Alliance, develop plans for the Mothers' Walk as an annual accountability event.
- Consult World Vision on their next campaign to end violence against children, to explore thematic synergies and priorities.

PART I: INTRODUCTION AND RATIONALE



Solutions to Zambia's high maternal and child mortality rates are complex. They call for a number of coordinated interventions in nutrition, hygiene and childcare, quality and accessibility of health services, and uptake of services. Rather than operating its own health programme, the Child Health Now campaign aimed to support the effectiveness of other programmes, including government, partner and World Vision efforts, through sound and targeted policy influence.

I.1 BACKGROUND: CHILD HEALTH NOW IN ZAMBIA

Project name:

Zambia Child Health Now Campaign Project

Location:

Nationally, plus in four World Vision area programmes (Mumbwa, Luampa, Mwamba, Mbala)

Donor:

World Vision US, through private non-sponsorship funds

Duration:

Five years (Oct 2011 – September 2016)

Goal:

Contribute to reduced maternal, newborn and child mortality in targeted communities in Zambia by 2015

Cost (to be confirmed at project closure, October 2016):
US\$321,000

The Zambia Child Health Now Campaign was conceived and designed in response to the pressing needs of Zambian communities for more effective and affordable health systems to promote the survival and healthy development of children under five.

Over a period of five years, the campaign implemented as part of World Vision's global Child Health Now campaign, triggering a variety of influences and actions from partners (including community partners), ministries, politicians and traditional leaders.

WV Zambia has a clear and dedicated strategy contributing to children's survival and healthy development. In fiscal terms, programming for health and its associated sectors (nutrition, WASH, HIV) forms around 40% of the overall country programme. Against this significant investment, the Child Health Now campaign is a small component with the entire project delivered at a cost of \$321,000¹ (annual breakdown at Figure 1, left). Even at its peak spend in 2014, Child Health Now was equivalent to 0.4% of the office's total health, HIV and WASH programme, and represented less than 0.2% of the overall programme. The table and diagram below show campaign investment patterns and comparative data with health programme spend.

OUTCOME GOALS

Outcome 1: Improved maternal and child health practices and behaviours

Outcome 2: Increased access to quality health services

Outcome 3: Project effectively managed

Total estimated project cost,
US\$321,000 over five years

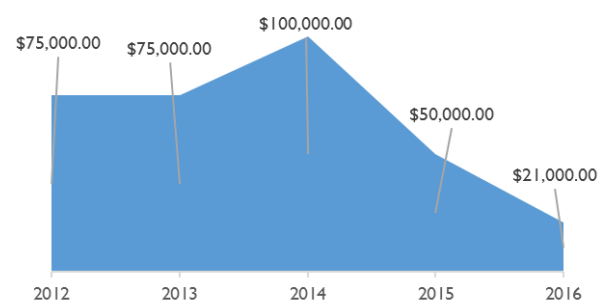


Figure 1: Breakdown of costs by year, CHN

	2014 (US\$)	2015 (US\$)
Child Health Now	100,000	50,000
Health, nutrition, HIV and WASH programme value	26,356,418	18,227,916
Zambia country programme value	64,764,798	58,737,413

Under the right conditions, building advocacy momentum need not be an expensive proposition. The operating model for the campaign emphasised building capacity and interest in others, inside and outside World Vision, to create the necessary social and political shifts towards change for children in Zambia. The challenges of rural Zambians have been of particular concern in this context, across a number of areas including access to antenatal and neonatal care, stockouts of vaccinations, ARTs and other essential health supplies, and extremely challenging ratios of health professionals to patients. Activities focused on upward accountability, with the intention to connect the perspectives and priorities of Zambia's health-vulnerable communities with national and international decision making.

The Zambia Child Health Now Campaign maintained one full-time staff member, the CHN coordinator, supported by health, advocacy and DME technical advisors. Local mobilisation for

¹ Final figures will be confirmed at the close of project, October 2016

The maternal mortality rate in Zambia remains among the highest in the world at 398 per 100,000 births (ZDHS 2014). The situation for mothers and their newborns is particularly critical in rural areas.

According to the January 2013 Zambia Child Health Now policy brief, the main causes of maternal deaths include haemorrhage and hypertension due to inadequate antenatal coverage, a lack of functional emergency facilities, low institutional deliveries and untrained staff. Out of 73 districts, only 12 have emergency obstetric and neonatal care facilities. Baseline survey in World Vision's partner communities indicated that even where these facilities were available, they were often too far from villages for women to attend.



Figure 2: Area Development Programs implementing Child Health Now

behaviour change and to drive priorities for policy strengthening occurred mainly through the efforts of the four area programmes taking part: Mumbwa, Luampa, Mwamba, Mbala (Figure 2, below).

By 2016, comparison of original design with monitoring data in annual reports shows a trend away from local engagement and accountability towards national level activities with government and partners. Document review initially suggests several reasons for this:

- The campaign's intended synergy with Citizen Voice and Action as a local advocacy model within area programmes was affected by budget constraints;
- National level partnerships on maternal and child health, particularly after momentum from A Promise Renewed, were an appropriate pathway for supporting government on budget and HR change;
- The campaign's support to globally coordinated advocacy and mobilisation was significant, including regular direct lobbying in advance of global governance meetings;
- Planning for World Vision's 'technical programmes' (TP) was only completed in 2016. Child Health Now has given strategic advice to the planning process based on the campaign's integration experiences. It is likely that, if in place earlier, stronger demand for advocacy and mobilisation would have been felt from local level programmes.

Originally scheduled as a three year project, the campaign was extended to 2015, then partially funded to continue one more year in line with opportunities and sustainability principles. WV Zambia commissioned this evaluation of the project in September 2016, the final month of funding, in line with the organisation's principles for accountability and learning.

The Zambia Child Health Now Campaign did not include a specific theory of change in its design, and has instead drawn on the global campaign's theory and principles. Figure 3 on the next page steps through this model and its linkages between different levels of governance and decision making, as well as different levels of change. Review of project documentation indicates that the majority of inputs have taken place in connecting national-national stakeholders and in triggering national to global linkages. Local-to-national efforts are also evident in community voice data; sources included Citizen Voice and Action (CVA) as a parallel initiative and the Citizens' Hearings of March/April 2015.

The global Theory of Change for Child Health Now

World Vision's first global campaign aimed to connect and leverage the organisation's influence across all areas where it worked: local, national, regional, global, with individuals, groups, NGOs and the public sector including ministries and politicians. The model theory was dependent on these linkages for exponential influence. Change could come working in isolation, but had greater potential for power and sustainability when synchronised at different levels of decision making. Figure 3a shows the different roles and approaches in this theory with community voice the starting point and community outcomes the end point. Figure 3b, built retrospectively based on the experiences of the campaign globally, maps an alternative view showing generic inputs and tactics that brought about change. Importantly, this shows that change happens at different levels, in a hierarchy of events where each level is dependent on success within the previous level. Child Health Now in Zambia demonstrates this pattern of multiple-level change, with the majority of outcomes falling within the progress phase. This indicates a campaign that is partway through its implementation and requires more time to fulfil its top-level goals.



Figure 3a: Local-global-local theory of change

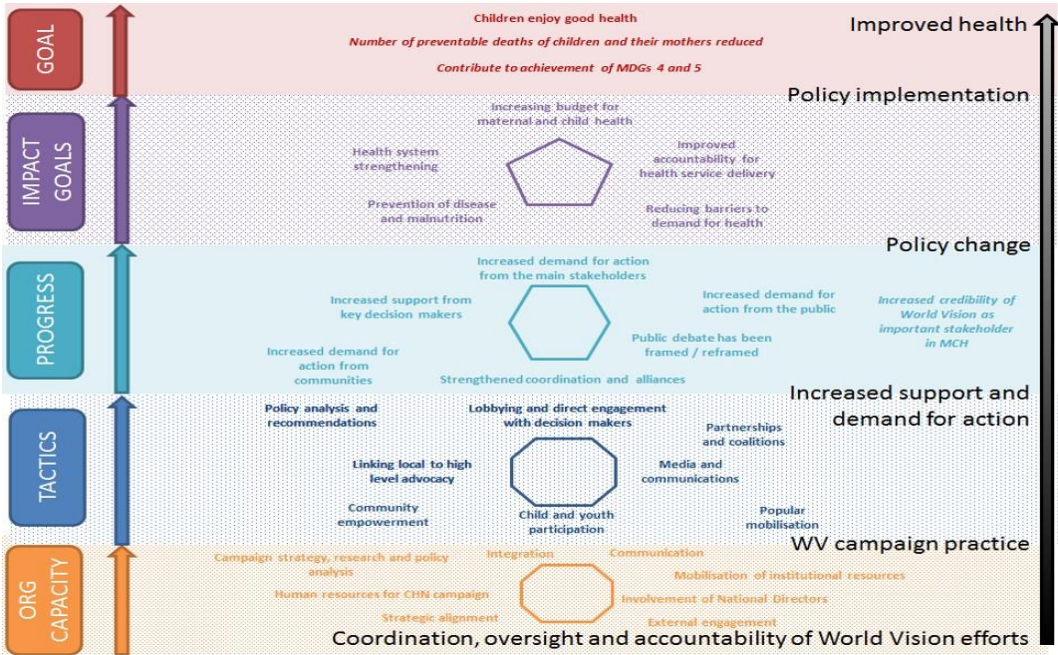


Figure 3b: Generic theory of how change takes place

I.2. BACKGROUND: HEALTH CHALLENGES FOR CHILDREN AND THEIR MOTHERS IN ZAMBIA

Zambia has one of the highest fertility rates globally; at 5.28 births on average per mother², it is driving a rapidly expanding population where shortfalls in antenatal care and attended deliveries are difficult to address. The population has doubled since 1990 (see Figure 4). While Zambia's economy is also growing, poverty and food insecurity at household level hinders women's ability to care for their children's, and their own, health and nutrition needs.

The relative poverty of districts and provinces across Zambia also determines who receives healthcare including maternal health services. Decisions to seek healthcare are certainly made at household level, but a scarcity of community resources will influence this decision, including proximity, opening hours and quality of clinics, along with availability of transport. Discrepancy of wealth across provinces is reflected in child mortality statistics, with the fewest deaths in well-connected Southern Province and the highest rate in isolated Northern Province (see Figure 5). Figure 6 maps over time (1990 – 2015) four important indicators for survival and healthy development of children in Zambia: under-five (U5) mortality, maternal mortality, skilled birth attendance and fertility rate.

Neonatal risk is significant for both mother and child. Figure 7 (next page) shows the proportion of newborns who lose their lives to birth asphyxia, birth trauma or prematurity, suggesting that over a half of all newborn deaths might be prevented with better facilities and skills to cope with birth complications and premature delivery. One in 59 children in Zambia will lose their mothers³; Figure 8 indicates, again, that more than half of these deaths are associated with the delivery and neonatal care phase, where Zambia struggles to provide the required volume of services and supplies⁴.

Figure 4: population growth in Zambia, 1990 – 2015

Source: World Bank Data <http://data.worldbank.org/country/zambia?view=chart>

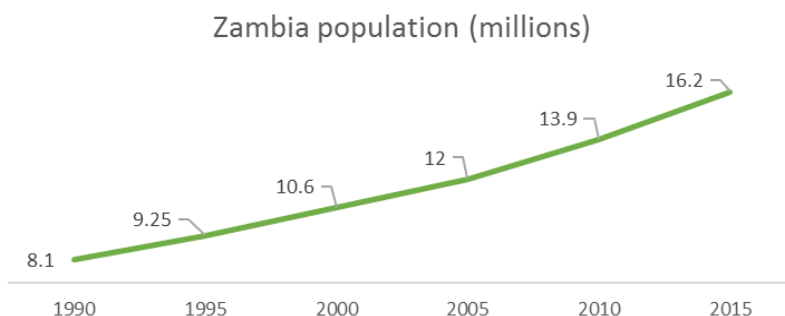


Figure 5: Child mortality by province, 2015

Source: WHO

http://www.who.int/maternal_child_adolescent/epidemiology/profiles/neonatal_child/zmb.pdf

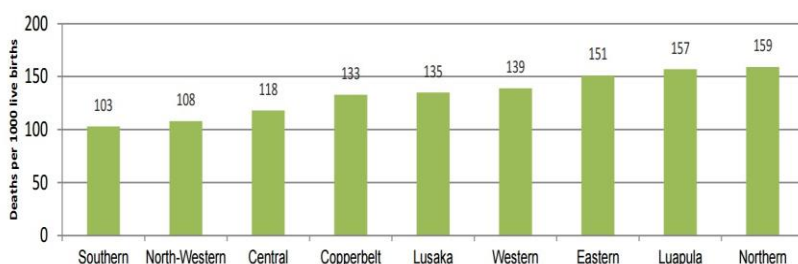
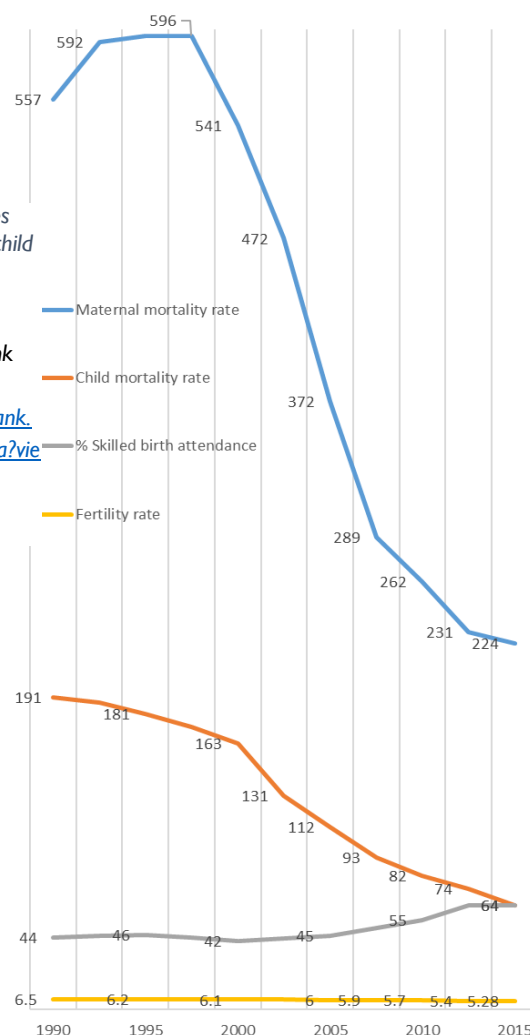


Figure 4: Trendlines for maternal and child survival indicators, 1990 – 2015

Source: World Bank Data,

<http://data.worldbank.org/country/zambia?view=chart>



² World Bank figure used, sourced August 2016:

<http://data.worldbank.org/country/zambia?view=chart>

³ http://www.who.int/gho/maternal_health/countries/zmb.pdf

⁴ Ibid.

As so much of the mortality ratio falls within the neonatal phase of life, there is a strong argument that increasing the levels and quality of care and advice for women during family planning, pregnancy and childbirth has the potential to bring about massively improved survival rates in Zambia. In 1990, 44 percent of women were assisted by a health professional to give birth; 25 years later, the rate has only climbed to 64 percent. Research in the mid 2000s found that the older a woman was, the more likely she was to deliver at home, due to transport and financial challenges and her own low priority on care-seeking⁵; however, the likelihood of birth complications for the mother increases with each child she has⁶.

Figure 9 shows the reductions since 1990 in child mortality taking into consideration age group: neonatal, infant and overall under-five; while Figure 10 shows current causes of deaths for children aged between one month and five years. Many of these causes mirror indirect maternal mortality shown in Figure 6. Thus, while maternal services are an urgent priority, other interventions can save thousands more lives each year: for instance, reducing malaria, managing and stemming HIV prevalence, treatment of ARIs and TB, broader vaccination programmes to eliminate measles and pertussis and reduce gastric rotavirus, hygiene and sanitation programmes to address diarrhea.

Addressing all priorities in a coordinated and resourced strategy for survival is a complex, multi-sectoral responsibility for the Zambian government. Since 1990, the year against which MDG achievements are measured, strong positive shifts have occurred, but the biggest inroads were made between 2000 and 2010. Zambia has participated with good intent in a number of movements aiming to accelerate progress towards MDGs 4 and 5: SUN, A Promise Renewed, Every Woman Every Child and Every Newborn. Despite these efforts, the rate of progress has slowed and the fertility rate is almost unchanged, indicating gaps and unmet challenges in the final push to protect mothers and children from morbidity and death.

Figure 7: Cause of death in newborns, Zambia

Source: WHO
http://www.who.int/maternal_child_adolescent/epidemiology/profiles/neonatal_child/zmb.pdf

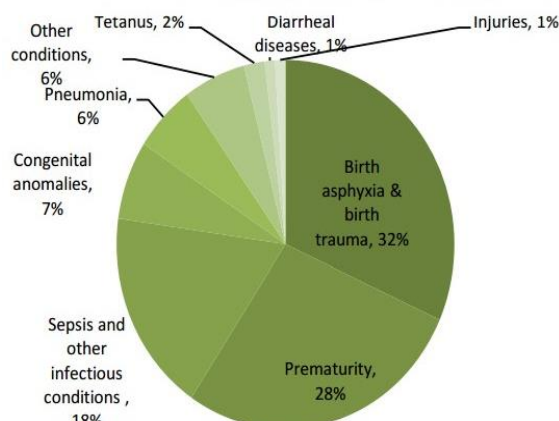


Figure 8: Cause of maternal deaths in Zambia

Source: ZDHS
Roadmap for accelerating reduction of maternal, newborn and child mortality
http://www.mcdmch.gov.zm/sites/default/files/downloads/MNCH_Roadmap20Map.pdf

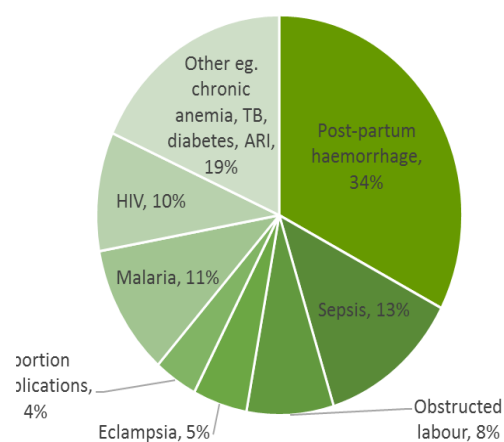
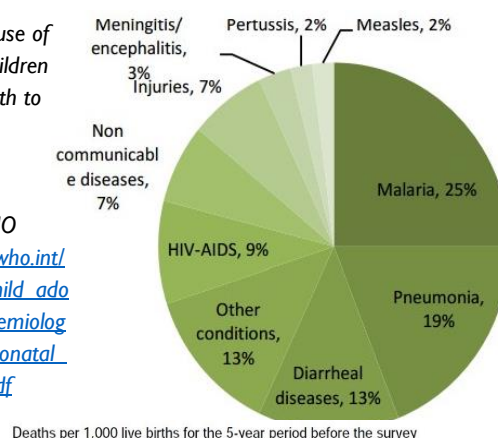


Figure 9: cause of deaths in children aged 1 month to 59 months, Zambia

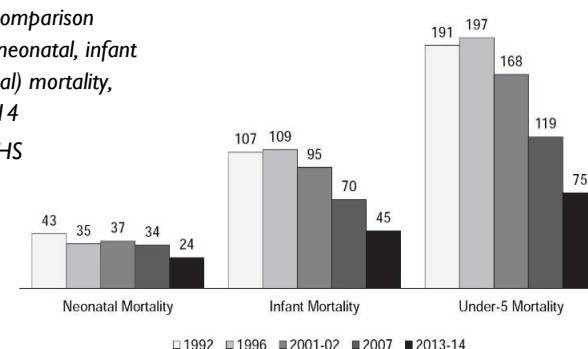
Source: WHO
http://www.who.int/maternal_child_adolescent/epidemiology/profiles/neonatal_child/zmb.pdf



Deaths per 1,000 live births for the 5-year period before the survey

Figure 10: comparison reductions, neonatal, infant and U5 (total) mortality, 1992 – 2014

Source: ZDHS



⁵ <http://www.prb.org/Publications/Articles/2003/DiverseFactorsLinkedtoMaternalDeathsInZambia.aspx>

⁶ <http://www.prb.org/Publications/Articles/2013/zambia-reproductive-health-women.aspx>

PART 2: EVALUATION METHODOLOGY



Safe Motherhood Action Group members (SMAGs) are vital assets in the Zambian government's 'First Thousand Days' strategy, visiting households to share knowledge of health and nutrition and to encourage assisted delivery at health facilities. In Mbala ADP, Northern Province, these women report 100% success rate in women intending to deliver at the clinic. They attribute this change not only to their own efforts but also to the bylaw passed by their traditional leader, Chief Nsokolo. 'Women used to be frightened of the clinic,' said one SMAG, 'but they were more frightened about disobeying the chief and being fined. Then when they came, things went well, and now women prefer to give birth safely here.'

2.1 RESEARCH RATIONALE; KEY QUESTIONS

Primary requirements:

- To assess WV Zambia's current position, potential, opportunities and strengths to continue maternal and child health advocacy and behaviour change.
- To understand the relative effectiveness of different practices and approaches used for the Child Health Now campaign, and their relevance to planning the upcoming EVAC campaign.
- To draw conclusions on the need to replicate, scale up or hand over campaign practice and process, in line with the organisation's capacity, strategy and commitments.

Secondary requirements:

- To identify if/whether health-seeking behaviour, particularly for antenatal and post-natal care, has improved as a result of WV influence in target communities; if so, to identify and understand how this has come about.
- To assess the quality of the project for accountability, including its relevance, effectiveness, efficiency, sustainability and impact, in line with OECD-DAC quality principles for international development.
- To examine the value of the Child Health Now campaign to WV Zambia as an organisation, and whether it has built capacity to manage advocacy and coordinated campaigning within the office.

For WV Zambia, the Child Health Now was a first-time experience, with much to be learned and applied to improve future policy influence. Terms of Reference for the evaluation acknowledged that learning from the project was of greater weighting than showing impact, particularly as any identification of external change for child would have limited linkage to the project's inputs compared to many other factors in play over a longer period.

The evaluation was guided by three research questions:

1. To what extent, and in what way, did WV Zambia achieve Child Health Now objectives?

This question calls on the campaign's overall theory of change, articulated through the project logframe and original design concepts, to confirm that the intended outcomes were pursued and to examine the journey towards reaching them. The question allows for midpoint mapping to constructively identify the current status of project goals. It also acknowledges the organisational, shared responsibility for health outcomes within WV Zambia rather than focusing only on the direct activities of the campaign and its coordinator. Answers to this question will help to identify whether particular practices or approaches have showed promise, along with hypothesis on what might have helped them to achieve more. Should the office decide to continue engagement on health policy at different levels of Zambian governance and civil society, this question will also provide specific next steps for campaign sustainability.

2. What have been the enabling and limiting factors to achieving change?

This question triggers enquiry on the levels and types of inputs and interactions, from organisational (financial, technical and human resource) to cultural (the landscape, governance systems and social structures of Zambia). It builds an inventory of assets and barriers to bringing change in this context. In response to the interest in planning for the next campaign to end violence against children, the question is broadly theoretical rather than focusing on the health sector.

3. Building on the experiences of the Child Health Now campaign, what practice and lessons learned can inform WV advocacy campaigns in the future?

This question pulls together threads around capacity and campaign management, focusing on recommendations for leadership at WV Zambia: capacity, training, learning, structures, partnerships, personalities, and processes, among other themes. It seeks to resolve perceived limitations of the Child Health Now campaign, using perspectives from inside and outside World Vision to 'think big' on CHN as a stepping stone to broader advocacy engagement and influence.

2.2 EVALUATION LOGIC

To answer the questions in the previous section, the consultant proposed a methodology with strong emphasis on qualitative methods and triangulation of perspectives. There are two important justifications for this choice:

- The project did not set quantitative outcome targets or articulate the particular policies in its sights. As a result, the existing logframe and theory of change did not have an end line. All achievements

were interim to the overall project goal. There was not, for instance, an expectation that child mortality would end as a result of the campaign in ADPs: more simply, there was a theory that increased engagement and interest would begin to drive change external to World Vision's efforts.

- Many of the changes sought were social changes, in attitudes, interests and increased action that promoted a more positive environment for services to children and their mothers. Measuring quantitative change to opinions can be expensive and is not always relevant; while the campaigning elements of CHN may have looked for large numbers engaging with its themes, the advocacy elements sought to influence a small number of decision makers who together held great power for change.

Removing quantitative comparison (baseline/endline) from the equation because of these reasons, there is good logic in pursuing a theory-based methodology instead:

- Theory-based methodology can retrospectively build and test theories of change, without being bound by activity-level monitoring in a logframe theory of change.⁷
- It allows for the 'unpacking of black boxes'⁸ by emphasising why something happened over whether it happened.
- It is well suited to constructive learning, encompassing appreciative enquiry ("What worked and what would we do differently?"), contribution analysis ("What did we do? What did others do? How did we connect?") and/or case study ("What was special or interesting about what we did?").

The realist philosophy that no two outcomes can be the same due to differences in context or starting point can also be helpful in understanding social change. By applying context-mechanism-outcome (CMO) or causal theory to understand a current situation and how it came about, insight is gained into all influences and their outcomes, not only those of the project under review. This is especially helpful for projects delivering advocacy as part or all of their activities, because the change is often (and appropriately) two or more steps removed from agency input. The generic Theory of Change on p.10 shows how policy change might come about, and the decreasing visibility of the agency in that change as it comes closer to realisation. Though the agency is necessarily less present at the outcome than other actors, the significance of its foundational activities do not decrease, as they can be seen in the outputs of others.

The more complex the project, its stakeholders and perspectives, the more complex the full history of context and causal mechanisms. The line of enquiry can reduce in academic rigour as a result. Literature has recently been suggesting that a combination of contribution analysis – to build a causal theory – and process tracing – to examine and validate that theory –

⁷ Eg. Rogers, P (2008), "Using Programme Theory to Evaluate Complicated and Complex Aspects of Interventions", *Evaluation* 2008 9: 29-48

⁸ Astbury and Leeuw use the black box recovered from aeroplane disasters as a metaphor for realist theory-building in evaluation. Their observation is that often there is no need to prove that the aeroplane crashed; the question is why. Astbury, B. & Leeuw (2010), "Unpacking Black Boxes: Mechanisms and Theory Building in Evaluation", *American Journal of Evaluation* 31(3) 363-381

can overcome this limitation⁹. The consultant has selected this combination as the most appropriate for Zambia CHN, because it will allow a good examination of mid-range outputs and outcomes and foster strong discussions on the context for next steps.

Specifically, the methodology is a combination of:

- Desk review to identify elements of change
- Contribution analysis, which built a map of causal factors behind these changes (and others) in a 'theory' that places World Vision as one of those factors
- Process tracing which uses logic and triangulation of viewpoint to test and prove (or disprove) the contribution theory.
- Allowance for field enquiry in the case of formal (government or institutional) evidence of quantitative change, linking back to a corresponding theory for World Vision's contribution to it.
- Presentation of results to key stakeholders for final consensus, engagement and refinement on implementable recommendations for WV, partners and government.

A description of the contribution analysis / process tracing (CA-PT) combination is included as **Annex 3**.

2.3 METHODS OF DATA COLLECTION AND ANALYSIS

The following data collection approaches were used:

Quantitative (25%):

- Analysis of existing data from World Vision monitoring records of activity (inputs) and any resulting outputs, to determine the adherence of programme management to agreed targets.
- Examination of primary data where available and relevant on increased clinic usage; the document review indicates little value from a broader survey.

Qualitative (75%):

- Document review of project records and other information relevant to project outcomes.
- Participatory contribution analysis in a facilitated workshop, followed by process tracing to test alternative explanations and conclude the extent and value of World Vision's contribution to change in child protection systems.
- As part of process tracing and to contribute to conclusions around sustainability and capacity, semi-structured interviews with key informants associated with the cases of contribution.
- As part of process tracing and to contribute to conclusions around sustainability and capacity, possible focus group discussions with relevant groups; child clubs, women's groups or others.

2.4 TARGET AUDIENCE FOR EVALUATION RESULTS

The dissemination of results commences within the evaluation methodology with presentation to key informants providing an opportunity for discussion and consensus. Dissemination of the final products is the responsibility of WV Zambia, with the recommendation to include:

⁹ Eg. Befani, B. & Mayne, J. (2014), "Process Tracing and Contribution Analysis: A Combined Approach to Generative Causal Inference for Impact Evaluation", *IDS Bulletin* Vol 45 Number 6 November 2014

- ADP staff, especially in implementing ADPs
- Regional office and support office
- Government counterparts in the Ministry of Health
- Members of the MNCH Alliance
- Possible availability on website

2.5 PARTICIPANTS IN CONSULTATION

Table 1: Consultation channels		
Consultation method	Who?	#
Pre-visit, TOR clarification and confirmation of research priorities	National office stakeholders	5
	Support office	1
Contribution analysis workshop	Implementing staff Implementing partners	7
Key informant interviews, Lusaka	MoH reps MNCH Alliance members SUN CSO Alliance members	9
Key informant interviews, Mbala	ADP teams Traditional leader Local health workers District MoH	8
Focus group discussion, Mbala	SMAGs/TBAs	30

During the consultation phase of the evaluation, 30 participants gave their perspective, using a variety of channels, shown in Table 1 to the left. The proportion of stakeholder types, shown at Figure 11 below, shows that, aside from the SMAG focus group, weight was given to stakeholders internal to World Vision. This was unavoidable as there was limited knowledge of the campaign outside the organisation. SMAGs did not know about the Child Health Now campaign. Consultation with this group focused on confirming changed behaviour trends in Mbala; in terms of stakeholders able to comment directly on the campaign, 15 were internal and 11 external. This has been acknowledged as a limitation.

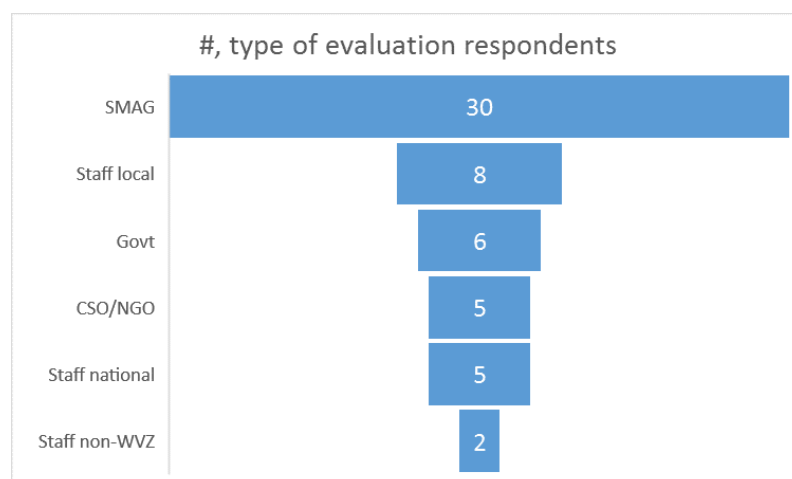


Figure 11: Number of interviews with each stakeholder type

2.6 ETHICAL CONSIDERATIONS, DATA STORAGE AND PRIVACY

This methodology has successfully tested against Bond evidence principles for quality evaluation process, including voice and inclusion, appropriateness, triangulation, contribution and transparency – though with some limitations in consulting beneficiaries on outcomes due to limited external visibility of the campaign. Addressing ethical considerations, the consultant considers participation elements of the study to be low risk, because:

- Questions are not intended to explore areas which place individuals at risk through their responses;
- The methodology is not experimental in its approach and provides full disclosure of conditions and purpose;
- The majority of respondents are associated directly and positively with the project;
- The majority of the respondents are in positions of relative power

and control and are consulted purposively because of this.

The consultant conducted all interviews directly, including an initial verbal and written briefing on the purpose of the research, guaranteed confidentiality and right to withdraw now or later. The form used is available as Annex 6. Respondent names and comments remain confidential to the consultant. All records will be kept securely with the consultant in case of complaint or dispute. Neither WV Zambia nor the consultant may use this information for any purpose apart from that initially agreed, without permission from the respondents.

2.7 METHODOLOGY LIMITATIONS

A number of limitations to the evaluation methodology are noted below, connected to the study process and challenge of measuring social change achievements:

- Due to the subject matter under review, the study was not able to deliver accurate measurements of impact for children or contribute aggregable data to the current structure for child wellbeing reporting.
- The likelihood of achieving social change in four years, especially considering cost and staffing limitations, is low. This challenged the description of this research as an 'impact evaluation'. While the methodology is ready and prepared to identify impact, it does not intend to measure the volume of that impact.
- Time constraints, and the need to complete the evaluation by the end of World Vision's financial year, does not allow followup research that might identify more significant change in the future; results including improvements brought about by policy can be reasonably projected, but cannot be proved at this time.
- Due to low recognition of the campaign brand among government and community partners, and because the campaign was implementing directly rather than through local CBOs, limited knowledge of the campaign has affected the number of external viewpoints contributing to the data. In total, 15 internal and 11 external stakeholder interviews were conducted, while ideally the external interviews would outnumber the internal.
- Aggregating qualitative interviews can be challenging as it can obscure individual viewpoints; at the same time, a single viewpoint with no correlation from others indicates an uncharacteristic finding that may be of reduced relevance. When aggregating, the consultant has chosen only themes that occur in two or more interviews. It should be noted even then that considering the small sample, trends are volatile.
- The campaign demonstrates results mainly at the progress or lower output range of the generic theory of change (see p.10). This limits discussion on impact and also on effective models, as results are yet to come.

PART 3: CONTRIBUTION CLAIMS



The August 2015 Urban Mothers' Walk represented a 'coming of age' for the MNCH Alliance, with government, NGO/UN partners and members of the public rallying to raise awareness of urban to rural discrepancies. Government stakeholders mentioned that the walk was an effective and timely reminder of infrastructure and staffing shortfalls. They suggested it could become an annual event with a welcome focus on reporting the government's progress in this regard.

3.1 BACKGROUND TO CONTRIBUTION CLAIM ANALYSIS

Building the theory

In line with the realist methodology outlined in Part 2 of this report, implementing stakeholders took part in a workshop to map the five years of the project's implementation. Impact-level change, while not altogether ruled out, was considered an unlikely finding, so the discussions focused on lower level change: inputs, outputs and interim outcomes. The first activity built 'shared memory' by identifying moments and milestones from differing perspectives: local staff, the national team and campaign partners. The second built these moments into a more cohesive and chronological narrative, including the identification of achievements against the project's two outcomes. Finally, the participants built retrospective theory for these achievements – context and mechanisms – to show how change had come about and Child Health Now's role. The project did not need to be the most important or visible contributor to change; however, its contribution needed to be necessary (the change would not be likely to happen without the project) and sufficient (the inputs were of appropriate volume, visibility and quality to bring about change).

Annex 7 maps the observations from the workshop by context, mechanisms and outcomes to build a complex theory of change. It is designed to be read from the bottom (context and foundational inputs by WV and others) upwards to outcomes and potential future impact. This theory of change shows a number of parallel mechanisms introduced by World Vision, the government of Zambia and other partners, all of which reduce the certainty that Child Health Now has been a necessary catalyst for change – but at the same time, do not rule it out.

Faced with counterfactual query – would this have happened without Child Health Now – participants could not be confident that several outcomes had either sufficient or necessary contribution from CHN to be considered a project result. As well, several examples emerged of context and mechanism without clear outcome, indicating unfinished work.

Eventually the workshop generated two firm case studies showing campaign contribution to a changed landscape for maternal and child survival:

1. **Contributing to Outcome 1** through a reduction of home births in favour of health facility delivery across Mbala district, and;
2. **Projected contributions to Outcome 2**, potentially from 2016 onwards, through coordination and technical support of the MNCH Alliance to government.

Testing the theory

The consultant conducted a number of interviews with stakeholders who were selected for their potential to provide alternative qualitative perspectives. The interviews were semi-structured, allowing respondents to talk about their own experiences with the campaign. While at times it was necessary to 'lead the witness' on specific causal logic, the case became stronger if respondents found their way unprompted to validating elements of the theory. The interview approach also gave space for respondents to build on workshop results with new information or unexpected feedback. Interestingly, this information increased the consultant's confidence in two of the cases voted out at the workshop:

3. **Contributing to Outcome 1** through SUN CSO replication of effective behaviour change engagement with traditional leaders on nutrition, and;











4. **Potentially contributing to Outcome 2** through increased advisory scope to the Zambian government from 2016 onwards.

The relative strength of validation is summarised in Table 2 below, using a traffic light rating to indicate confidence levels after the workshop, and then at the end of stakeholder consultation. Strengths and weaknesses in the causal logic between each mechanism are also highlighted to give perspective to the final rating.

Based on this, it is very likely that Child Health Now brought value to both outcomes through the top two cases above and that further inputs have supported World Vision's health programme outcomes in a way that has been appreciated, if not conclusively necessary.

The following pages examine the top four cases in greater detail including next steps to achieve or build on results. Where relevant (which is often) mechanisms both internal and external which ran parallel to the Child Health Now campaign have also been highlighted. See also p.30 for a description of World Vision's different health initiatives at local level and the challenges of separating CHN initiatives from the broader spectrum of local health programming.

Table 2: Strength of validation, Child Health Now contribution claims

Case	Confidence, end of workshop	Confidence after stakeholder consultation	Strongest validation	Weakest validation
Traditional leaders call successfully for zero home births			Messages from and meetings with CHN raised issues of health injustice and led to action	Attribution between CHN and ongoing ADP engagement; primary relationship with Chief is that of ADP.
Establishing the MNCH Alliance for improved government/public campaigning			CHN's expanded vision for the group; CHN as secretariat; joint ownership of Urban Mothers' Walk	None
Local and national nutrition policy change			SUN CSO visit to Mbala, organised by CHN, triggered replication of practices	Necessity in DNCC (ADP, govt, SUN CSO already working together)
CHN provides government advisory function on maternal and child survival			Value of CHN coordinator in processes including MNCH Alliance, joint lobbying and direct technical support to government.	Whether this outcome is valid, as the current political climate has not given opportunity to test collaborative influence.
Measurable MNCH improvements, Luampa ADP			Usefulness of IEC materials in raising staff and community interest, all ADPs.	Necessity in Luampa, as holistic health grant already had CVA, traditional leader engagement and SMAG strategies.

3.2 CASE 1: TRADITIONAL LEADER CALLS SUCCESSFULLY FOR ZERO HOME BIRTHS

Narrative

“We gave out pamphlets from WV Zambia on the MDGs and people started to ask: how can we go about reducing this? Ministers and chiefs were part of the change. Child Health Now gave a reason for everyone to talk about it more.”

WV ADP staff

Building on World Vision’s existing relationships with traditional leaders as the authorities and gatekeepers on community access for development and behaviour change, Child Health Now encouraged an increased focus on the role of leaders in promoting safe motherhood. Themes included male involvement in the health processes for ANC and child birth as well as the importance of assisted births in a health facility. These efforts aligned with Zambia’s 2010 national policy to increase sensitisation work on health centre deliveries, and to shift the role of the traditional birth attendant (TBAs) away from actual delivery towards counselling and care during pregnancy and the first 30 days after delivery.

ADP health programmes were supporting the goals of this policy by conducting training with TBAs and other interested volunteers to reinstate them as Safe Motherhood Action Group members (SMAGs). The difference between TBAs and SMAGs was:

- Increased knowledge of 7-11 principles and ttC to provide a long-term service to expectant and new mothers;
- Shifting the role in childbirth from assistance with delivery to accompanying the mothers to health facilities;
- With an awareness of due dates, encouraging mothers to travel earlier than due and stay in the newly built mothers’ waiting houses.

Child Health Now provided messages and materials for ADPs to extend awareness training on safe motherhood to the traditional leaders and their headmen, so that the local governance structures could play a greater role in bringing about behaviour change. This included an individual meeting with Chief Nsokolo in Mbala, Northern Province, as well as a gathering of chief ‘champions’ to learn from each other on the best ways to convince mothers and their husbands to seek appropriate maternal care.

Child Health Now’s petition was strongest when the target had existing concerns and interests in maternal and newborn survival. Chief Nsokolo had lost family members in childbirth and was also aware of the poor uptake and accountability for services to mothers in his chiefdom. He began to make unannounced visits to maternal clinics where he would praise men who had accompanied their wives. Chief Nsokolo also lent his support to the construction of mothers’ waiting rooms in three clinics. In 2015, he introduced a local bylaw enforcing the national policy to give birth in facilities, or otherwise incur a cash fine.

While the situation was already improving due to SMAG influence, Chief Nsokolo’s decree was a defining shift, leading to zero home births within a year. Facility births at one clinic increased from a few per week to between two and five a day, and maternal mortality at the clinic is now very rare. ANC visits including those accompanied by husbands have increased. Two challenges emerge as next steps in Mbala: firstly, that mothers who leave late and go into labour on the way are at significant risk; secondly, that the increased number of deliveries has led to crowded facilities and shortages of trained health professionals to attend. SMAGs will sometimes stay with mothers and assist the delivery within the facility, but this is not the long-term vision for safe, medically attended childbirth.

Validation

Consultation with Chief Nsokolo and community health workers (SMAGs and TBAs) confirmed a distinct behaviour shift in the district. It was now extremely rare for mothers to intend to give birth at home. All SMAGs and TBAs were aware of the chief’s bylaw. General consensus was that it had created a powerful

'ANC and PNC attendance has greatly improved, spouses are accompanying their wives, and both husbands and wives are learning about nutrition in their homes.'

*Chief Nsokolo,
Mbala District*

Table 3: Mbala District MNCH indicators

INDICA- TOR	2013	2014	2015	% change in 2 years
Maternal deaths	4	10	11	(see below)
ANC 1st visit	10918	12806	12048	+10%
Family planning 1st visit	5291	6355	6937	+50%
Family planning usage	12150	13680	15515	+28%
Institution deliveries	3244	4886	5370	+66%

Note from MoH, Mbala: -Maternal death is noted as increasing. Province maternal death surveillance training was done in 2014 and the surveillance at district level was strengthened to capture community deaths, whereas before it only captured facility deaths. In reality the deaths are decreasing.

Conclusions

'Maternal deaths have reduced. Of that we are certain. Distance is the final challenge, because mothers still might die on the way to our facility.'

Health official,

Nsokolo Health Clinic

tipping point. Previously, women had hesitated to use health facilities because of fear; they preferred to be at home where things were familiar to them. However, the greater fear of disobeying the chief and having to pay the fine has led to more than 95% clinic delivery.

The district health coordinator in Mbala provided comparative figures for the last three years which showed a 66% increase in institutional deliveries, a 28% increase in family planning and a 10% increase in first ANC visit (see Table 2, left) and confirmed that the bylaw had been effective as part of a broader campaign to bring mothers closer to appropriate levels of care. The role of the SMAGs in this change is also significant, as described by several local stakeholders including the health coordinator. While Child Health Now did not specifically train or promote to this group, ADP teams here and elsewhere in Zambia felt that the greatest contribution CHN made to their programme was to enhance 'big picture' discussions within communities. SMAGs were aware that each maternal or child death contributed to an overall mortality rate that could be reduced with simple and consistent practices of maternal and child care, alongside better services when danger signs occurred. During the focus group with TBAs and SMAGs, many participants expressed the injustice of high mortality rates and described key issues of distance, transport, inadequate hospital facilities and staff as elements needing urgent attention. This correlated with ADP staff observation that the community discourse on maternal and child health had changed from case-by-case to root cause and accountable action.

Chief Nsokolo was an existing advocate for community development including health in his district, and his stance connects to many motivators beyond the meetings with Child Health Now and ADP teams. Based on his and other feedback, however, he has appreciated the health and nutrition programme in Mbala and, while seeing the full range of community development as his responsibility, has paid particular attention to statistical improvements in maternal and child survival since passing his bylaw.

The Child Health Now campaign did not need to create separate and independent relationships with traditional leaders because ADP managers and their teams were already in regular contact. However, converting some of the discussions to cause campaigning has led to strengthened action within the significant remit of the chief. The chieftdom network is formal and powerful, with clear mandates in place that chiefs represent and advance the development of their citizens, and so the accountability element is equally strong with that of district and provincial ministries. Traditions and myths around childbirth, particularly nutrition, are hard to challenge from outside the community, so chiefs in Zambia hold a pivotal piece in effective long-term behaviour change.

Some chiefs are more likely than others to take steps towards prioritising maternal and child health. High gender inequality in Zambia results in most household decisions being taken by men, and Child Health Now has not generated any 'gender in development' discussions often needed to convince male leaders to encourage their male constituents towards better gender inclusion. The champion approach which identified and lobbied chiefs most likely to listen has given good practice and results that can now be shown to other, more hesitant, traditional leaders. A full strategy for expansion might also include particular dialogue with female chiefs (who represent around 10% of total chieftdom¹⁰).

¹⁰ <http://news.trust.org/item/20150922060356-4m6zv/>

3.3 CASE 2: ESTABLISHING THE MNCH ALLIANCE FOR IMPROVED GOVERNMENT / PUBLIC CAMPAIGNING

Narrative

'At the beginning we were not calling ourselves the alliance, just working together to speed up the process to demand better systems for mothers and children. World Vision was one of the prime movers along with UNICEF, PATH and ASD.'

NGO stakeholder

Zambia's government is committed and transparent in its efforts towards nationwide development, attracting a large number of international donors supporting local and international NGOs¹¹. Despite this, it has failed to achieve MDG targets for child and maternal survival. Challenges are connected not only to infrastructure but also to implementation of and budget for promising national policy, particularly as the distance increases from the nation's capital. Donor programmes including World Vision's programmes have achieved isolated pockets of change without necessarily addressing the systemic challenges that could empower district and provincial health structures.

In 2013, UNICEF sent invitations to a number of MNCH NGOs to campaign together on A Promise Renewed¹² to accelerate progress towards institutional change in Zambia. World Vision connected the Child Health Now coordinator with the group, as the focus was advocacy and public campaigning. Also joining were Save the Children with their Every One campaign, Path International, local urban NGO ASD, the recently-formed SUN CSO Alliance and several other local and international NGOs.

Child Health Now's resources and coordination were important inputs to the group forming and stabilising. The Child Health Now coordinator suggested the group could fill a gap in civil society influence with government by expanding to become a permanent advocacy and advisory coalition. In 2014, CHN became the secretariat, while the SUN CSO Alliance, then Path, took the role of chair. After around eighteen months of learning how best to work with each other, the MNCH Alliance formally launched in March 2015 under its own brand and banner, with a clear MoU on structure and goals and four key focus areas:

1. Health financing
2. Timely national data on MNCH
3. Strengthening coordination of CSOs
4. Engaging various influential leaders to be champions of MNCH

The Alliance has been dependent on individual organisations' human and financial resources. In this, Child Health Now had the advantage of being able to incorporate many of its goals, and therefore its resources, into Alliance activities. Upon assuming the chair, Path International assigned a proportion of an existing role specifically to Alliance coordination, and Path also funded a pivotal training for all alliance members on coalition building and advocacy in 2015. From this the Alliance was able to build and begin implementing an action plan, including successful funding proposals to UNICEF and FACT. In August 2015, the MNCH Alliance held the Urban Mothers' Walk, a joint awareness event with government drawing on Child Health Now data from pre-WHA 2015 community hearings to demonstrate for faster action to reduce the distance to clinics in rural areas. In line with MoH priorities for technical advice, the Alliance has budget advocacy as one of its four pillars.

Validation

Among partner NGO and government stakeholders, a sense of satisfaction and pride exists when discussing the MNCH Alliance. It has indeed been a shared outcome with lessons learned along the way. Nobody wished to dwell on early challenges of competing agendas and brands, with one stakeholder describing the first twelve months as 'teething problems'. Emerging from this phase, the MNCH Alliance has remained strong and strategic, taking the necessary time to identify its core function,

¹¹ A recent OECD-DAC survey commissioned by EU aid agencies found that 92% of agencies were satisfied with Zambia's harmonisation and coordination of aid priorities with donors. There was a strong belief that the health sector within this was appropriately coordinated and monitored with government leadership: <https://www.oecd.org/dac/effectiveness/33814093.pdf>

¹² <http://www.apromiserenewed.org/>

'The delay in startup is challenging impact reporting, but the platform creates a cadre of citizens who can sensitise and mobilise communities across Zambia.'

Government
stakeholder

Conclusions

'The only problem (with the Urban Mothers' Walk) was that government was not involved in the initial planning. We needed to meet and plan properly instead of rushing.'

Government stakeholder

'World Vision is very big in Zambia, so it commands respect.'

NGO stakeholder

working approach, structure and action plan through to 2017. All members of the Alliance who were interviewed felt that the platform was right now at the point of delivering on its intent, with the ability to work on multiple issues and draw in appropriate technical expertise to support its action plan.

The Urban Mothers' Walk was mentioned consistently by external stakeholders, with a sense that this event was a 'coming of age' for the Alliance. Several organisations blogged or reported on it¹³, though, interestingly, not WV. The clear messages, and the acceptance of these messages by government, imply that the event will become relevant as a mechanism for increased will and action on clinic construction in the future. The government stakeholder most closely involved with the coordination of this event confirmed that there are already plans for a repeat event in 2017. When questioned on whether this was awareness or advocacy, she believed that it was both, and that the event could provide a collaborative reminder for government to report on its progress for infrastructure and human resource.

Child Health Now has a strong contribution claim in the development and current sustainability of the MNCH Alliance. While not the original instigator, and never the chair, Child Health Now has taken an appropriate coordination and encouragement role, supporting different members to understand and engage with the value adds of working in coalition. In exchange, areas where World Vision might struggle to work as a lone voice of authority, for instance in budget advocacy, can be met with complementary skills from other partners. Increased visibility as a policy thinker with other partners has also led to cases of bilateral collaboration for policy influence with UNICEF and the SUN CSO Alliance.

The value of the MNCH Alliance is not in doubt, reiterated by every relevant external stakeholder interviewed. Its existence was not well recognised by the programmers within World Vision, especially at local level, though most knew about the Urban Mothers' Walk and its effective repurposing of data from Community Hearings.

Partners saw World Vision's membership as an asset because the organisation connected technical thinkers with local data and trends. Internally, while the challenges of doing so were sometimes raised, including current frustrations with aggregating CVA action plans, there was also general agreement that this could be (and should be) a key contribution to national level government engagement. The Urban Mothers' Walk demonstrated that it could be done, an important practice for further reflection within World Vision.

Partners expressed some alarm that Child Health Now was described as closing or ending, wanting to understand what that would mean for ongoing involvement in the Alliance. While sustainability without World Vision is the ultimate goal of programming, World Vision's advocacy and policy work has opposite implications; the more prominent World Vision becomes as a partner and voice, the more necessary its continuation. WV Zambia's technical programme due to launch in October 2016 covers local advocacy models including CVA and partnership with traditional leaders. Ways should be found to match this at national level and continue to provide the data, coordination and influence appropriate for an organisation of World Vision's standing.

¹³ Eg. Daily Mail: <https://www.daily-mail.co.zm/?p=40361> PATH: <http://blog.path.org/2015/10/marching-for-safe-motherhood/> Save the Children: <https://zambia.savethechildren.net/news/urban-mothers-walk-maternal-health>

3.4 CASE 3: NATIONAL NUTRITION POLICY CHANGE

Narrative

The Zambian government was an early signatory to Scaling Up Nutrition (SUN) in 2012, and a first step in the process is bringing together a SUN Civil Society Organisation Alliance (SUN CSO). In its first year the SUN CSO Alliance worked with World Vision's technical teams for nutrition. It was not until the MNCH Alliance formed that the SUN CSO became aware of the policy and campaigns side of WV's health strategy in the Child Health Now campaign.

The CHN coordinator instigated closer collaboration with SUN CSO to provide planning to nutrition policy influence. An important target for SUN CSO was to see the National Food and Nutrition Commission Act (NFNC) updated, with the last review dating back to 1967. Child Health Now dedicated team time to reviewing the policy and feeding changes to the SUN CSO to collate and present. The policy moved to draft stage with 75% of the SUN CSO changes upheld. Unfortunately, at that stage the political situation in the country, involving elections and constitutional referenda, made it impossible to push successfully for ratification of national policy, and the policy was shelved.

In consultation with government, SUN CSO identified 14 priority districts for nutrition action. These districts were to receive some coordinating budget and other resources to form ward and district nutrition coordination committees (WNCCs and DNCCs). Mbala district was included in the priority 14 but not initially in the startup for the committee strategy. CHN invited the lead of SUN CSO to the nutrition project in Mbala ADP for a visit of around two weeks. This visit had two effects:

1. Mbala was fast tracked for inclusion in the government's DNCC/WNCC rollout
2. SUN CSO documented and successfully reused approaches for nutrition behaviour change involving the traditional leader in Mbala.

World Vision's involvement with the DNCC at its formative stages has helped this committee to develop well compared to some other examples in other districts. Currently the DNCC meets at the World Vision office. While technical expertise and decisions are provided directly between SUN CSO and government, the ADP nutrition manager attends DNCC meetings as a responsive partner to decisions taken.

Validation

'Nutrition groups are functioning well in Mbala from ward through to district. We are part of this but we don't need to provide technical support; it's self-sufficient between government and SUN CSA.'

ADP staff, Mbala

The activities behind this case study were identified by internal stakeholders in the contribution analysis workshop, but the contribution of CHN was eventually considered too tenuous to continue with the claim. The consultant has reinstated the case after discussion with stakeholders, due to their strong emphasis on the support role of CHN, though versions do not match exactly. While the ADP representatives saw the DNCC as the major outcome of the SUN CSO visit to Mbala, SUN CSO representatives did not mention this outcome at all. For them, the highlight was learning how to work collaboratively on shared goalsetting with traditional leaders, including pre-empting certain traditions and myths that were leading to poor maternal and breastfeeding nutrition practices.

Neither outcome was articulated or monitored by CHN, but because the CHN coordinator organised the visit to Mbala as part of SUN CSO engagement, the two outcomes can be linked to CHN inputs as a necessary trigger.

In terms of the NFNC policy review, interviews with SUN CSOs highlighted the inevitability of placing the policy work on hold, and a clear intent to pick up the lobby to parliament as soon as it made sense to do so post-election. The quality of CHN's review including knowledge of local barriers to change was also noted.

Conclusions

'We have worked well on nutrition with CHN and the SUN CSA. World Vision was able to provide good data and information along with other partners.'

Government stakeholder

Child Health Now's contribution to improved nutrition was slight compared to its focus on safe motherhood. Activities appear to have responded to opportunities that presented themselves, creating ad hoc additions to the overall theory of change.

World Vision is a significant investor in nutrition advancements including with WFP and other food donors, and World Vision's 7-11 strategy¹⁴ guides health programming across ADP and grant projects. Thus, there have been some missed opportunities in synergy between nutrition challenges and the campaign's two outcome areas of behaviour change and access. In particular, Zambia's Code on Breastfeeding Substitutes, an internationally accountable convention, was suspended pending review in 2010, with corresponding vulnerabilities to unclear marketing for new mothers. Given the extent of programming work on breastfeeding, it is surprising that no analysis on breastfeeding policy took place to identify this as an urgent and relevant platform for CHN action.

If World Vision intends to continue advocating for health, an ideal alignment with programming would be to re-engage with the NFNC and to ramp up a supporter and partner base, including corporations, to demand reinstatement of the Breastmilk Substitute Code. Considering World Vision's size and respect, there is good potential to deliver significant change under a strategic and targeted campaign.

3.5 CASE 4: BUILDING RELATIONSHIPS TOWARDS A GOVERNMENT ADVISORY FUNCTION

Narrative

'CHN strengthened structures at community level because it created one call to support good health in the community.'

ADP staff, Luampa

'It was mandatory for CHN campaigns to participate in the national lobbying to ask national governments to support global policy calls and resolutions at the key moments. The coordinator developed a strong

One of the earliest activities for Child Health Now, after the recruitment of the coordinator, was to take part in World Vision's November 2012 Global Week of Action. Working through ADPs and some opt-in church activities in Lusaka, World Vision recorded 1,550 hands raised for child survival, including influential government officials and the First Lady of Zambia. This represented the first phase of visibility for Child Health Now, well before the campaign launch.

With a sole staff member and limited technical support from health, nutrition, other leaders or communications, much of the Child Health Now coordinator's time was spent in meeting subsequent Action Circular requirements from the global campaigns team, including:

- Lobbying and meetings twice a year before World Health Assembly (May) and UN General Assembly (September)
- Coordination of the Global Week of Action 2012, 2014, 2015
- Coordination and aggregation of Community Hearings 2015

Between 2012 and 2015, results of community mobilisation were forwarded directly to the international team representing Child Health Now at global events, rather than being used to promote and resolve issues within Zambia.

The results of the Community Hearings in Kasama and Mbala, however, pointed strongly to distance to clinics as a cause of maternal and newborn deaths, limiting ANC checkups as well as presenting in time for health facility delivery. These results also connected with the national government's promise in 2011 to ensure a health facility within 5 kilometres of every Zambian by 2015¹⁵, and to construct 40 hospitals and 650 health posts by 2016¹⁶. The resulting Urban Mothers' Walk in August 2015

¹⁴ 7 interventions for maternal health and 11 for the health of under-twos, delivered at age-appropriate times; teaching mothers about these lifesaving practices is at the heart of all WV household health projects.

¹⁵ Ministry of Health (2011). *National Health Strategic Plan 2011-2015*; Republic of Zambia, Central Statistical Office (2011)

¹⁶ Minister of Finance (2014). 2015 Budget Address to the National Assembly

relationship with key government ministries... our calls were supported at the global level by the Government of Zambia.'

WV advocacy staff

Validation

'There was enthusiasm to start but it didn't stay the distance. Advocacy needs to stay edgy, you need to be out there and confident that you can do what's needed when you see it.'

WV stakeholder

(see Case 2) indicates the increased standing of the campaign by that time to link different levels of influence.

During the Action Circular lobby to government before WHA 2016, CHN proposed that the coordinator accompany Zambian delegates as a country representative. As a result, the coordinator was allowed access to planning meetings and briefings before leaving for Geneva, and also to sessions at the WHA which would ordinarily be closed to NGOs. All four resolutions in the Action Circular were supported by the Zambian government and passed globally, paving the way for discussions to commence on how the government would now apply these resolutions in practice. So far, CHN has not followed up with government delegates on the WHA platform resolutions due to a period of election campaigning. The government has not changed, and with the election result finalised, the next phase of implementation influence can commence.

Stakeholders, particularly internal stakeholders, are aware of the national-to-global mobilisation activities but often question their purpose, and a decrease in enthusiasm for taking part is evident. According to ADPs, the first global week of action was significant because it provided information and incentive to staff to talk about big picture child and maternal survival. The MDGs and global process were a world away from local community development, but thinking and discussion around injustice, solutions and accountability for change became more relevant. Community members began to ask about comparing their situation to others.

In followup mobilisations, because this transformation in thinking had already taken place, both staff and community were more likely to question the relevance of taking part compared to more intentional mobilisation, for instance for CVA or community hearings. One stakeholder described this as 'mobilisation fatigue.' However, where community hearings had taken place, ADP staff praised the model, knew how the data had been used, and linked its usage clearly with the Urban Mothers' Walk as a way to bring their challenges into national view.

Some, though not all, internal stakeholders highlighted the 2016 WHA attendance as a pivotal achievement for the campaign. They recognised the shift from outsider to advisor that this represented, and saw it as an indication of the perseverance and personal qualities of the CHN coordinator. However, as noted in the workshop, the need to follow up, ensure appropriate guidance on WHA decisions and continue building relationships is becoming urgent. The theme of adolescent health is currently high on the list of ministry priorities, including SRH and self-care in line with WHA recommendations, suggesting that this area in particular might benefit from advocacy and technical support with multi-sector government.

Conclusions

By attending the WHA as a delegate, the CHN coordinator in Zambia has achieved something unique within CHN campaigns. As with many of the campaign's activities, the achievement was based on relational opportunity rather than a calculated means to a strategized end. It indicates a personal journey for the CHN coordinator who, by the final year, was no longer waiting to be told what to do and when. Thus, the case contributes somewhat to understanding results under Outcome 3: Project Management, and also to an underlying theme and promise from the global campaigns team: that CHN can build organisational capacity for advocacy and campaigning.

There is not currently any outcome associated with the coordinator's direct engagement with ministries. The Zambian delegation supported the four resolutions on child health and nutrition, but may equally have done so without any influence from CHN. Delivery of accountable action and roadmaps is a logical next step when

resolutions are passed, but so far this has not happened except to a limited degree through the MNCH Alliance. The timing of the election in 2016 is a valid reason to delay followup in the current year; however, it seems vital considering the relationships built in May 2016 to ensure advice and support on implementation are prioritised. If the CHN coordinator is transitioning to another role with the closure of the project, then dedicated and diplomatic handover of the relationship with ministries must be a priority.

PART 4: OBSERVATIONS ON PROGRAMME QUALITY



Child Health Now in Mbala ADP has helped with uptake of health services but gaps remain in the services themselves, particularly in human resource implications of increased demand.

4.1 OBSERVATION STRUCTURE

RELEVANCE



IMPACT



EFFECTIVENESS



EFFICIENCY



SUSTAINABILITY



This section takes as its structure the OECD-DAC principles of programme quality: impact, sustainability, relevance, effectiveness and efficiency (including cost efficiency). Observations are drawn from a variety of sources:

- The stakeholder interviews with internal and external reviewers, loosely aggregated into quality themes
- Where relevant, observations from stakeholder interviews and the SMAG focus group on activities, outputs and desired next steps
- Desk review of monitoring records, correspondence and other project management tools
- Desk review of IEC materials, media hits, policy briefs and case study reports

Against the OECD-DAC principles, flaws and risks to sustainability are evident, and the traffic light figure to the left summarises programme quality conclusions. Many of the problems stem from limitations of startup and design and from the lack of cross-functional planning which could have shared and multiplied CHN inputs. There is a strong sense from stakeholders that the campaign is only now hitting its stride at national level, but that relationships have been built in preparation for a powerful phase of influence in post-election stability and accountability. At local level, stakeholders see lessened momentum from CHN, but also lessened need considering the positive programming outcomes of other initiatives: '1000 Days', CVA, Channels of Hope and other social change models. Figure 12 to the left shows the scope of parallel World Vision efforts containing accountability and behaviour change elements. Understanding this interplay, and at time competition, between different health models is important for creating effective integrated programming in the future.

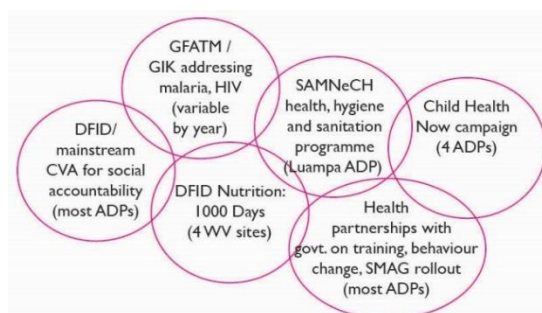


Figure 12: World Vision health programming intersections in Zambia

4.2 RELEVANCE

'I was impressed with them. I hadn't thought of them before as policy partners. Our organisations have worked together for many years but never like that before.'

UN Stakeholder

Stakeholder interviews explored two facets of relevance: the relevance of the health issues that CHN was raising at local and national levels, and the overall necessity of the campaign in the context of Zambia's crowded MNCH sector.

On the relevance of health issues, there was good consensus that Child Health Now was highlighting the urgent priorities for Zambia in line with World Vision and other health strategies, the government's own promises and intentions, and global mandates for improving services and survival rates. Child Health Now conducted a baseline before there was strong understanding in the office of the types of indicators a campaign might aim to change. The baseline survey identifies a number of mortality factors along with their underlying causes, with recommendations for programming priorities as a result. Not all of these recommendations were taken; while there is a clear focus on maternal ANC and delivery services and some partnership on nutrition, very little discourse has taken place on under-five killers (malaria, ARI, diarrhoea) or on the increased vulnerabilities caused by HIV and AIDS. Challenges such as drug stockouts, trained counsellors, bednet supply

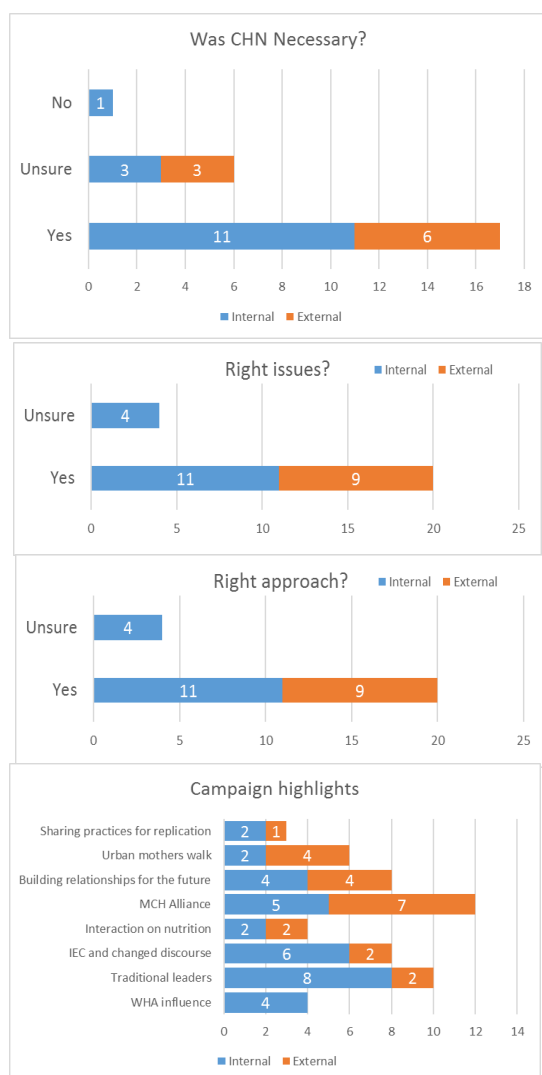


Figure 13: Grouped stakeholder feedback (including internal/external split)

'The campaign didn't come with tools and guidelines. We had to work it out ourselves from other organisations, then tweak to see how it would fit in with our work. The coordinator has been passionate about the work, and we can see her behind all the positive aspects of the campaign.'

WV stakeholder

and usage and PMTCT were not taken up as advocacy platforms. Stakeholders within WV suggested this was due to parallel programming, particularly in HIV counselling and CVA, or with other major donor programmes operating in the same areas.

This explanation does not neatly translate to the national level, where these health challenges may have benefited from increased dialogue on supply, budget and human resource. World Vision's capacity to work on these issues has been limited by its in-house resources; however, there are signs that within the MNCH Alliance, complementary expertise is now joined together and ready to work in these specialist policy areas.

The overall necessity of the campaign does not come out as clearly in project documentation as in stakeholder interviews, because its contributions to others as a support mechanism and resource do not fit into standard monitoring frameworks. Though there are many restrictions inherent in the generic campaign design (see efficiency section), at least the CHN coordinator was flexible to make her own decisions on where the campaign was most needed and where her personal strengths lay. For instance, administrative and relational support to MNCH Alliance startup was a much-needed element. Almost without exception stakeholders saw CHN as a necessary campaign for the Zambian context, some emphatically so. External stakeholders were certain that the MNCH Alliance would have struggled and even folded without patient and consistent support from CHN, while internal stakeholders cited the first year of implementation as the gamechanger, bringing a new rights-focused dialogue into community health activities.

For the ADPs, activities were not as valuable as IEC materials. Because of these, staff and community representatives were able to mobilise action through better awareness of health inequities, statistics and root causes.

Figure 13 groups feedback from stakeholders on three questions: whether CHN was necessary, whether it targeted the right issues with the right approaches, and what the main achievements of the campaign were. The data is segmented between internal and external respondents. Actual numbers, rather than proportions, are cited; because of the small sample size, proportions may be misleading.

Note that in the breakdown on right approach and right issues, though the data appears to be the same, a different set of internal respondents contributed to the 'unsure.' It is positive that all external respondents saw CHN approach and issues as appropriate to the context.

The last question allows more than one response from respondents. The achievements fall largely within the progress phase of change (see Figure.3 p.10) and respondents could not name specific examples of change with the exception of Chief Nsokolo's bylaw. This correlates with the findings of the workshop and implies that from the perspective of stakeholders, the campaign is still mid-implementation.

While there was general agreement on the necessity of the campaign, a high proportion of feedback across stakeholder groups suggested improvements for next time. External stakeholders felt that others from World Vision could have been more visible in promoting and attending the MNCH Alliance considering the respect World Vision commands in Zambia as a programming NGO. While they found the CHN coordinator very responsive to their requests, they were unsure exactly how much they could ask of their partnership with World Vision.

Internal stakeholders were often direct about the campaign's flaws in integration with other programme areas and its reduced relevance and visibility in the final two years. ADP managers felt they were not consulted on the design or the purpose of being a 'CHN ADP'. Each ADP responded to this shortcoming in different ways, and so there was not a unified ADP experience of CHN.

Internal stakeholders also used justification language against their feedback such as 'given the circumstances', 'not a priority' or 'with just one person'... This indicates that CHN was considered the responsibility of the CHN coordinator, more or less in isolation. The activity map from the workshop underscores this observation, with very little CHN input from others within World Vision. Child Health Now was intended to be an organisational campaign with different drivers at local and national level including a cross-functional team for a wide range of partner and community engagement. But interest in attending the cross-functional meetings was low and soon slipped altogether. As a result, internal stakeholders did not see campaign delivery and results as relevant to them. This will be discussed in more detail in the efficiency and effectiveness sections.

4.3 IMPACT

Core to the methodology of contribution analysis / process tracing is enquiry on outcome level change or impact, simply to ascertain whether it exists or not. Two impact areas were found, as described in cases 1 and 2 previously.

The first is tangible. Maternal deliveries have increased in Mbala and maternal and newborn survival has increased as a result, between 2014 and 2016. The graph on p.22 shows data from the district health office provided directly to the consultant. World Vision's contribution to this change, in close partnership with the district's traditional leader, is clear; Child Health Now's contribution within the World Vision initiatives a little less clear but still necessary. Child Health Now reported the bylaw in Mbala district as part of the office's advocacy contributions to World Vision's Partnership Strategy Measures (PSMs)¹⁷, estimating the number of children for whom a root cause of mortality has been addressed in Mbala to be 150,000.

The second impact area is in coordination and better functioning of public health campaigns to improve maternal and child survival. In a

¹⁷ The PSM process collects the advocacy-related measures used to track World Vision's progress towards its overarching goal. Since 2013, offices have provided a national summary of advocacy achievements to which they have contributed, along with an estimated number of children who are likely to benefit from the change. This includes both policy changes and improved or more accountable implementation of those changes.

mainstream programming evaluation, the installation of a government advisory institution such as the MNCH Alliance would not qualify as impact; however, the certainty of its members and associated government representatives that it resolves a number of complications and bottle necks to public health confirms its significance. CHN did not commence the negotiations – it was UNICEF – but stakeholders from government and partner organisations attribute Alliance consensus on purpose, as well as the relatively smooth move towards strategy and sustainability, to the influence of the CHN coordinator.

‘The MNCH Alliance is the right model but it needs to do more. A more consistent noise is needed.’

Government stakeholder

Stakeholders also believed that the Alliance was positioned ideally to start delivering policy results within the year, with a clear action plan including roles and responsibilities written to the end of 2017. Ideally, the MNCH Alliance would retain a small portion of resources for monitoring and assessing change as a result of its interactions with government at different levels in Zambia, so that proof of its value could be drawn more clearly in years to come.

Other areas of measurable impact within ADPs, in particular thorough quasi-experimental results on MNCH indicators from the Luampa-based grant project SAMNeCH¹⁸, are too far removed from Child Health Now to be considered examples of CHN impact. The links were considered at the contribution analysis workshop and also tested with ADP staff, but in reality very little was done through Child Health Now in Luampa ADP. By 2015, after staff turnover and with reduced focus from CHN on local activities, there was little awareness of CHN among staff in the ADP.

4.4 EFFECTIVENESS

Though the campaign does not currently demonstrate a high volume of results, its contributions to overall health programme effectiveness in the four ADPs has had sufficient similarity to be considered a trend. These similarities are:

1. Simply having a campaign, with internal communication, staff reflection and community discussion, has broadened health rights concepts among community members of both genders;
2. Sharing examples of good leadership on health among traditional leaders has set precedents for others to follow, though the shift, particularly for male leaders, takes time;
3. CHN information and mobilisation has acted as a firestarter for Phase I of CVA, and also helped to bring government, traditional leaders and community together for big picture goal-setting in CVA Phase 2¹⁹.

There are important implications for future campaigns in understanding the first point above. IEC materials produced by CHN were minimal, and not translated to local language. It is almost as if, just by existing, the campaign strengthened the resolve of ADP staff to negotiate with local decision makers on health barriers. Next time around, a specific behaviour change communication strategy including regular messages catering to local language and low literacy settings could bring

¹⁸ CHNIS Combined Data Placemats Zambia: Luampa ADP

¹⁹ The CVA model involves four phases of action: the first is awareness raising and the second is participatory mapping of local gaps in services.

'When we went to the NO we would see nice brochures but we didn't have them. They needed to be localised, in the offices of the DC and the chief, translated to local language.'

WV ADP staff

significantly more community support for ambitious reduction goals. In this scenario, the link between campaign inputs and external outcomes would also be easier to identify.

At national level, there is full agreement that the MNCH Alliance is an effective structure, though currently in its stabilising phase and thus not fully tested. It fills a gap and represents new opportunities for recognising and responding to urgent or emergent MNCH issues with awareness and sound policy support. Throughout, World Vision has taken an appropriate support and coordination role. As the Secretariat, CHN has provided the energy and structural guidance to keep other members motivated. The current interest of non-health NGOs to join in order to explore multi-sector solutions to children's and mothers' health is a particularly promising sign that the Alliance is valued. For full effectiveness on policy support, government stakeholders have suggested the MNCH Alliance takes a more proactive role in promoting itself and its action plan, so that the strategic planning converts more intuitively into aligned action with multiple Ministries.

Ordinarily a discussion of campaign effectiveness would include a broader scope of activities, for instance the inclusion of child and youth campaigning, empowering mothers' groups to advocate directly, engaging faith leaders at local and national level, or commissioning and leveraging research. Many of these activities may be taking place in ADPs but not under the banner or guidance of Child Health Now; they do not appear in the project's activity plans.

'We also need an advocacy link to hygiene and WASH.'

WV stakeholder

No policy analysis or situational research was directly commissioned or published over the campaign's lifetime²⁰. This is unusual. Research is not only a lifeline tool for all MNCH actors; it also positions advocacy organisations for influence by showing that they are well informed of evidence and arguments to support a case. Before the identification of distance to health facilities as the final, and most challenging, barrier to full facility deliveries, the campaign had not presented any primary data, or indeed, any compelling analysis of existing data, to support its claim to be an authoritative voice. Even now, it is not possible to pick up a document that, for instance, combines the results of the Citizens' Hearings with the realities of health post shortages in Northern Province compared to government commitments, and identifies solutions to fast track infrastructure and human resource.

The evaluation site visit to Mbala showed that with the increase in facility deliveries, existing health posts were under extreme pressure to meet demand. TBAs and SMAGs sometimes stayed with their clients throughout delivery because it was evident that clinic staff were too busy to give anything but basic care. While all this is undoubtedly saving lives, it is not the intended model.

4.5 EFFICIENCY, INCLUDING COST EFFICIENCY

In terms of programme efficiency, and linking to the conversation above on effectiveness, CHN was able to trigger actions in others through relatively small inputs. Many of these were ad hoc, rather than planned.

²⁰ Zambia was included as a high burden nutrition country in the multi-country nutrition 'Nutrition Barometer' (World Vision and Save the Children 2012), but unfortunately this was released earlier than the recruitment of the CHN coordinator, and was not subsequently used to leverage discussion and action.

'Stopping and starting because there is a new idea from outside WV Zambia is hard. We need to let things go longer, to run their course.'

WV stakeholder

At the same time, some of the planned activities took some time to show their relevance. This seems linked to the design phase. The logframe and monitoring indicators do not reflect a clear Theory of Change linked to Zambia's contextual opportunities. For instance, in Year 1 and Year 2 the campaign engaged through ADPs with traditional leaders, but it was not until Year 3 that the purpose for doing so began to become clear. The campaign was then able to develop and explain a more formal engagement strategy with solid targets for change.

A number of activities would have had greater momentum with better internal integration, particularly with ADP annual planning, CVA and communications. Particularly in the early years, CHN appeared to be duplicating activities that may have been more effective and sustainable if delivered directly by ADP teams. There is a case to be made that CHN's slow start and integration challenges were linked to the existing strength of the health programme in Zambia. From engagement with traditional chiefs through to CVA and data collation, campaign principles were already in motion and needed few additional activities in order to gather momentum.

CHN worked as instructed by regional and global teams on the global mobilisation moments of the campaign in Years 1, 2 and 3. It does not seem that the office received sufficient advice from the technical teams outside WV Zambia to convert these activities into advantages for the local campaign. With the exception of the Community Hearings, which became the data source and inspiration for the Urban Mothers' Walk, activities of this nature do not connect at all with the campaign's change map (Annex 7).

'I don't know if it was just coincidence that CHN and CVA were working in the same ADPs but it was a strong combination that should continue.'

WV ADP staff

The MNCH Alliance is the only area where the campaign worked directly to fill a gap, and as it strengthened, so did the clarity of purpose for the campaign. Activities began to connect with greater accuracy and effectiveness to hit targets. The campaign coordinator also began to take more decisions around annual planning and best use of budget, including the decision not to engage in the 2015 Global Week of Action.

By the end of the project, most of the loose ends created by isolated activities were beginning to tie back together. The exception is media engagement, which does not appear to have left the ground despite multiple activities. Renewed efforts, probably through the MNCH Alliance, will help to foster discourse and demand in the public space on MNCH issues longer term.

The project experienced some compliance challenges in budget management, including underspends in most years which were negotiated as carry-forwards.

Cost efficiency

It is not practical or particularly accurate to attempt a full cost benefit analysis of Child Health Now. As is usual for advocacy, this was a low cost model with no capital expenditure and the majority of activity funds allocated to transport, hosting exposure visits and meeting costs. The decisions taken at the WHA in 2015 and 2016 have potential

under the right implementation to benefit all children in Zambia over time, while improvements to the National Food and Nutrition Commission act, when it passes into law, will likewise bring new opportunities to overcome undernutrition, stunting and wasting across the country. However, these are future results; as well, to connect a small set of CHN engagement activities to a projected Zambia-wide quantitative measure of change is a step too far for this methodology.

More tangibly, it has been validated that CHN has contributed uniquely and necessarily within the broader frame of World Vision activities to the uptake of health facilities for delivery in Mbala and to the installation and effectiveness of the MNCH Alliance at national level in Zambia. In the first instance, the ADP covered costs of the majority of engagement and training activities in partnership with local MoH representatives, meaning the cost burden for CHN remained low. Costs of setting up the MNCH Alliance were largely covered by a successful funding proposal to UNICEF for US\$13,000. A further proposal to FACT for US\$100,000 is at final stages, with the money to be used to scale up activities in line with the Alliance's workplan to the end of 2017.

Based on this, it appears that CHN funds have been efficiently used to bring about exponential change through other actors. A stronger results focus in monitoring activities would have helped to draw more helpful conclusions in this regard; for instance, the reach and results of radio media buy were not measured, so the value and cost effectiveness of this decision cannot really be determined.

4.6 SUSTAINABILITY

'Child Health Now needs to go to ADPs now, repackaged on what we want to do and the resources we have to do it.'

WV ADP staff

The campaign's potential for sustainability of efforts and outcomes is high, but certain decisions and actions must be taken now to deliver this. It was generally agreed among stakeholders that the work is unfinished, but, particularly with internal stakeholders, not a strong intent to push through on the final pieces once the project is finished. This can be linked to the observations on low organisational ownership. The pieces are actually in place for health advocacy to continue and expand in the hands of ADP teams, through the LEAP3 technical programme

Programmers still wanted a central entity to plan, coordinate and remind them about health policy goals, seeing this as the main value of the campaign to date. On closer reflection around this theme, many recognised that local planning of relevant campaigns was preferable to top-down coordination. There was good consensus that a continuing technical role should be folded into the health team, rather than remaining in advocacy. This solution matches with the current strategy for the technical programme, as health advocacy can be an approach within the ADP toolkit where appropriate.

At national level, World Vision is no longer needed as an instigator and builder of the MNCH Alliance, as it has been confirmed by many that the network is strong and effective; that phase is complete. But World Vision is a major actor in maternal and child survival across the country, partnering with the Ministry of Health to implement a number of nutrition, IYCF, IMCI and CHW/SMAG policies. Foregoing a leading role in the Alliance would be out of keeping with the organisation's size

and influence, and reduce opportunities for ongoing coordinated collaboration with multiple government ministries. It is vital that World Vision stays deeply engaged with the Alliance.

With regard to the unfinished business of direct policy influence on WHA 2016 resolutions, the value of a significant proportion of campaign activities is on the line. If nothing further happens, efforts from 2014 onwards lead nowhere, but if change progression to implementation roadmap and partnership takes place, then it becomes a substantial long-term legacy of CHN in Zambia. The CHN coordinator is at this stage best placed to continue discussions, due to her unique relationship with the delegation, and there is no succession plan in sight yet.

There are a number of pathways to be chosen based on these observations:

- The best way to build skills and will within the health programmers to claim more influential relationships with local authorities;
- How to set integrated goals and targets for policy improvements locally;
- Selecting an appropriate long-term participant for the MNCH Alliance and ensuring a thorough and relational handover;
- Finding ways to continue the post-WHA engagement to its logical conclusion.

PART 5: CONCLUSIONS, LESSONS AND NEXT STEPS



Zambia delegation to the 2016 World Health Assembly, Geneva, with Child Health Now coordinator Ms. Chitimbwa Chifunda, front row, second from right.

5.1 CONCLUSIONS ON RESEARCH QUESTIONS

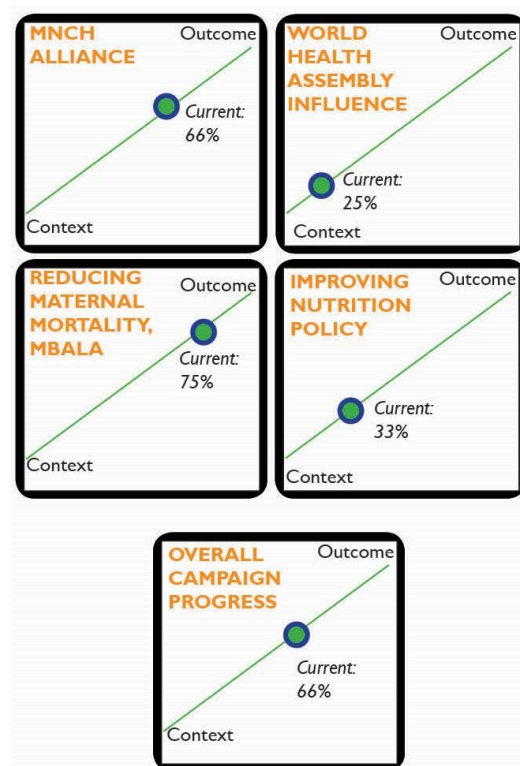


Figure 15: Pinpointing progress: four mapped outcomes plus overall campaign progress

1. To what extent, and in what way, did WV Zambia achieve Child Health Now objectives?

The Child Health Now campaign in Zambia started hesitantly, but picked up speed along the way, and eventually found a legitimate space between programming and policy where it could support the outcomes of other health partners. This is not directly comparable with the project logframe which was too generic in its high level objectives to be of help in measuring extent of results. The campaign brand and identity were not highly visible in or necessary to achievements; however, the actions taken by staff as a result of the Child Health Now project led to tangible positive changes in landscape and policy for maternal and child survival.

Stakeholders at the workshop mapped where they believed the campaign currently sat on its pathway to change for the two identified outcomes: the MNCH Alliance and the traditional bylaw in Mbala. For consistency, the consultant has added the same map for the case studies reinstated after the workshop based on positive stakeholder feedback: the support to SUN CSO Alliance and the positioning of World Vision as an advisor to government on the 2016 WHA results. Figure 15 to the right shows the four maps, plus an overall pinpoint of the campaign's position as of September 2016. These are intended to give some – though qualitative – perspective on extent of campaign's achievement against outcomes goals developed during the campaign.

2. What have been the enabling and limiting factors to achieving change?

Enabling factors:

- The campaign's emphasis on health rights
- Engaging traditional leaders and customary law
- Relationships

Limiting factors:

- Low campaign visibility
- Generic guidelines and technical support

Enabling

The campaign's emphasis on health rights: bringing concepts of health rights, inequity, accountability and policy solutions into local level programmes, appears to have been an enabler. Measurable ADP results, particularly in Luampa ADP, had no tangible connection with CHN activities, yet staff from all four implementing ADPs said that the early years of CHN had been important to their programme. In this organisational context, CHN was timed and positioned in a way that appealed to staff wanting more from their programme results. It seems that this was serendipitous, rather than a planned organisational change, which is highly relevant to the next campaign; imagine what might have been possible if this ethos change had actually been planned and resourced?

Engaging traditional leaders and customary law is part of WV Zambia's strategy for community development and core to success in this context. In line with this strategy, activities from Year 1 onwards connected the CHN messages and desired outcomes with chiefs in ADP areas to encourage greater responsibility for behaviour change in particular. Chiefs met each other to learn by example, which appears to have been a powerful moment for shifting the horizons on what they personally could do to bring change. Statistics on district inequities were also used to good effect. With traditional leaders keen to see improvements resulting from their actions, some are now monitoring primary sources of data on behaviour, morbidity and mortality.

Relationships emerge clearly as foundational necessities for achieving change. Where relationships were already in place – for instance with

traditional leaders in ADPs – or able to form quickly, based on shared vision and goals – for instance with the first few members of the MNCH Alliance – subsequent inputs were welcomed and acted on. The CHN coordinator brought good relational skills to the campaign which helped to build collaborative networks. Direct and MNCH engagement with the SUN CSO Alliance also brought SUN results.

Limiting

Low campaign visibility, including within WV Zambia, is related to the point above as a limiting factor. The campaign coordinator was the only member of staff consistently using the brand to engage on children's health, and even then, it was not well recognised by external stakeholders. More consistent interaction between World Vision technical teams (health, nutrition, HIV, advocacy) and their counterparts in other Zambian organisations or government departments was needed to cover the full range of issues and opportunities in this context.

Generic guidelines and insufficient technical support from regional office, global centre and support office limited the success of WV Zambia in terms of growing into a campaigning organisation. Though Zambia has similarities to other sub-Saharan African nations, its context is of course unique. In the absence of targeted, two-way technical support, the office drifted towards what they already knew best: health programming. Without situation analysis or policy gap analysis to guide, the design was generic, the baseline anthropomorphic and the outcomes lacking acknowledgement of policy as a target. With hindsight, the internal stakeholders involved from the beginning of the campaign agree that they would do things differently given the chance.

3. Building on the experiences of the Child Health Now campaign, what practice and lessons learned can inform WV advocacy campaigns in the future?

The lessons listed below are intended to support planning and design process for the next campaign, but they also highlight ways that integrated health advocacy might continue and strengthen in a new phase of mainstreamed implementation.

Campaigns lose time by being generic

The Child Health Now logframe articulated three outcome goals: one on practices and behaviours, one on increased access to health services, and one simply entitled 'project effectively managed'. None of these were supportive to rapid and compelling external engagement, the cornerstone of successful campaigning. Until the campaign was able to identify a clear strategy for change in policy or political will, its activities were mainly compliant, to an annual plan of good but isolated ideas. Many campaigns underestimate the time needed to find their feet and their real purpose. Thus there is a choice implicit in this learning: firstly, to allow 18 months to 2 years of relative inaction while quality landscape analysis and other behind-the-scenes work takes place, or secondly, to select and articulate a campaign policy target as the very first step to designing the campaign?

Policy analysis and policy monitoring technical skills are essential

WV Zambia is conducting advocacy in more than one sector, at national level through the Director of Advocacy and Communications, and at local level largely through CVA, Child Protection and Advocacy (CPA) and Channels of Hope. The organisational structure for advocacy does not include a policy specialist. This may have been the reason for the slow adoption of a specific policy platform for Child Health Now. Effective

'Policy at national level, implementation at local level; it could be a great model with more practice.'

WV ADP staff

advocacy should include a 'finger on the pulse' for constant updating of policy climate, allies and foes, opportunities and precedents. Whether World Vision maintains or outsources this function, or even borrows it through skill-sharing in arrangements similar to the MNCH Alliance, it should be considered essential to the next campaign.

'Go-to' activists in church and youth groups represent a missed opportunity

Two important mobilisation audiences visible in other CHN campaigns – church congregations and youth groups – have been left out of implementation activities in Zambia. Both partner on a massive scale with World Vision throughout Zambia and both can be enthusiastic and compelling advocates in their community for issues affecting children. Youth groups in particular usually enjoy the challenge of a new topic for peer education or street theatre. Local level activities and outcomes may have been multiplied with more 'go-to' campaigners engaged and active.

Advocacy benefits from a steady human resource base

The CHN campaign in Zambia has benefited from staffing consistency with the same person in place for four years. Any staff movement now places these relational advantages at risk. Once the CHN coordination position formally ends, it will be important to shift the focus of health advocacy relationships with this in mind. There is still demand both internally and externally for a 'familiar face' to help steer conversations and negotiations on health advocacy requirements. A long-term structure using existing positions will have better success than stopgaps or phase outs.

Strengthened networks of advice and support are needed for first-time campaigners

World Vision maintains advocacy technical capacity at regional and global levels, and a specific Child Health Now regional coordinator was in place in Southern Africa during the majority of the Zambia CHN implementation. But the startup delays of the campaign, as well as feedback from staff, indicate that there was a problem with sharing this technical support of the RO and GC in a meaningful way with offices. These systems are in place specifically to build office capacity on campaigning. World Vision needs to question the responsiveness of their inter-office technical support to work in context and partnership with offices as clients.

Campaigning required greater organisational redefinition than anticipated

Advocacy can be a low-cost, high-impact proposition in the right hands, but requires others to free up time and funds for activities contributing to campaign goals. In the Zambia context, there was little take-up of Child Health Now as an approach for change in ADP designs, as well as some hesitation to give time to the campaign at local and national levels in light of competing priorities. The communications components of the campaign were also not absorbed smoothly into ongoing communications work plans. Under better organisational ownership, a greater volume and diversity of outcomes might have taken place.

Traditional leaders are key

WV Zambia's local engagement approach pays great attention to the role of traditional leaders as guardians and champions of local development. CHN built a path for these leaders to follow, including a presence in

existing networks through presentation at House of Chief gatherings as well as creating new connections with 'Change Champion' meetings. However, it is important to note that CHN did not create the initial relationships with leaders and has never been the primary contact. Appropriately, this relationship already sits with ADPs, meaning that similar engagement and requests for support to MNCH can and should continue.

Community-led 'zero' campaigns

The experiences in Mbala ADP with the participation of the traditional leader along with the softer encouragement of the SMAGs led more than one stakeholder to compare the approach to Community-Led Total Sanitation, and to wonder if more models aiming for universal behaviour change could be created. Zero home births and full vaccination appear to be strong contenders as issues to be resolved through these approaches. As the line between campaigning on accountability and on public health / behaviour change has been blurred in ADPs for this campaign, the experience in Mbala seems highly relevant for further refinement of this idea.

Working in alliance overcomes organisational limitations

Stakeholders associated with the MNCH Alliance note a critical advantage to their membership in the expansion of skills and experience at their disposal, mentioning in particular the value of dedicated coordination resources from World Vision and Path. In exchange, CHN was able to call on expertise previously unavailable to World Vision. For instance, budget analysis was an area where significant pressure was applied from the global campaigns team, as well as from MoH representatives. This is a highly specialist and scrutinised skill not held internally at World Vision. In partnership, however, it is now possible to track and advise on health budget as one of the Alliance's four core functions.

Local to national works - and is needed

World Vision staff showed a good understanding of the principles of local to national data transfer, particularly for advocacy priorities and evidence of gaps and needs. Actually doing it was more challenging, but there were tangible examples where it was working. External stakeholders expressed satisfaction with nutrition figures and IMCI gap analysis provided to them, while internally the ADPs involved in the community hearings were pleased to see their data eventually feed into the Urban Mothers' walk. The CVA stream has also advised at provincial and national level on gaps, though the link to CHN in this is negligible. The ability to do this is a core organisational asset for World Vision, and partners want more.

Research is a crucial input to policy change

The ability to say something new, or in a new way, is essential to advocacy campaigning. For World Vision in particular, access to community data including anthropomorphic, social and action research has clear potential for reframing dialogue on MDG / SDG national statistics. For CHN, spending time and money in the first six months on flagship issue research might have seen reduced implementation delay, clarity of messaging to partners and internal stakeholders and activities that linked systematically to the change desired. Quality research has an additional advantage in profiling the organisation as a research and learning partner, which in turn increases access to media and partner platforms to share key messages.

5.2 NEXT STEPS

For the global campaign on child protection

The new campaign launches in a significantly changed organisational context from that experienced by CHN in 2012.

- Firstly, advocacy is a well-articulated approach in the Child Protection and Advocacy toolkit, where offices across the Partnership select contextually appropriate models to improve reporting and referral, community awareness, support to families and life skills for children.
- Secondly, the EVAC campaign begins as it means to continue, in an integrated and community-led planning process. Each ADP or associated project takes ownership of campaign activities and outcomes. The new reporting database Horizon is core to this proposal as it allows indicator and outcome reporting across different projects and programmes. DME guidelines for the new campaign are now available.
- Thirdly, WV Zambia is launching its technical programme from October 2017. Earlier lessons from CHN formed the basis of guidance within the TP on health advocacy, and now, though dependent on the knowledge and confidence of local staff to negotiate policy, the advocacy components seem likely to lead to further thinking and spontaneous engagement on policy implementation across a broad range of sectors.

However, considering the lessons above, there are still several decisions to be taken around strategy, staffing and structure for the next campaign. It will be crucial to ensure sufficient funds and expertise are available to step into a research function this time around. For ADPs, participation in the campaign needs to be driven by community planning and priorities and, though Horizon may solve many data transfer issues, programmes are still likely to require support and encouragement to monitor social and policy change. In terms of national level campaigning and coordination, with the new campaign a cross-sector outcome, a broader range of technical support and coalition membership is likely to be called for than was the case with the health campaign.

The shift to integrated campaigning also leaves a gap in strategy and design at the national level. At the least, a clear multi-year, resourced workplan should be set for national engagement. Given the right technical support, it may even be possible to create a whole-of-advocacy workplan that incorporates and integrates multiple themes and ministry relationships and anchors activities to outcomes at local, district and national levels.

For ongoing health advocacy

The evaluation demonstrates a project that is only partially complete, with stakeholder consensus that certain aspects are only now maturing. Both at local and national level, ways should now be found to build on CHN relationships and shifts and maintain World Vision's presence as a supporter and implementer of policy.

The Ministry of Health works closely, and almost daily, with World Vision in many districts, on training of SMAGs, CVA for health, implementation of IMCI and IYCF strategies and on public health

'We still need Child Health Now because we still have the issues - low participation, low understanding, councillors who need the technical advice. As long as these challenges remain, the model of advice and accountability is needed.'

WV stakeholder

'We need to stop 'preaching to the converted' and start working with non-conventional actors, for instance commerce on the suspension of the Breastmilk Substitute Code.'

NGO partner

campaigning including the '1000 Days' campaign. All of these activities have policy and negotiation components. ADP managers interviewed were confident to ask both local government and chiefs for help in progressing towards behaviour change (CHN's Outcome 1), while effective CVA supported increased access (CHN's Outcome 2). But even at the same time as doing these influential activities, ADP staff expressed trepidation that they would need to stop, because the campaign was ending. There needs to be clear leadership on this as the campaign transitions, so that advocacy remains a valued tool in the health programme. At national level, World Vision is needed by the various committees, consultations and alliances advising government on health policies and accountabilities, and a succession plan, not a phase-out, is needed.

The campaign has been using MDG goals and associated global structures as its guide. In 2016, the dust is settling on a changed global landscape as the SDGs begin to become familiar. Health SDGs are highly relevant to Zambia including maternal, newborn, under-five and adolescent targets. This is an important time for further examination, even research, of policies needed to deliver specific SDG results in Zambia. While root cause research was a conspicuous gap in the Child Health Now campaign, it is not too late to redress this, and is needed just as much as it ever was.

If Horizon delivers on its promise, it should become easier to aggregate and compare statistics and promising practices from health programmes across Zambia. Government and partner stakeholders expressed great interest in these sorts of reports, with one government representative saying it was an unmet accountability of World Vision to provide greater transparency into their reach and results.

5.3 RECOMMENDATIONS

For the End Violence Against Children campaign in Zambia

- Select issues and goals that are 'campaignable' – that have maximum potential for audience reach and interest.
- Develop full and consultative secondary strategies for the next campaign in: communications (including internal communications), gender, CVA and Evidence and Learning.
- Within this, articulate an outcome-focused media engagement strategy to ensure that media buy, hosting and pitching connect to the campaign's long-term goals.
- Use national situation analysis to target membership on influential coalitions and working groups, rather than going it alone.
- Continue to upskill both communications and advocacy teams in campaigns communication and stakeholder engagement.
- With the election over, conduct a multi-sector analysis on policies affecting child wellbeing, **in advance** of the design workshop and decisions on the next primary campaign theme.
- Include government and partner representatives in the design workshop for full alignment of priorities and purpose.
- Encourage internal questioning and dialogue on advocacy and campaigning purpose, to refine both the effectiveness and the measurement of advocacy and campaigning inputs.
- Ensure plentiful, reader-friendly IEC materials are available for

staff and community in ADPs.

- Invest leadership time in necessary organisational change for shared ownership of the global campaign; try the cross-functional team planning approach again under these changed conditions.
- Connected to the above, ensure CEO-level networks exist to encourage collaboration and shared voice in Zambia on campaign issues.

For ongoing health advocacy in Zambia

- Add World Vision voice to relevant national policy pushes: the reinstatement of the Breastmilk Substitute Code, the completion of the NFNC, and the roadmap for 2016 WHA ratifications.
- Connected to the above, scale up support to adolescent health programming based on World Vision's experience and current Partnership research in this important field of health.
- Succession planning for continuation of national relationships (MNCH Alliance, WHA delegation).
- Set annual organisational KPIs for local to national data transfer and health reporting, to meet accountability expectations from government

For World Vision as an advocacy partner in Zambia

- Urgently change internal messaging on CHN to remove the perception that health advocacy is finishing.
- Include deliverables for the EVAC campaign in WV Zambia management expectations and reviews.
- Create systems for regular aggregation and analysis of health data, to share with government and partners.
- Standardise the use of theory of change for advocacy initiatives to ensure advocacy across all sectors is not activity-focused (and thus dead-end/loose-end)
- Seek support of regional or global Evidence and Learning Unit to set a research strategy for the office that can support campaign engagement.
Consider networking with other offices who work with dual laws and governance to enhance advocacy approaches to traditional leaders.

For government and partners to World Vision in Zambia

- Discuss data and research requirements in detail with WV, who is often in a good position to provide these.
- Within the Alliance, continue to work on health budget support on behalf of the Ministry of Health.
- Raise the possibility of M&E practices within the MNCH Alliance to demonstrate its value medium-to-long term.
- Through the MNCH Alliance, develop plans for the Mothers' Walk as an annual accountability event.
- Engage in early conversations and consultations on the EVAC campaign with World Vision, to explore thematic synergies and priorities.

ANNEX I: BIBLIOGRAPHY AND DOCUMENT REVIEW

World Vision documents	Government, agency and academic literature
<p>2012: Child Health Now Campaign Strategy</p> <p>2013: Child Health Now Annual LEAP report</p> <p>2013: Child Health Now Indicator Tracking Table</p> <p>2014: Child Health Now Annual LEAP report</p> <p>2014: Child Health Now policy brief</p> <p>2015: Luampa ADP Annual Report</p> <p>2015: Southern Africa regional CHN Scorecard</p> <p>2015: Child Health Now Annual LEAP report</p> <p>2015: Child Health Now Indicator Tracking Table</p> <p>2015: Child Health Now Campaign Programme</p> <p>2015: CHNIS Combined Data Placemats Zambia: Luampa ADP</p> <p>2015: Citizens' Hearings Report</p> <p>2015: Urban Mothers' Walk policy brief</p> <p>2016 Child Health Now Semi-Annual LEAP report</p> <p>2016: The New Global Campaign to End Violence Against Children v.1.0</p> <p>2016: WV Zambia Technical Programme design and logframes: WASH, MNCH</p> <p>2016: DME guidance, EVAC campaign</p>	<p>ACCA 2013 <i>Key health challenges for Zambia</i> Association of Chartered Certified Accountants 2013</p> <p>Amsterdam Institute for International Development 2011 <i>Budget Support in Zambia: Health</i> January 2011</p> <p>Family Care International 2013 <i>Mapping Maternal Health Advocacy: A Case Study of Zambia</i> ed. Beth Ann Pratt</p> <p>GoZ 1994, <i>Chapter 287 The Chief's Act MoLA, Govt. of Zambia</i>, Ministry of Legal Affairs 1965, updated 1994</p> <p>GoZ 2011 <i>National Health Strategic Plan 2011-2015</i>, Government of Zambia, Ministry of Health</p> <p>GoZ 2012 (1) <i>Adolescent Health Strategic Plan 2011-2015</i>, Directorate of Public Health, Government of Zambia April 2012</p> <p>GoZ 2012 (2) <i>National Health Policy 2012</i>, Government of Zambia</p> <p>GoZ 2013 <i>Roadmap for Accelerating Reduction of Maternal, Newborn and Child Mortality, 2013 – 2016</i>, Government of Zambia (MoCD, MoH) April 2013</p> <p>GoZ 2015 <i>Demographic and Health Survey 2013-2014</i>, Government of Zambia with USAID, UNICEF, UNFPA, CDC</p> <p>IHME 2014 <i>Assessing Impact, Improving Health: Progress in Child Health Across Districts in Zambia</i>, Institute for Health Metrics and Evaluation, University of Washington/University of Zambia, Seattle 2014</p> <p>Kyei et al. 2012 'Quality of ante-natal care in Zambia: a national assessment', in <i>BMC Pregnancy and Childbirth</i> 2012, 12:151</p> <p>Millennium Development Goal Initiative 2014, <i>Assessment of the Regulatory Framework for Maternal, Newborn Child Health and Nutrition Services in Zambia: Final Report</i>, MDGi/Govt. of Zambia/UNICEF/EU July 2014</p> <p>Path International (undated) <i>Improving the health of women and newborns in Zambia</i></p> <p>Phiri and Ataguba 2014 'Inequalities in public healthcare delivery in Zambia', in <i>International Journal for Equity in Health</i> 2014, 13:24</p> <p>UNDP 2010 <i>Assessment of Development Results: Evaluation of UNDP Contribution, Zambia</i>, Evaluation Office February 2010</p> <p>UNICEF 2013 <i>Immunisation Summary to 2011</i>, updated version 2013</p> <p>Zulu, K. et al. 2013 'Developing the national community health assistant strategy in Zambia: a policy analysis' in <i>Health Research Policy and Systems</i> 2013, 11:24</p>

ANNEX 2: CONSULTANT SCHEDULE AND DELIVERABLES

Task	Approximate date
Phase 1: <ul style="list-style-type: none"> Finalisation of TOR, agreement of timeline based on consultant availability, identify potential external indicators, identify supporting documentation, notification of workshop stakeholders and setting workshop date. Interview schedule, content, purpose drafted and approved; shortlist of primary (essential) key informants; report structure drafted and approved; documents provided; document review and background/inception report drafted and approved. 	17-19 August 22 August – 2 September
Phase 2: <ul style="list-style-type: none"> Travel to Zambia In-country workshop; site visit 1; interviews Lusaka; writing results Site visit 2; coordination and analysis of any external data collected; final interviews; analysis, report writing and delivery of executive summary; presentation to WV Zambia of results Travel from Zambia 	3 September 5 – 10 September 12-16 September 17 September
Phase 3: <ul style="list-style-type: none"> Draft full report written and submitted for review Review and feedback; final changes, external version and any associated materials ready for use 	19-23 September 26-30 September
Deliverable: all associated materials submitted, reviewed, signed off	30 September

ANNEX 3: CA-PT overview

Theory-based evaluation starts with a theory, generated by logic and common sense, describing how and why a certain outcome happened. This form of research notes that every social situation is unique. We assume that a series of mechanisms, in a particular context, and playing out in a particular way order, have together been the cause of a particular outcome. This is CMO theory.

Contribution analysis and process tracing are both theory-based research applications that aim to understand the significance of individual mechanisms within a CMO story.

Contribution analysis (CA) is often used in policy impact evaluation but is accused of lacking rigour; results are sometimes seen as subjective. Process tracing (PT) is not usually suited to impact evaluation because it requires the prior existence of a case in order to test it.

Combining the two lines of research solves both these problems. Contribution analysis builds a case for process tracing to examine. Cases can also be linked together when mechanisms contribute to more than one outcome, making it possible to map the full range of influences (contextual and actor) that have brought about change.

The CA-PT combination is also a 'stepping stone' measure. It can be used even if the final level of change (social impact) has not been achieved. For instance, if a policy has been tabled but not yet passed, we can still examine the steps that have led to this partially achieved goal, and use this information to make sure the next steps make the most of what has gone before.

How can we apply this to Zambia's Child Health Now campaign?

1. Desk review of project history, monitoring, indicators of change.
2. Stakeholder workshop to map change and build CMO theories for them (a case)
3. Considering evidence for the CMO; what could prove or disprove this case?
4. Interviews to collect broader and different perspectives to triangulate versions of the case.
5. Logical analysis of results: is the case proven 'beyond reasonable doubt'? Are there any other possible explanations?
6. Causal mechanisms confirmed or ruled out; final interlinked CMO map shows programme results (impact, and the stepping stones beneath impact).

Context

Policy and political landscape

Mechanism

Influences including our own

Outcome

Positive change to policy; positive change to demand, attitude, political will, public debate

Logic proves/disproves the case

The logic of process tracing is often compared with detective work, where a crime has been committed and there are multiple suspects, clues and connections. The role of the evaluator is to find the most likely chain of events that have led to the outcome whether or not it includes our intervention.

"A coincidence! The odds are enormous against its being a coincidence... No, my dear Watson, the two events are connected—must be connected. It is for us to find the connection."

Detective Sherlock Holmes,
in Arthur Conan Doyle's
Adventure of the Second Stain

ANNEX 4: WORKSHOP BRIEF AND AGENDA

Workshop brief

Participant criteria:

People who:

- Have worked closely with the project with a good understanding of its multiple approaches and outcomes;
- Are able to identify anecdotally changes to systems, capacities and will to benefit maternal and child survival now and in the future
- Are able to describe how the project links with these changes, but also other contextual factors in play that were present and necessary to the case outcome

Ideal participant numbers:

- 12 -16 people plus facilitator

Participant mix:

- Around one half internal staff: project managers, technical advisors and donor liaison
- Around one quarter government or ministry representatives who have played a part in policy change or implementation within their sphere of influence
- Around one quarter partner representatives, for instance: (national) coalition partners, ongoing joint campaigners, affiliated health activists or contributing researchers; (grassroots) community mobilisers, child advocates, health clinic managers, who have shared in the implementation process and its results

Benefits for participants:

- Sharing their own experiences while learning about parallel experiences and perspectives, to shape 'shared memory' of the project over time
- Ensuring that priority themes are included in evaluation enquiry, including their own achievements
- Early consensus on programme results, what can and cannot be included among them, and standout practices or models for influencing child protection systems and structures
- Celebration of teamwork and a share in results

Tentative workshop agenda: September 5 and 6, Lusaka

(Note that due to lower than expected attendance at the workshop, the agenda was covered in a single day.)

DAY I		
Time	Session	Purpose/Outcomes
8.30	Introduction <ul style="list-style-type: none"> Welcome and overview of methodology (Katie) Recap of program history and key achievements (Chitimba) 	Participants understand the value and legitimacy of qualitative theory-building for evaluating policy improvement.
9.30	Theory-based evaluation overview (Katie) <ul style="list-style-type: none"> What is theory-based evaluation? Global CHN theory of change and the evaluation methodology. Summary of results, global and national evaluations. CA-PT Overview Constructing Contribution Claims through CMO 	Participants are ready to place their experiences of Child Health Now within the broader framework of results and outcomes.
10.30	Break	
10.45	Mapping results: groupwork <ul style="list-style-type: none"> Participants identify significant milestones and achievements and assign them loosely by: <ul style="list-style-type: none"> Logframe outcomes Outcome/interim outcome/output 	Participants have built a results framework through consultation and sharing of experiences.
11.45	Analysing mapped results: together <ul style="list-style-type: none"> Validation of identified milestones/achievements Removal of duplicates and identifying connections and interdependencies Adjustments to assignment where necessary between outcomes, interim outcomes and output Consensus on which cases are most significant for further enquiry (5 to 7 is ideal). 	Participants have jointly identified what has been important or impactful about the project, as well as an agreed timeline of project history
1pm	Lunch	
2pm	Case study building: group work (small groups) <ul style="list-style-type: none"> Appropriate stakeholders in identified cases construct a theory of change showing steps, shifts and contextual factors inside/outside World Vision. They are also encouraged to come up with alternative theories that devalue the project's significance, as the disproving of alternatives is important to contribution claim. 	5 to 7 case studies with interlinking elements, agreed by participants as representative of program experiences including external context.
3.30	Break	
3.45 – 4.45	Continue case study building	

DAY 2		
Time	Session	Purpose/Outcomes
8.30	Presentation of cases: together <ul style="list-style-type: none"> Q&A allows all participants to add to the case and question the logic. Facilitator identifies counterfactual or alternative theories and seeks initial advice on evidence sources for proving causal links. Allow half an hour per case study. 	Line of enquiry for further analysis and validation is set with participant input.
10.30	Break	
10.45	<ul style="list-style-type: none"> Continue previous session 	
12.30	Lunch	
1.30	Current state, next steps: recommendations <ul style="list-style-type: none"> In groups, analysis of opportunities and priorities for future health policy and partnerships. Discussion of transition from health-focused CHN to child protection – synergies and challenges (Katie to present global CP organisational baseline summary) 	Questions of sustainability of progress are raised and answered with clarity of responsibility for continuing momentum.
3.15	Break	
3.30	Stakeholder analysis: together <ul style="list-style-type: none"> Proposed KIs: who, and which case studies will they be best placed to comment on? Discussion of tools, final questions on methodology and process from here. Identify provision of additional documents where relevant to back contribution claims. 	Participants agree on the right mix for further consultation, ensuring transparency and balance for qualitative enquiry
4.30	Workshop closes with short feedback session and thanks	Facilitator identifies any outstanding issues or concerns with methodology and is able to address them post-workshop.

ANNEX 5: GUIDE QUESTIONS FOR SEMI-STRUCTURED INTERVIEWS (SSIs)

Introductions, confirmation of informed consent.

Please describe your role and how it connects with maternal and child survival.

Please describe your role or connection with Zambia's CHN campaign (how long, how close, for what purpose?)

Please describe the challenges of maternal and child survival in Zambia. Getting worse or better? Why?

To what extent is this as a result of the Project, and to what extent as a result of other factors? What / who else?

What were some of the Project's best achievements? (If appropriate, what are you personally proud of?)

What were Project strengths? Any particular approaches or ideas to highlight?

What challenges were faced? Could the Project overcome them?

How did you find the process? Efficient, relevant, good quality? Any examples?

(If not already discussed) How does this project reach the most vulnerable? Was enough done on inclusion and participation of all community groups and children?

What needs to happen next? What should World Vision / government / partners prioritise?

Additional lines of enquiry may need to be added as a result of the workshop and the validation requirements for case studies.

Is there anything else you'd like to talk about? Were there any questions you thought I might ask that I didn't?

ANNEX 6: INFORMED CONSENT HANDOUT

Participation, privacy, confidentiality – informed consent

About this interview

Thank you for agreeing to share your perspectives on the Child Health Now campaign in Zambia, as part of an independent evaluation of its activities and achievements. The interview phase of this review seeks observations and feedback from a variety of individuals associated with the project, including:

- Ministry staff and officials
- Partner agencies and civil society representatives
- Health workers and volunteers
- Local implementers

The information you provide is of great importance in supporting strategies for change to maternal and child health policy, now and in the future. This is not limited only to the World Vision inputs. Our review aims to identify and understand the full range of actors and influences contributing to any recent changes.

The purpose of the evaluation

The evaluation aims to provide a thorough debrief on practices and partnerships for health in Zambia and how they can contribute to changes in maternal and child survival. It will identify the strengths and limitations of different initiatives, models and networks from World Vision's CHN project in the context of broader efforts by government and partners. The results will be used to clarify World Vision's current position in health policy influence. As well, the lessons on practice and partnerships will help World Vision to plan future campaigns in other sectors.

About the researcher

Katie Chalk (Chalk It Up) is an independent consultant contracted by World Vision to conduct the project review. She formerly worked for World Vision's global campaigns team but has had no direct affiliation with the Zambia Child Health Now project. Katie has selected a qualitative approach for the review, which allows for a full description of the project's activities and outcomes including unexpected results. She is using three main sources of information:

- Project monitoring records and other relevant documents
- These semi-structured interviews
- Case studies built from memory and discussion among project stakeholders, including staff and partner implementers

Katie will hand over the results of this review to World Vision for final release in early October.

Participation, privacy and confidentiality

All participants in this review have been selected because of their knowledge of one or more aspects of Child Health Now in Zambia. We expect subjectivity and differing viewpoints. You are warmly encouraged to speak candidly and to raise issues or concerns. The interview is recorded for future reference by the consultant only, and the file remains the property of the consultant. World Vision will not hear or see your words in a way that attributes them to you. The consultant will store the files securely for two years, and will not use the information in any other way than described above. Your participation in this review is voluntary and you are entitled to withdraw at any time. If you choose to withdraw from the project at a later date for any reason, this will be respected and your interview file deleted. Should you have any queries or concerns about the review, you can contact Katie on the details below.

Katie Chalk / Chalk It Up

Email: katie@projectchalk.com.au

Mob: +61425 801 137

ANNEX 7: MAPPED THEORY OF CHANGE, ACTUAL

