

Norwegian Lutheran Mission (NLM)



Ethiopia



RMMP –Gamo Gofa and RMMP –Segen Zone terminal, RMMP-south omo
end term RMMP-Bale mid term evaluations

(FINAL)

TERMINAL/MIDTERM EVALUATION REPORT

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ABBREVIATIONS AND ACRONYMS

ANC	Antenatal Care
BEmONC	Basic Emergency Obstetrics and Newborn Care
C/S	Caesarean Section
CC	Community Conversation
CEmONC	Comprehensive Emergency Obstetrics and Newborn Care
CSO	Charity and Society Organization
EECMY-SWS	Ethiopian Evangelical Church of Meane Yesus South West Synod
IESO	Intergrated Emergency Surgical Officers
HC	Health Center
HEW	Health Extension Worker
IP PS	Infection Prevention and Patient Safety
JGH	Jinka General Hospital
MWA	Maternity Waiting Area
NICU	Neonatal Intensive Care Unit
NLM/E	Norwegian Lutheran Mission/Ethiopia
NLM/N	Norwegian Lutheran Mission/Norway
RMM	Reducing Maternal Mortality
TOT	Training of Trainers
VSO	Voluntary Service Organization
<i>FGD</i>	<i>Focused Group Discussions</i>
HRD	Human Resource Development
<i>KII</i>	<i>Key Informant Interviews</i>
MELS	Monitoring, Evaluation, Learning and Sharing
<i>NLM</i>	<i>Norwegian Lutheran Mission</i>
<i>RMMP</i>	<i>Reducing Maternal Mortality Programme/Project</i>
<i>SMART</i>	<i>Specific, Measureable, Achievable, Realistic & Time bound</i>
<i>SNNPR</i>	<i>Southern Nations and Nationalities Peoples' Region</i>

EXECUTIVE SUMMARY

This document is an independent DRAFT final evaluation report prepared in line with the shared Terms of Reference (TOR) and contract agreement signed between LID consult (the consultant) and Norwegian Lutheran Mission (NLM)/Ethiopia (the client) as one of the main deliverables. To enhance the attainment of its organizational objectives, NLM implements, the objectives of the evaluation and documentation are enumerated in the TOR among which the evaluation criteria: relevance, effectiveness, impact and sustainability and documentation of project achievements remain critical.

The Evaluation approach levels and methodology are defined by the TOR consisting of three phases: the preparatory office works, field exercise and synthesis (office works) phases. The first round office works were devoted to collection and review of secondary data sources. The field exercise phase was used for consultations with project beneficiaries and wider communities; consultations of Government stakeholders (KIIs) at Zonal and woreda levels; and physical visits to the project outputs. The second round office work/synthesis phase was utilized for data organization, manipulations and analyses. After first round office works field exercise was conducted in all the 4 RMMPs with randomly selected Woredas, Hospitals, health centers and Health Posts; and field accomplishment report was Discussed with project steering comitees at Zonal levels. These methodologies are substantiated by capturing and documenting case studies as success stories.

The project RMMPs was intended to reduce maternal mortality at target project areas focusing on three major components. RMMP Gamo Gofa, RMMP Segen, RMMP South Omo and RMMP Bale were implementing focusing on the components of human capacity building, provision of medical equipments and joint supervisory activities. The activities performed by the project in all the RMMPs includes Training of health professional in Hospitals; training of Health Officers, assistant anaesthesia nurse, scrub nurses and midwives on CEmONC management in health centres. Moreover, competence of health officers and midwives were also enhanced in basic neonatal resuscitation. In addition the capacity health extension workers were also enhanced for promoting ANC and referral systems. Moreover, the supply of motor ambulance and other neonatal and maternal equipments were done by the projects. The joint supervision coordinated by the project with all relevant stakeholders in implementation of RMMP in target areas was found to be successful. Particularly, RMMP project was successful in implementation of Mothers village and enhancing referral system to its next higher health institutions besides community conservation on maternal and neonatal care systems and capacity building systems.

As judged from many angles like policy support, satisfaction of beneficiaries, needs and priorities at local grassroots level, regional /national and international levels the RMMP is found relevant and appropriate. From all points of view like timely input and outputs in quality and quantity, resources utilization and respect of implementation schedule, in meeting project objectives the project is said to be effective and efficient. The project brought substantial impact on outlooks of the direct beneficiaries and community in catchment areas. The RMMP is sustainable in many of its requirements.

It was learned during the field exercise that the local government has high admiration and respect for the project. The local government sees the Mothers Village as model which is changing the situation in before. They also recommended that the Mothers Village should be replicated to other non project areas.

The study results showed that there have been remarkable involvements of stakeholders (1:5 government structure, HAD, traditional Community conversations (CC)) in programme promotion, planning and implementation to bring remarkable behavioral changes for the improvement of institutional deliveries whereby maternal and new born babies/neonatal death is reduced. In line with these, as the project equipped relatively accessible/nearby health institutions, the study revealed that the community saved costs and labour.

The RMMP project has satisfied the selected evaluation criteria, relevance, effectiveness, efficiency, impact and sustainability. Hence, the specific objectives are met; pregnant women were able to stay voluntarily at mother's village/maternity waiting center for safe delivery.

The linkage created through the referral system from Health post to Health center to Hospital was well established in all the RMMP project areas. The established Maternity waiting rooms are recognized by the local authorities as MODEL Health development activity evolved not only in their Woredas but rather at zonal and Regional/National levels. The community contribution in recognizing the importance of the mothers village at health center in constructing the rooms and helping in facilitating food for pregnant Womens during their stay for birth.

In all RMMP project Woredas and the Selected health centers in implementing RMMP the capacity of health professionals and other staffs were well capacitated that their knowledge attitude and practice in serving for maternity service in particular and health service in general is improved. The training for BEmONC and CEmONC are very unique and successful in capacitating CS at health centers which was new in the area. The payment and incentive mechanism for these professionals were low and there is high turnover in some places interrupt the service in the area.

Different materials were supplied to the health centers and Hospitals to strengthen the delivery unit like NICU and other services. Some of these equipments were very sensitive needs wise use and management and require proper management. Thus, material capacity buildings needs to be properly handled and managed

The joint supportive supervision regularly made by government health department at Zonal and Woreda level was found to be the best approach in strengthening the services and providing corrective measures at the sites with the presence of all stakeholders. This helped the enhancement of the participation of all stakeholders with great responsibility. The project was extremely best coordinated where Government HEWs, health center workers and Woreda level health department and other Government workers in taking part irrespective of the efforts being made by NLM/E.

From the success stories we learned that there are individual women who were fully understand the importance of the project and started voluntarily serving the other pregnant Women at Mother village. These individuals women are changing their attitudes and including their families for sustainability of the services.

The following are some of the activities to be mentioned with reasons for the change or their cancellation:

- a) TBA Dialogue Meeting: Dialogue meetings with traditional birth attendants (TBAs) were planned to be conducted on how the TBAs will refer mothers to the HEWs. However, during the project period the government policy changed and only recognized the work of the HEWs in addition to the strong push for fully institutional deliveries where the HEWs are supposed to refer pregnant and laboring mothers to health centers for skilled birth attendance. For this reason the dialogue meetings were not conducted and cancelled.

- b) Birth Registration: Because of the revised health management information system (HMIS) of the government, which includes the family folder system where the HEWs are supposed to register health statistics of each household, the Birth registry activity was omitted and instead the project supported some of the health posts by translating the family folders into Amharic for the HEWs can easily understand the content was good action and showed the flexibility of the projects
- c) Access for Safe Blood Transfusion at CEmONC Health Centers: The aim of this training was to create an access for safe lifesaving emergency blood transfusion in the health centers running CEmONC. Based on this, trainings were provided to four lab technicians from three health centers and JGH who were sent to the Blood Bank at Arba Minch Hospital where they got knowledge and skills on social mobilization for blood donation and on techniques of drawing blood, safer management of blood, etc. However, this activity of the project was cancelled because it was decided by the government that blood shall only be collected safely and be ELISA-tested by blood banks and, therefore, direct blood transfusions with blood collected from relatives at health facilities including at hospitals were discouraged. Due to this the blood need by the HCs/Hospitals were became critical in many Health institutions,

In general, RMMP projects of South Omo, Gamo Gofa, Segen and Bale were well working in reducing maternal and neonatal mortality and successfully implemented. The activities of the major components under the human capacity building, equipment provision and joint supervision brought an integrated result in attaining the project objectives. Finally, the Consultant recommends and put the way forward on the following major points:

- It was recognized that the training of BEmONC and CEmONC by the project was one of the major areas contributed for attaining of the project results. The Government should provide special attention in establishing a system for sustainable training center at Zonal levels
- In addition to Health Extension Workers (HEWs) facilitation in mobilizing target communities to make use of available health facilities, strengthening community groups like 1 to5 network groups, WDA, and CC leader in community health mobilization should be noted.
- Mothers' village was found that a number of pregnant Womens were held in the rooms at a time and management of mothers village needs a community contribution for food and other service during their stay. In some Health centers the awareness of the community is well and can be a model which need to be considered
- Experience sharing mechanisms should be more considered in future RMMP projects so that the best practices could easily be adopted from best performing sites
- The project should design some phase-out strategy to sustain and best link with government structures on some of the components of the projects like human resource capacity building and joint supervision works
- The initiation and experience of community conversation at South Omo RMMP was found important and should be scaled-up
- The RMMP Project should be deigned to include other health aspects like family planning service and other health sector development services

1. Introduction

NLM and its back donor supported Reducing Maternal Mortality of the four Projects (in Gamo-Gofa Zone, Segen Area Peoples' Zone and South Omo Zone) have been operational for the last almost 5 years, since 2012; RMMP-Bale Zone intervention started in 2013 and is in 4th year intervention. The RMMP-Bale midterm evaluation will focus on the efficiency, effectiveness and results achieved for the last three years (2013-2015) including encountered challenges in project implementation. However, prior to termination of the project period, a comprehensive evaluation is necessary to create better understanding of the impact, relevance and effectiveness of the interventions undertaken these far by all four RMMPs.

This evaluation will serve as both an evaluation of NLM and its back donor-supported initiatives to date, as well as provide recommended directions and strategies that will help both NLM and local Government to improve mothers and their new-borns mortality. Lessons, experiences and recommendations from the project areas, as well as from other COs operating in the same geographical area will provide a guidance for two projects (RMMP-GG and Segen smooth phasing-out, RMMP-South Omo end term analysis and new phase planning process, and RMMP-Bale to utilize remaining project period efficiently and effective utilization to achieve set project objectives.

NLM and its back donor supported RMMPs main focus is to contribute to the reduction of mothers and their new-borns mortality through human and material capacity building including monitoring and joint supportive supervisions. Past experience has shown that the most effective way to accomplish this task is through utilizing local government structure and seconded staff.

Access to health services in project areas, particularly maternal and neonatal mortality problems were critical. Awareness within the project area communities towards health institution delivery services and capacities of health institutions (human capacity, medical equipment and also MELS system) in these regards were found to be low. These situations in project areas have been resulting in high maternal and new born babies' mortality rate. The health problems, particularly maternal and neonatal mortality problems highlighted above justify the implementation of the interventions designed in the NLM/E strategic plan (2012-2016) in Ethiopia.

As the programme implementation completes NLM/E commissioned Live International Development Consultants PLC to conduct the evaluation of the programme implementation in Ethiopia and assess the performance of the interventions over the strategic period. The evaluation focused on assessing the relevance, effectiveness, efficiency and sustainability of the programme outcomes as per the Terms of Reference (Annex 1).

2. Objective of the Study

2.1 General Objective

The general objective of the assignment is to conduct RMMP –Gamo Gofa and RMMP –Segen Zone terminal, RMMP-south omo end term RMMP-Bale mid term evaluations and to determine the relevance, effectiveness, efficiency, impact as well as sustainability of the project and to conduct baseline survey.

2.2 Specific Objectives

The specific objectives of the evaluation and baseline of the RMM projects are:

- ❖ Review the *Relevance* of the project and its approaches in the context of the reducing material mortality project areas;
- ❖ Verify the *Efficiency and Effectiveness* of the results achieved and trace the changes observed in the operational capacity of the target beneficiaries, as a result;
- ❖ Critically examine the continuing validity of the assumptions on which the project's likely *Impact* was based
- ❖ Analyze *Sustainability* and *Replicability* of the project initiatives from the point of view of local stakeholders including target beneficiaries participation, institutional arrangements, compatibility of project objectives and target community need and attitudinal changes, etc
- ❖ Document the project achievements over the years
- ❖ Draw lessons and give respective recommendations having strategic significance for improvement in future similar actions.
- ❖ Conduct baseline data collection for the RMMP on health development workers with interaction to maternity

3. Methodology of the evaluation

3.1 Document Review

One of the first steps in this evaluation was conducting desk review and review of existing RMMP documents. Accordingly, the consultant reviewed baseline studies, project proposals, monitoring and joint supportive supervision reports, progress reports, relevant Government department reports and the internet browsing. In this review, the consultants contextualized the specific information needed from the field and also understood the context and besides identifying the information gaps required from the field.

3.2 Development of data collection tools

Data collection tools were designed to collect both qualitative and quantitative information. The data needed under each was used to develop the data collection framework. It is from these that the consultant developed questionnaires. The tools developed include 1) Structured questionnaires which was used to collect quantitative data 2) Semi-structured questionnaires used to collect qualitative and quantitative data during Key informants' interviews and Focus Group Discussions and 3) Quality checklists which was used during direct observations of infrastructures and practices.

3.3 Meeting with steering committee (SC)

The consultants met with the steering committees after drafting the data collection tools. During this consultative meetings were held to finalize the evaluation tools and methods.

3.4 Key Informant Interview (KII)

Interview to key informants at various levels were held which helped in exploring the basic data and other important issues to get sufficient information for the evaluation. The consultant conducted an interview to key informants such as NLM/E project staffs at head office and project office, health professionals at BEmoNC and CEmONC sites, Pregnant women, community leaders, elders, religious leaders, health extension workers, development agents, local administrators and other stakeholders in order to have a well-defined analysis.

3.5 Focus Group Discussion

Focus group discussions (FGD) with community members/pregnant Women were conducted to generate qualitative and quantitative data from small focus groups. Focus groups were organized from a group of men, women, boys and girls. In addition, consultants coordinated FGD which includes beneficiaries, community leaders, group leaders, religious leaders, local administrators and local development agent (Government and Non- governmental organizations) in the process of focus groups organization in order to have a well consolidated and reliable data and information.

3.6 Field Observation and Verification

Observation was used to obtain some qualitative data which was obviously supplementing the quantitative data collected by other tools. Field observation and verification was conducted through random sampling methods. The consultants Visited Mother villages, equipments provided to the Hospitals and Health centers, pregnant Mothers attending delivery at health institutions, documentations and recordings of health service at the institutions and others. The data and information collected through these methods was used for supplementing and complimenting quantitative and qualitative data collected through aforementioned methods.

3.7 Presentation of preliminary findings

During the finalization of the field work, the consultant provide a brief presentation of preliminary findings, conclusion and recommendations to each project steering committee, Zonal and Woreda pertinent sectors including project staffs. Feedbacks, comments and suggestions were collected during the meeting and carefully incorporated in the report.

3.8 Data analysis and reporting

All data and information collected through aforementioned methods were made readily manageable for easily operation of data analysis. The readily manageable data was analyzed using appropriate statistical data analyzing tools likes descriptive statistics, tables, graphs and maps. The Consultants compiled a draft report which was presented to NLM/E and other stakeholders for comments and feedback. The draft report comprises findings and recommendations.

4. Project Implementation performance

4.1 Human Capacity Building

4.1.1 Gamo Gofa and Basketo SW RMMP

The RMMP Gamo Gofa and BSW was designed in strengthening existing three target Hospitals and health centers, human and material capacity to carry out Comprehensive Emergency Obstetric Care CEOC and start CEOC at new health centers. The project was originally planned to support 43 health professionals from project target areas providing Masters Degree program in CEOC at Arba Minch University. As explained by the project staff the master's degree program for professionals was not conducted. The reason forwarded was that Arbaminch University was assigned to conduct the program which took more time than expected. On the other hand, facilitating and supporting 520 midwives upgrading training was conducted during the period and short term skill development training for 19 HOs, 13 Scrub nurse and 11 anesthesia nurses were successfully accomplished as planned.



Moreover, the project performed practical skills development to capacitate the service at three hospitals and 6 HCs level in close cooperation with experienced hospital staff to develop and run training programs. The training programs focused on maternal and neonatal health care besides other parts of nursing care within surgical, medical and pediatric wards. During the field trip the consultants consulted trained staffs and respective institutions that the activity is performed well as scheduled and to the best of its standard.

Arba Minch, Sawla and Meles Memorial special hospitals were providing short term training in Emergency Obstetrics for HOs, in anesthesia for nurses, training of scrub nurses and midwives to build up the CEOC capacity at HC level in Gamo Gofa and Basketo special Woreda target health institutions with in a total of 6 Health Centers and 3 hospitals supported to build up Comprehensive Obstetric Care. The project facilitated the human capacity building of 2 teams in Kemba, Basketo, Melokoza, Beto and Gezez health centers, besides 1 and half team in Sawla, Arba Minch and Chenchu including Kucha health center. One team consists of Health Officer, Anesthesia nurse and Scrub nurse. In addition it enhanced competence of target Hospitals in financial management.

In general the human capacity enhancement in Gamo Gofa and Basketo special Woreda RMMP was well performed. In all sample health centers and Hospitals visited the FGD discussants and KII respondents revealed that the training and human capacity building done by the project helped to perform the required health service confidentially.

4.1.2 Segen RMMP

The project was designed in Segen Zone by RMMP to conduct Human capacity development in Darashe, Gidole and Konso Woredas. At the start of the plan project lanching workshop was conducted for a day involving all stakeholders from the target Woredas and institutions. The project conducted short term training in Emergency Obstetrics for 8 HOs, 8 scrub nurse and 8 anesthetise to build up their CEOC capacity at HCs level in the project target health institutions. Moreover, Strengthen training unit within project target hospitals and primary level for health professionals selected from project target areas were performed as planned. The project also helped in strengthening existing health post functionality to actively serve wider community in the area. During the project

period 220 Midwives and nurse received short term training related to RMM. In addition the project organized and conducted short term training for 90 HEWs in maternal health care and community mobilization. In one district Hospital and 3 health canters the project strengthened financial management systems for the institutions.

On the other hand, the project planned to support 12 health professional training in CEOC Masters degree program from 1 target hospitals and 3 health centers but the activity was not accomplished. This was not accomplished due to the fact that the curriculum was not designed in the country during the project period.



During the feild work the Focus group discussions and Key informants revealed that the huan capacity bulding at target HC and Gidole Hospital helped the pregnanat women to easily use the service with out delay. The benficires were very much happy in having the service from skilled professionals in their vizinity. The hierarchal strengthen capacitating professionals from HEW up to the Hospital specialists make the service very effecient.

The challenges in implementation of the activities human capacity building were low incentive mechanism in relation to other NGOs in the area, in that for example the peridium rate was about 500 birr for NGOs while only a 171 Birr is paid to them. The other challenge, as stated during the field trip, was the high turnover of trained staffs mainly for searching better opportunity.

4.1.2 South Omo RMMP

The human capacity building in south omo RMMP comprises mainly trainings for health professionals from different health centers, Health Posts and from Jinka General Hospital (JGH), training of facilitators for the Community Conversation in kebeles around the catchement of Koibe Health Center in addition to supportive supervision of antenatal care (ANC) for health extension workers (HEWs) at health post level. In the majority of the cases, the trainings were run totally by the RMM Project in South Omo in close cooperation with JGH who provided trainers and training facility.



BEmONC Trainings and CEmONC Trainings were provided to staffs from heath centers and JGH on basic and comprehensive obstetrics and newborn care. BEmONC training is a one-month training given to midives, health officers and nurses from health facilities in South Omo Zone, while CEmONC is a five to six-months training



for health officers as surgeons, three months for nurses as anesthesia technicians and one month for nurses as scrub nurses. The CEmONC is mainly implemented to the four target health centers namely Turmi, Koibe, Tolta and Gelila, certain CEmONC activities were implemented for JGH, too. The trainings were given by trainers from JGH who were provided with initial and refreshment instructors's trainings by the project on how to teach and evaluate their trainees both theoretically and practically.

In-service trainings were provided to 627 hospital staff from clinical and related working units on selected clinical topics proposed by the hospital. The trainings were given by the

hospital staffs who had got training skills and was certified from the past (TOT) and sometimes by relevant others who were assigned by the hospital to give the trainings. The training areas through the in-service training for the improvement of the service delivery in the hospital includes Auditable Pharmacy, on the management of pharmaceutical resources Infection Prevention and Patient Safety (IP PS) medical waste management, Nursing Care Process, the components of the nursing care process such as nursing diagnosis, nursing care plan, nursing care implementation and nursing evaluation. Management in Neonatal Intensive Care Unit (NICU) was a four to six weeks training provided to five nurses from the paediatrics ward who were sent to a NICU at Arba Minch Hospital where they obtained both theoretical knowledge and practical skills on neonatal management. The trained nurses shared their experiences to the remaining nurses in Jinka General Hospital and the NICU management in the hospital has been improved. As a result the NICU ward was established in Jinka hospital as a separate department and the care to the newborns have been improved.

Health Extension Workers training for the health extension workers was a two-weeks theoretical and practical training focusing on “Focused Antenatal Care” mainly on skills of conducting antenatal examination, early detection and referral of obstetric risk factors, conducting delivery and essential newborn care. After the first half of the project period, the project was asked by the zone health department to change the two-weeks practical training to “Safe and Clean Delivery” which is a standard approach of the government for health extension workers training. In this approach, the course is extended to one month.



Based on the request from the zone, the project revised its plan and halved the number of trainees due to the doubling of the budget with this approach. During the early second half of the project period, a government policy was revised where the health extension workers were supposed to refer all pregnant mothers at their 36 weeks of gestation to health centers for skilled birth attendance except in special conditions where referral is impossible. As a result of this the number of conducted deliveries by HEWs in the community has dropped remarkably.



Community Conversation (CC) Activities were mainly on the harmful traditional practices on women and children as well as the health seeking behaviours of mothers especially on skilled birth attendance. Training was given to CC facilitators a head of time and the facilitators conducted local meetings bimonthly with the community in the “Limat Budin” at kebele levels regularly. They submitted CC reports to the RMM Project and to the woreda health office through the health extension workers.

Regular quarterly follow-up review meetings were conducted by the project in collaboration with experts from EECMY-SWS from Arba Minch, Koibe Health Center, Male Woreda Health Office, Male Woreda Women and Children Office and Male Woreda Administration and Justice office. In the review meetings, community representatives and religious and traditional leaders from Koibe Health Center Catchment, CC facilitators and CC supervisors, women representatives of each kebele were involved.

Feedbacks were obtained from the involved government stakeholders and the community that the community conversation activity contributed to improvement of the health seeking

behaviour of the women resulting in increased number of institutional delivery and dramatically minimized the the practice of harmful traditions up on womwen and children. The activities were phased out by the end of 2015 as a matter of phase out strategy of the project. During the final and the closing review meeting, the community and woreda staeholders requested for the continuation of the community conversation activity to the kebeles in the catchements of the other health centers of the woreda.

The performance of human capacity building by South OMO RMMP is accomplished successfully. The activity of Community conversion which was very successfully and well recognized by its good impact in community capacity building was performed in addition though not planned in original project document.

3.1.4 Bale RMMP

In the startup phase of the project there were 7 Woredas/Health centers planned as target areas for intervention; then reduces to 4 target Health center/Woredas by the request of the Zonal government , and finally to two target health Centers/Woredas based on the Zonal Health Department recommendation. These changes resulted in, because of HOs assignment problem to the target health centers by the Government for CEmOC training and high turnover of health professional form these areas.

In order to gradually build its capacity the project designed to focus on one health center per year for the first three years. During the last two years, when routines are firmly established, the project will increase its efforts and train health workers from two health centers each year. The estimated training period for each health worker is listed in the table below.

Type of health worker	Length of training in months	Number trained per HC	Number trained per year
Health Officers	4-5	2	2 or 4
Nurse Anesthetists	3	2	2 or 4
Scrub Nurses	2	2	2 or 4
Midwives	1	2	2 or 4

The gynecologist, nurses, and midwives at Goba Hospital, in partnership with the expatriate midwife at Ginnir Hospital, were training HOs, nurses, and midwives from participating HCs in proper antenatal care and basic delivery services, CEOC, and neonatal care. During our field visit trainees from Gindhir and Barbare HCs were attending training at Gindhir Hospital. The HC worker hosted workshops for HEWs from surrounding kebeles to teach them to properly monitor pregnancies within their kebele, perform risk assessments, and assist with normal deliveries. This activity was also performed in both Barbare and Gindhir Health centers.

The hospital's gynecologist, a senior nurse anesthetist, a senior scrub nurse, and a senior midwife were providing the training to the trainees. The whole hospital staff was assisting these trainers. Particularly, the hospital's surgeon played an important supporting role and give HC workers training in minor surgery.

Goba Hospital is providing training for CEOC for health officers in order to assist with C/Ss. The trainees obtain skill on procedures such as instrumental deliveries, vacuum aspiration, and manual removal of the placenta.

Gindhir Hospital was hosting neonatal care workshops for HC workers after their training at Goba Hospital to maintain and improve upon their skills post-training in Goba. The project organized training for health extension workers (HEW). The expatriate midwife at Gindhir Hospital was responsible for organizing these workshops.

Once they return from training, HC workers was expected to keep accurate and detailed logs of maternal activity at their HC. Through a simple and organized record-system participating HCs was tracking women who seek maternal care, including number of antenatal care visits, assisted deliveries, and C/Ss, as well as complications and fatalities. The number of expecting mothers referred by HEWs was also be noted. The importance of maintaining good records will be heavily emphasized to HC workers.

3.2 Material capacity Building

3.2.1 Gamo Gofa and BSW RMMPs

RMMP Gamo Gofa and BSW provided the basic medical equipments to health centers initiate to perform CEOC service. The respective Health Centers and hospitals were found responsible for the running of the activities. The project provided material capacity building to strengthen maternal and neonatal resuscitation corner. The project facilitated the building of 5 Maternity Waiting Village at target Health institutions to provide CEOC.



The purchase of 2 motor cycle ambulance to facilitate referral cases from lower health structure to health center or Hospital done by the project, and during the fieldwork the consultant observed the motor cycles were providing the service. Moreover, one Toyota Land cruiser was also purchased to facilitate project planned activities implementation. The performance in material capacity building by the project was well performed by the project except the blood bank service which was delayed.

3.2.2 Segen RMMP

The RMMP of Segen was planned to equip training unit in Gidole District Hospital with basic training facilities and related supports. In addition, basic material supplies to target health institutions to strengthen maternal and neonatal health service besides the provision of basic medical equipments supply was undertaken.



By the project it was planned to build 3 Maternity Waiting Village at 3 Health Centers providing CEOC and accordingly it was successfully implemented. One Toyota Land Cruiser Hard top and 2 motor cycles was purchased by the project to facilitate the implementation of project. Moreover, the project provides 2 Moro Cycle Ambulance to facilitate pregnant women referral case. In addition the

purchase of computer with printer was also done to facilitate project office work.

3.2.3 South Omo RMMP

The project has built the capacity of health facilities in the zone by providing medical equipments and other materials provided for the running of both BEmONC and CEmONC services in the health centers and Jinka General Hospital. For this purpose of running the practical training within the hospital, a training center having a conference room, library, demonstration room and two dormitories for BEmONC and CEmONC trainees was built in the compound of JGH. The demonstration room has been well equipped with a variety of teachings materials including simulators. In addition to the training run by the RMM project, JGH has facilitated a large number of workshops, meetings etc by renting out the conference room and thereby creating some income for the hospital itself. The administration and running of the conference room and the library is fully the responsibility of the hospital.

Maternity Waiting Areas (MWAs) were built and equiped in Turmi, Koibe, Tolta and Gelila Health Centers and the existing MWA in Jinka General Hospital was equiped with beds and mattresses. The building of the MWAs was the responsibility of the local partner whereas the project financed the constructions.

The neonatal intensive care unit (NICU) was supported with materials and renovation of the room in addition to the training of NICU nurses on the initiation of the NICU health service at the hospital. Later this has been additionally supported by VSO both through the presence of an expatriate specialised neonatal nurse and material capacity building. The unit has been shifted to new facilities and the hospital has today a well functioning and well equipped NICU department. The RMM project provided support during the practical establishment of the new ward.

A motorbike ambulance was provided to Turmi Health Center to assist obstetric referral from health posts to the CEmONC service in the health center. The running of the motorbike is the responsibility of the Health Center. Maintenance has proved challenging as some spareparts had to be imported from abroad which the project facilitated.



One Toyota Land Cruiser was bought for the use to run the overall project activities and two motorbikes were purchased and have been in use for the facilitation of supportive supervisions to the health centers and health posts in addition one of the motorbike serving the work of the Project Coordinator.

3.3.4 Bale RMMP

The project was helping HCs outfitting HCs to perform CEOC. The organization provided all surgical instruments and equipment needed for the service. Additionally, essentials such as bed linens, scrubs, and shoes for the operating room was purchased supplied for two HCs.

Proper neonatal resuscitation equipment was supplied by the project. Obstetric services were provided immediately upon their return in order to keep their newly acquired skills intact.

Recognizing the importance of a well functioning training facility and good trainer moral to the success of the RMM project, it was intends to partially fund a new operating room at Goba Hospital. Ginnir Hospital outfitted to perform its training duties. Construction of a basic neonatal care unit in Ginnir was done by the project. This improved both hospitals' ability to carry out training and treat referral patients.

The Bale health authorities were providing the necessary drugs and basic supplies for all perinatal care and delivery services at HCs. This includes a consistent supply of drugs such as ketamine, which was not available at HCs. Local government was ensuring proper provisions of water and electricity at all project-participating HCs.

3.3 Monitoring and Evaluations

3.3.1 Gamo Gofa and BSW RMMPs

Project coordinator was appointed to coordinate the project who was based at Arbaminch where as, Arba Minch, Chench and Sawla Hospitals were responsible for the monitoring/supervision/visits of the CEOC service at the capacitated HCs. In addition strengthened the referral system at three target hospitals and conducted mentoring the Health Centers in carrying out regular visits to the Health center with the aim to teach, build relationship and discuss difficult medical cases. The project conducte followed up with quarterly supervisory visits/monitor to ensure the quality of the service.

The Health Centre providing CEOC is carried out supervision of the BEOC of the referring HCs. The project initiated the implementation of birth registers in selected Kebeles. The HEWs was responsible for the follow up of the registration. The respective Woredas health offices takeover the follow-up and the quality assurance of the registers information. And improved the monitoring/ supervision reporting system.

3.3.2 Segen RMMP

The monitoring and supervision component of RMMp segen strengthened the referral system functionality quarterly monitored and follow up. Follow up and supervision birth registration in selected Kebeles implementation through full responsibility of HEWs was also conducted by the project. Target Woredas took over responsibility of follow-up and supervision of the quality assurance of the birth registers. Regular supervision and quarterly monitoring of project performance to provide professional backstop was also undertaken. In addition preparation and submission of annual plan, quarterly, biannual and annual project financial and narrative reports weve also done.

3.3.3 South Omo RMMP

This part of the project activities involves quarterly supportive supervisions to health centers running CEmONC and health posts and visits to non-CEmONC health centers for technical supports onsite.



The quarterly supportive were conducted together with South Omo Zone Health Department, respective woreda health offices and trainers from Jinka General Hospital.

Checklist was used for the supportive supervisions and field reports were sent to the health centers as a feedback with copies to the partners involved in the supervisions. The checklist comprises enquiries on minimum requirements for the delivery of maternal and newborn health service in health centers running CEmONC.



Supportive supervisions to health posts were conducted where the health extension workers are involved to help them practically learn how to conduct antenatal examination and early identification and referral of obstetric risk factors.

These types of supervisions were conducted partly by expatriate midwives and the employed Health Extension Supervisor which was in cooperation with EECMY-DASSC-SWS. A total number of 38 health posts have been reached in Hamer, Dasenech, Bena Tsema and South Ari Woredas. The project did not succeed in reaching as many health posts as first planned for various reasons. To mention some of them: during the full project lifespan the project only succeeded in having one expatriate, late employment of the HEW supervisor, difficulties in planning the outreach work due to many other responsibilities of the HEWs themselves, high turnover of HEWs and unsettlement in Hammer woreda.



Occasional working visits was been made to the referring non-CEmONC health centers in Male, Bena Tsema, Hamer and South Ari Woredas throughout the project period by expatriate midwives of the project.



The aim of these visits was to look into the obstetric statistics of the health centers, to fill the gaps of logistics with limited medical and other related equipments needed for the implementation of basic emergency obstetrics and newborn care (BEmONC) and to provide onsite trainings to the health staff on assisting childbirth by vacuum and on newborn resuscitation. Neonatal resuscitation corners have been established by the project in more than 50% of the health centers in the stated four woredas. The existing needs for BEmONC training were recommended to South Omo Zone Health Department and to the respective woreda health offices based on the observations.

The project recognizes that the planned activities on this has not fully been achieved for various reasons. The project will attempt to catch up within the remaining months of this project period.

3.3.4 Bale RMMP

Close follow-up of trainees at participating HCs post-training was an important component of the RMM project. The focus of follow-ups was in-service education, motivation, and continuous evaluation of the RMM model. The expatriate midwife stationed in Ginnir, supported by a local midwife, was responsible for in-service training and motivation. She made regular visits to participating HCs to ensure that health workers' skills are maintained and consistently improved upon.

A national Project Coordinator performed monitoring activities in partnership with a representative from the Bale Zone authorities. The Coordinator was responsible for making quarterly visits to participating HCs, inspecting each facility's medical records, and writing assessments based on the collected information. The Coordinator was also note any shortages in necessary drugs or supplies, as well as examine the functionality of medical equipment. Partnering with the zonal authorities to perform monitoring activities help ensure that deficiencies are addressed and dysfunctional equipment is repaired in a timely manner.

The monitoring activities were performed in collaboration with an expatriate Administrative Advisor. Together the Project Coordinator and Administrative Advisor established a routine schedule for monitoring visits and determine what information needs to be collected as well as how that information should be presented in reports. The Advisor uses the assessments to determine the success of the project and any modifications that need to be made.

4 RMMP Project as Judged Against Evaluation Criteria

4.2.1 Relevance or Appropriateness

4.2.1.1 Relevance or Appropriateness at Tiered Levels

At national Level the GTP-II of the Ethiopian Government stated under health sector development that the strategic direction of major priorities of the Health Sector include strengthening and implementing equity, access, and quality health care services. Here emphasis was given to improving the health of the population especially maternal and children by providing preventive, curative, emergency care and rehabilitative health services. On the other hand Ethiopia priorities work to achieve the Sustainable Development Goals (SDG) in which particular emphasis was on child health and maternal health services. RMMP projects design was relevant and appropriate in attaining national development strategies of health sector in the country. The project helped in fulfillment of the necessary manpower, finance, and health infrastructure, usage of modern technologies and modern equipment in health facilities, and drugs in health centers which was the strategic directions of health sector development.

The three major objectives of RMMP which includes the physical and human capacity building of health service and strengthening the monitoring and supervision components coincides with priority areas of the health sector improvement as set by GTP-II of health service delivery and improvement health system capacity which refers to the enhancement of resources for health, which includes the human and financial resources, health infrastructure and supply that are accessible to communities.

The existing evidences show that health institutions (health centers, hospitals, etc) in project areas were critically in shortage of medical equipments. The availability of these medical

equipments at health centers and hospitals is with crucial roles in improving health services to communities in general and to mothers in particular. Parallel with promotion works within the communities to give birth at health institutions, supplying medical equipment to these health institutions is strongly complement the efforts in improving maternal mortality rate. Under situations prior to programme interventions, significant number of mothers did not go to health institutions (health centers, hospitals etc)/they were giving birth at home; for those who tended to go to health institutions to get delivery services at available health institutions there were no sufficient medical equipment, and they had to go a distance to access the services. In travelling to other far areas to access these medical services there were high risk of death cases and costs. The mission of this theme is well aligned with the national priority of reducing maternal mortality rate in Ethiopia as well as practical levels. The results of the KII and FGDs with community members (mother village, project beneficiaries and other key stakeholders) indicate that the supplied medical equipment are pertinent to reduce maternal mortality rate.

This project focuses on women and their newborns. It works with all levels of society to mobilize awareness and develop a good practice. Most midwives and health extension workers are women's, and this work strengthen their work in the local community and contribute significantly in attaining the project target and sector goals. Improvement in financial and geographical access to good quality intrapartum care based in local communities, hospitals and health centers is important in any poverty eradication strategy, as well as a means of reaching MDG-5. Thus, improved maternal health services helped to reduce the gap in numbers of maternal deaths between rich and poor people. It further contributed in the reduction of the economic effect on poor families. It will also increase women's empowerment (MDG-3), and reduce the number of neonatal deaths (MDG-4).

At regional levels the project aimed to improve maternal health and make large decline in maternal and neonatal mortality in respective regions SNNPR and Oromia, Ethiopia. Each component under this project will improve access to essential delivery services for women in these remote areas which complement the regional health service plans.

At Zonal and Woreda Levels as per the need assessment made by NLM/E during the RMMP project design it was recognized the project focuses on women and their newborns. Discussion made with Zonal and Woreda health sector stakeholders during the evaluation of this program confirmed that the project was designed in line with the priority needs of the Zonal and Woreda offices. The Zonal and Woreda Sector staffs participated in FGD and KII revealed that the project is highly aligned with the health sector activities undertaken by the government that they are fully confident that the output of the project can be easily sustained even with the absence of the coordination of the project staff.

On the other hand, RMMP work closely together with government hospitals, health centres and health posts focusing on essential training, equipping institutions and supervising the work of the participating institutions which was created synergy in implementing the Comprehensive Emergency Obstetric Care, CEOC in hospitals and health centres.

At Grassroots Community Level during the FGDs communities in project woredas were asked to respond whether or not they were communicated before the RMMP started. The communities, especially, women community groups replied positively that they were given a chance to identify their needs by setting priorities. The consulted more women groups attested that they identified and prioritized the project activities. Thus, the project implementation

process was in line with the needs and priorities of the local community which they noted during the discussion that the RMMP is appropriate.

The quality of the problem analysis and the project's intervention logic and logical framework matrix, appropriateness of the objectively verifiable indicators are all found matching. The project was implemented in accordance with intervention logic, KPIs and assumed source of information gave positive results.

The evaluation team testified that the project implementation processes and procedures annexed some degree of flexibility/adaptability to facilitate responses to changes in circumstances and in accordance with the consensus reached among stakeholders. Starting from planning, management/ implementation/ monitoring of the project, the level of local ownership, absorption and implementation capacity was found amazingly very well.

The RMMP project worked on decreasing maternal deaths, neonatal deaths, and stillbirths, in addition to reducing illnesses and disabilities caused by labor complications to both mother and child. Therefore, all the above mentioned facts confirm that the RMMP project is need based at all levels leading to conclude it is relevant or appropriate.

4.2.2 Effectiveness and Efficiency

4.2.2.1 Costs Incurred to Implement Activities and Outputs

The efficiency criterion concerns how well the various activities transformed the available resources into the intended results/outputs, in terms of quantity, quality and timeliness. Comparison should be made against what was planned. The planned inputs have delivered the desired outputs as explained and witnessed by the health professionals, entire communities around and woreda line departments. For example the FGD discussants pointed out that the construction of mothers/pregnant Women waiting village constructed was very effective that the inputs used was very small and with that very few resources a house building which match the local house construction design and successful in utilization for the intended purpose. On the other hand the human capacity building was very effective that all the costs paid for the trainees and trainers with regards to per diem and other logistics it was very minimum as compared to similar/the same training programs undertaken by other NGOs. All the trainees and trainers were paid according to the government rate which was by far less than other NGOs are paying. The Government and Local project beneficiaries were very happy that all the procedures were according to the government structures that the services of the project will continue with minor external assistance.

4.2.2.2 Timely Provision of Inputs

It was learned during the evaluation that the project has one project coordinator each in respective RMMPs who were own recruited staffs. The projects have their own vehicles and other transportation facilities. The project was implemented using own force of NLM field office with backstop support from HQ. Budget disbursement was doing as per the schedule and as requested. There was no problem of budget release and no delayance reported during the project evaluation from all stakeholders. Health equipments were also purchased at the head office and supplied to the project sites during the project time period.

4.2.2.3 Level of Respecting Planned Implementation Schedule

The implementations of the planned activities were done with the time frame project life. In general, all the major activities planned were implemented within planned time frame with

minor flexibility with regards to external effects. For instance the training programs scheduled for human capacity building in Bale RMMP, Oromia Region was delayed due to the security problem which was happened to block roads at that period. Some minor activities such as blood bank service were not yet completed. This activity was missed to be implemented that the general direction given by Ministry of health on Blood bank service development not coincide with the planned service. Its not allowed to collect and use blood at each health institutions except those appointed by the government to do the service.

4.2.2.4 Comparison of Costs and Benefits

Extent to which the costs of the project have been justified by the benefits whether or not expressed in monetary terms in comparison with similar projects or known alternative approaches, taking account of contextual differences and eliminating market distortions. The project has accomplished the activities/outputs in very economical ways. The effectiveness of RMMP projects can be justified by looking at the activity and financial performances evaluated as can be seen from above implementation performance topic.

During our analysis the consultant understand that there were more benefits obtained when compared to the original design of the RMMP as well as in comparison with similar projects in the area. In our view the cost incurred is very minimal in obtaining the results of reducing maternal mortality in the project implementation sites.

4.2.2.5 Extent of Benefits Delivered and Received

The various consultations and field observations made the planned project benefits have been delivered and received, as perceived by all key stakeholders (including women and men and government staffs). Among the benefits the attitudinal change in health professionals and confidence built in experiencing the service helped the benefits very acceptable and receivable.

4.2.2.6 Degree of Satisfaction of the Beneficiaries and Local Government Stakeholders

The same field observation and judgment shows that the beneficiaries of the project are very much satisfied. Especially, the mothers village have succeeded in maintain access to institutional delivery and in reducing neonatal and maternal deaths. The surrounding communities have witnessed that the mothers villages are center of solutions for pregnant Womens that could be risky might be accompanied with death cases otherwise. Satisfaction of the beneficiaries and local government stakeholders in terms of timely availability and quality of project inputs (materials, finance, and human resources); quality of results (respect for standards) is found real during our field visit to sample project areas.

4.2.2.7 The Extent that Project Results/Outputs used by Beneficiaries

Mothers villages were very important project output which was observed that the pregnant womens were using actively. In Most of the Health centers visited all sample there are a lot of pregnant Womens waiting for delivery, delivered and ready to return back to their villages. The beneficiaries were gaining services in their nearest health institution from a trained BEmOC and CEmOC professionals, trained health extension workers and other trained staffs. To this extent the beneficiaries were very much satisfied.

Moreover, the health equipment supplied to the Hospitals, Health Centers and Health Posts were well used by the beneficiaries. The Mothers village performances are recognized by rural communities including traditional clan leaders. The beneficiaries are making wise use of all project outputs.

4.2.2.8 Degree of Appropriation of Roles and Responsibilities

Right from the very beginning the project well identified its stakeholders at local/woreda/zonal levels. The stakeholders consulted underlined that the NLM has had sufficient communications with those stakeholders through regularly periodic project progress reports. Therefore, the balance of responsibilities between the various stakeholders was appropriate and acceptable.

4.3 Impact

The first and dimensional impact brought by RMMP projects are the change in thinking paradigm at grassroots community/reproductive age mothers and target professionals from different disciplines. During the field visit and reports from the project, the consultant learnt that, RMMP target health institutions (Hospitals, health centres and Health posts) were providing better quality and sustainable maternal health care services which contributed directly to reduction of maternal mortality rate. There is was increased numbers of women referred to health institutions for safe delivery and it was found that there is a substantially improved utilisation of the maternal health service offered at both health centres and health posts level. There was also improved and increased access to maternal health services at target health institutions.

The knowledge, attitude and practice of health professionals participated in human capacity building at different levels of the project have improved, and the capacity of health centres and



hospitals targeted were shown great impact on service delivery of maternity service in their respective institutions. Some of the BEmONC and CEmONC trained professionals interviewed explained that the skill and knowledge gained during the training helped them to acquire the skill and build confidence in providing the services in the institutions. They said a lot of pregnant women were saved due to the service in which otherwise due to lack the service majority could have been died.

By and large, the cumulative effects of the major programme activities in the project areas were mainly found to be contributed for not only in reducing maternal and neonatal mortality rate but also reduced expenses associated with medical services and improved labor utilization for better production.

In general RMMP projects in all the project sites helped in reducing maternal mortality performance in all respective project areas and supported health development service of the target area. The project sustained RMMP outputs by the target health institutions in the target areas.

Moreover, the RMMP project have brought attitudinal change by husbands in addition to pregnant Women. This is also a great change in respect of the reducing maternity death and womens empowerment in general.

Replicable

Mothers waiting Area: MWA were replicated by Community and Government in many areas that shows the project have positive impact in the community and Local government

BEmONC and CEmONC training: The training of BEmONC and CEmONC is being undertaken by other NGOs like AMREF (in south Omo, Jinka) and Government structures by gaining experience from RMMP project. Of course we have learnt that they got assistance from RMMP project staffs at ground levels.

4.4 Sustainability

The sustainability criterion relates to whether the positive outcomes of the project and the flow of benefits are likely to continue after the project. The final evaluation made an assessment of the prospects for the sustainability of benefits on basis of the following aspects:-

4.4.1 Policy Support – Existing policies and programs of FDRE is serious about Maternal health in health development aspects. These policies and programs strongly support the RMMP project objectives and outputs. There are strong sentences in MDG (2015) and GTP1 and GTP2 about the maternal mortality reduction and womens empowerment.

4.4.2 Institutional dimension – The RMMPs implementation and management arrangements were well suited with the government health sector institutional arrangements. The projects weare implemented in government hospitals and health centers. The Zonal and Woreda health offices were responsible and managing the implementation of the projects. The project coordinators were also seconded staffs who are fully working with the government sector offices though government structure. As a result the institution dimension of the project testifies the sustainability of the project outputs/services.

4.4.3 Socio-Cultural Dimensions – Due to its varied advantages demonstrated, the project is attracting/pulling local attentions in changing local perceptions on women delivering at home by traditional birth attendants and needs and ways of producing and sharing benefits of the project as beliefs in rather modern ways. Womens are adopting of delivering at institutions bringing it as their culture and improved trust in using maternal services in local areas.

4.4.4 Financial Sustainability – RMMP project is run within the framework of government structures and the Regional and Woreda governments have shown their commitment to allocate adequate budget to continue the output of the projects even after the phase-out of the project.

4.4.6 Technical Sustainability: - Most the purchased and delivered health service equipments demand easy operation and maintenance systems. The trained professionals can easily operate the equipments and the linkage system the RMMP created will help to promptly maintain the equipments by Higher level technicians when the fail to operate.

5. Documentation of good practices and learning of the project

5.2. Documentation of success stories

1. W/R Abrkie Areda

Age 35

Address:

Region- SNNPR

Zone: Gamo Gofa

Woreda: MaloKoza

Kebele: Gada

Ketena/Village:Galaze

W/Ro Abrkie, age 35 was a mother of 6 childrens, lives about 90km far away from the woreda capital and away 10km from Gada health center. She was farmer. In her 7th child pregnancy she encountered a new situation. A labour which very different and hard was encountered w/ro Abrkie. When the labour continued and no delivery of baby as she was waiting. When she couldn't deliver at home as other 6 children she was brought to Gada HC by caring her by the community which was one of the 75 health centers in Gamo Gofa Zone. Again the labour becme above the capacity of the Gada health center that the midwives referred her to Laha Health center which was the Woreda Health center with RMMP which provide operation service. Since there was no transportation service in the area again the decided to carry her by human labour which was about 90km from that to survive her from death. Her family decided to pay a money above her capacity as a farmer to carry her to the Laha health center. Finally they hired to take her with 4800 Birr.

When she reached Laha HC the health professionals found that the baby was dead and her maitsan was raptured. Now she was refred to Sawula Hospital 90 km from Laha Health center. The challenge again was the road between Sawla and Gada was under construction and make hard for Ambulance to drive and take her urgently. Finally the Health team decided to call to both Woredas Basketo Woreda and Gaze Gofa Woreda to cooperate so that the respective Woredas Bring the Ambulance and drive in respective Woreda and carry her where the Road is closed due to Mud. Finally after a lot of efforts she reached Sawla Hospital. Finally she recovered by operation and return to her village after two months. This was one of the worst cases encountered this mother due to lack of appropriate maternal service there. This situation now remembered as history as the material and human capacity building done at all levels from Hospital to Health center, and Mothers village was constructed and mothers were staying at this maternity waiting room such the worst situation is now resolved.

2. W/ro Bayush Bekele



Age 28
Address:
Region- SNNPR
Zone: Gamo Gofa
Woreda: Bonke
Kebele: Gazeso
Ketena/Village:

W/Ro Bashush, Age 28, was a mother of three children's. Her first son is age ten while her last daughter is age three. Bayush Delivered her last baby at Gazeso health center. She delivered the baby with no problem as compared to the two previous babies she delivered at home. Understanding the very significant of of RMMP in the area and the suffering pregnant womens encountered during the birth, she started to voluntarily serving Mothers staying at maternity waiting home found in the HC. She help them in preparing food they want, she advise her, and in collaboration with Woreda and HC officials she coordinate voluntary persons to contribute food items and prepare and provide to the mothers. Bayush explained pregnant Women were very happy in staying in the Mothers Village without much problem and savely deliver their baby and back to their villages.

3. Etago Mengeshari

Name: Etago Mengeshari
Zone : South Omo
Woreda : South Ari
Kebele: Shepi
Age: 38

W/ro etago, 38 was a mother of two children's. She was rferred from Gather Health Centre. She had also ddelivered her 2nd child with CS in Jinka hospital. Gather HC referred Etago to Jinka hospital for 3rd SC delivery, as she had pervious SC scar. She arrived to Mother weighting room of the hospital a week before . She said the referral system was effective and she arrived the hospital safely and now she feels omfortable and feel safe to be at Mothers waiting room at home. The midwives were frequently visiting her and she was very happy.

4. W/ro Elo Kara

Name: Elo Kara
Woreda : Amer Gale /Airbore
Kebele: Goderba
Age: 36

W/ro Elo, age 36 was a mother of 5 children. She was at Jinka Hospital Mothers weighting room for delivery. She was referred from Gazare HC which was away from the hospital. She

was referred as she detected for triplet pregnancy. In her view, she is informed / aware of the importance of institutional delivery, by HEWs and HC professionals. Now she decided to deliver at health institutions and to stay at mothers waiting room of Jinka Hospital. During the interview w/ro Elo was comfortable and feel safe to be there, in the hospital, which she believed, otherwise; could be died, if she could had not been there in the hospital to deliver than at home.

5. Challenges and during the implementation of the project

During the field work different group of discussants revealed major challenges encountered in implementation of RMMP projects. One of the major problems encountered was absence of health officers in some of the targeted health centres for CEmONC training. This lack of appropriate professional to send for training, forced to replace other professionals and this somehow affected the quality of the service (eg Basketo Hospital).

In some health institutions it was found out that the CEmONC and BEmONC trained professionals either transfer to other sectors in the Woreda or shift to other better job opportunities. This situation also affected the timely implementation of some of the activities as per the planned project activities.

The poor infrastructure facilities (road network) in some of the project Woredas challenged the implementation of the project as efficiently as required. Access to road network in the woreda to transport pregnant Women to the HC and from the health center to the Hospital when referred it create a big challenge. This also created an impact in attaining the project objective in some woredas (eg. Gazase HC in Gamo Gofa Zone).

Shortage of ambulance in Woreda in some cases affected the performance of the project. The Car ambulance or Motor ambulance in the area is not sufficient to transport the pregnant Womens to the HC. Thus, Additional Motor ambulance are need to be available, as the demand to service constantly increased by the community. The other challenge with respect to the Ambulance was the mis-utilization with local administration for other than maternity service.

The other major constraint reported was the budget constraint for joint/ integrated supportive supervisions. The Woreda have no sufficient Budget to conduct regular Supervision of the project activities and provide timely feedback for instant corrections.

The commitment of woreda administration is very minimal in some of the target Woredas. The allocate much of their time to other activities and provide low attention for implementation of RMM (case of Lagehidha HC).

The pastoral communities in some of the project target kebeles like Turmi HC where about 12 kebeles being a pastorals community and in these kebles there was some ethnic conflicts, as a result there is more staff turnovers, lower number of HEW. For instance only 1 HEW per HP in these kebls. Thus this have great impact on the smooth implementation of the project.

Shortage of Emergence Kit for follow up of pregnant mothers was another challenge in some sites. Shortages of materials like IV fluid and Gloves...etc. Moreover the food supply for

mothers in weighting room was another critical challenge. In some areas like (Sawla Hospital, Jinka Hospital) the staffs of the hospital were contributing for the food supply.

Referral System, not complete, needed to be further improved, as sometimes required for the patient to come with securing IV, particularly; for a mothers developed PPH and NASK (especially with urethral rupture).

Lack of blood bank service in some of the health institutions make the delivery service e very critical. In addition, RMMP supported the hospital like A/Minch equipping with basic medical equipments, but still experienced shortages, like Octometer, examination apparatus/BP apparatus for services delivery.

4. Conclusion and recommendations

5.1 Conclusions

The study results showed that there have been remarkable involvements of stakeholders in programme promotion, planning and implementation. The promotion of institutional delivery has been mainly undertaken by/at 1:5 government structure, HDA, traditional Community conversations (CC) etc. Promotion works undertaken through these methodologies/approaches resulted in significant behavioral changes. As a result there has been significant improvement of institutional deliveries whereby maternal and new born babies/neonatal death is reduced. In line with these, as the project equipped relatively accessible/nearby health institutions, the study revealed that the community saved costs and labour.

As can also be recognized from previous sections it is evident that RMMP project has satisfied the selected evaluation criteria, relevance, effectiveness, efficiency, impact and sustainability. Hence, the specific objectives are met; pregnant women were able to stay voluntarily at mother's village/maternity waiting center for safe delivery.

The linkage created through the referral system from Health post to Health center to Hospital was well established in all the RMMP project areas. Health Posts identify status of pregnant Womens timely attend regularly and refer to Health centers when their delivery approaches. Similarly the referral system between health center and Hospitals were functioning effectively during the evaluation. This service should be strengthened and sustained.

The established Maternity waiting rooms are recognized by the local authorities as MODEL. Health development activity evolved not only in their woredas but rather at zonal and Regional/National levels. The community contribution in recognizing the importance of the mothers village at health center in constructing the rooms and helping in facilitating food for pregnant Womens during their stay for birth. Maternity waiting rooms were done through a good effective referral system organized and mobilized by HEWs from community to health post/ health centers /health institutions.

In all RMMP project Woredas and the Selected health centers in implementing RMMP the capacity of health professionals and other staffs were well capacitated that their knowledge attitude and practice in serving for maternity service in particular and health service in general is improved. The training for BEmONC and CEmONC are very unique and successful in capacitating CS at health centers which was new in the area. The payment and incentive mechanism for these professionals were low and there is high turnover in some places interrupt the service in the area.

Different materials were supplied to the health centers and Hospitals to strengthen the delivery unit like NICU and other services. Some of these equipments were very sensitive needs wise use and management and require proper management. Thus, material capacity buildings needs to be properly handled and managed

The joint supportive supervision regularly made by government health department at Zonal and Woreda level was found to be the best approach in strengthening the services and providing corrective measures at the sites with the presence of all stakeholders. This helped the enhancement of the participation of all stakeholders with great responsibility. The project was extremely best coordinated where Government HEWs, health center workers and Woreda level health department and other Government workers in taking part irrespective of the efforts being made by NLM/E.

The other dimension of RMMP project is that the project worked on awareness creation on institutional delivery for reproductive age mothers. The project contributed a lot and pulled the

interest of local government in that it provided critical awareness campaign done through the Community conversation approaches have helped towards empowering women. The pregnant Women and their husbands have changed the attitudes of the whole community to attend pre and post delivery services at health institutions and ignoring home delivery. Involving all concerned stakeholders and cooperating with them, in the beneficiaries' selection, speeded up the timely implementation. This was evident from the coordinated Mothers village establishment and become functional. Positive attitude of the beneficiaries and the stakeholder towards the project facilitates smooth implementation and full ownership of the project.

From the success stories we learned that there are individual women who were fully understand the importance of the project and started voluntarily serving the other pregnant Women at Mother village. These individuals women are changing their attitudes and including their families for sustainability of the services.

The RMM-SO project recognizes that the great improvement of the maternal and neonatal health service within South Omo Zone over the past 5 years, is not due to the presence of the RMM-SO only. However, the project contributed to the improvements. Many other factors have influenced this improvement. To mention some of them: The strong commitment of the government towards the reduction of maternal mortality with the known slogan: "NO mother should die from giving birth"!, Implementation of the HEW and Health Army, making the maternal health service free, distribution of ambulances, the building of maternity waiting areas in addition to the contribution of other CSOs within the zone.

Sustainability is ensured as judged from all limiting factors; from the ownership created by beneficiaries, project outputs being handed over and recognition of the entire communities. However, all stakeholders at woreda and zonal levels have recommended that the RMMP should strengthen in project sites and expand to non project sites as required.

The following are some of the activities to be mentioned with reasons for the change or their cancellation:

- d) TBA Dialogue Meeting: Dialogue meetings with traditional birth attendants (TBAs) were planned to be conducted on how the TBAs will refer mothers to the HEWs. However, during the project period the government policy changed and only recognized the work of the HEWs in addition to the strong push for fully institutional deliveries where the HEWs are supposed to refer pregnant and laboring mothers to health centers for skilled birth attendance. For this reason the dialogue meetings were not conducted and cancelled.
- e) Birth Registration: Because of the revised health management information system (HMIS) of the government, which includes the family folder system where the HEWs are supposed to register health statistics of each household, the Birth registry activity was omitted and instead the project supported some of the health posts by translating the family folders into Amharic for the HEWs can easily understand the content was good action and showed the flexibility of the projects
- f) Access for Safe Blood Transfusion at CEmONC Health Centers: The aim of this training was to create an access for safe lifesaving emergency blood transfusion in the health centers running CEmONC. Based on this, trainings were provided to four lab technicians from three health centers and JGH who were sent to the Blood Bank at Arba Minch Hospital where they got knowledge and skills on social mobilization for blood donation and on techniques of drawing blood, safer management of blood, etc. However, this activity of the project was cancelled because it was decided by the government that blood shall only be collected safely and be ELISA-tested by blood banks and, therefore, direct blood transfusions with blood collected from relatives at health facilities including at hospitals were discouraged. Due to this the blood need by the HCs/Hospitals were became critical in many Health institutions,

5.2 Recommendations and the Way forward

RMMP projects of South Omo, Gamo Gofa, Segen and Bale were well working in reducing maternal mortality and successfully implemented. The activities of the major components under the human capacity building, equipment provision and joint supervision brought an integrated result in attaining the project objectives. The Consultant recommends and put the way forward on the following major points:

For the NLM

- a. Mothers' village was found that a number of pregnant Women were held in the rooms at a time and management of mothers village needs a community contribution for food and other service during their stay. In some Health centers the awareness of the community is well and can be a model which need to be considered
- b. Experience sharing mechanisms should be more considered in future RMMP projects so that the best practices could easily be adopted from best Performing sites. As RMMP at Bale zone is late comer and planned to share experiences from other RMMP areas/zones, the study showed that Bale did not share best practices and lessons from these areas, to make life easy in these regards and cover more target groups;
- c. The project should design some phase-out strategy to sustain and best link with government structures on some of the components of the projects like human resource capacity building, material capacity and joint supervision works
- d. The initiation and experience of community conversation at Suoth Omo RMMP was found should be scaled up
- e. The existing sensitization / initiations of the community required for reviewing the project to include other health services like community awareness and family planning
- f. Capacity building training for project seconded staffs on basic gaps needed to be incorporated.
- g. Training on management and installation and maintenance of Medical equipments / machines should be well considered.
- h. Supplies of additional medical equipments, like *oxygen Cylinder, delivering set, delivering coach and examination coach should be considered***
- i. The project need to further work with lower level of the community, through providing training to the HEWs (capacitating the HEWs). Relevant training to HEWS, on early detection of danger signs of pregnant mothers should be given attention
- j. RMMP need to expand its services to other similar woredas in the Region and if possible at National level.
- k. We recommend that the reporting system of the programme needs to be synchronized with the government HMIS system to easily communicate with government reporting arrangements;

For the government

- a. It was recognized that the training of BEmONC and CEmONC by the project was one of the major areas contributed for attaining of the project results. The Government should provide special attention in establishing a system for sustainable training center at Zonal levels

- b. As the project supplied motor bikes (for transportation and ambulance services), the assessment realized that the drivers are with no driving license. This also needs corrective measures;
- c. There still needed to provide special attention in designing the project for pastoralist community like Hamar and Nyangatom. HEWs, were not motivated to serve the communities. They reasoned out that the communities are not easily accessed, the climate and conflicts. In this regard, feasible incentives to HEW should be designed, working with local administrations for the conflicts and accessing the communities.
- d. The mechanism developed at referral linkages is promising but its feedback mechanisms are weak and need to be worked on;
- e. The programme supplied medical equipment. But the study revealed that on one hand ultrasound service is missing in some or limited target health centers, and on the other hand as the supplied medical equipments are modern ones their operations also require relevant health professionals; at some places such compatibility is missing;

Annexes

1) APPENDICES

Annex 1: Terms of Reference of RMMP Evaluation

1. General information

Digni no.: 10619
Norad no.: *(To be filled in by NLM/N)*
Project name: RMMPs-Gamo Gofa, Segen, South Omo and Bale
Country: Ethiopia

2. Initiative

Added on its past experience as project implementer, NLM/E took the initiative to undertake two projects (RMM-Gamo Gofa and RMMP-Segen Zone terminal, RMMP-South Omo end term and RMMP-Bale midterm) evaluations by the hired, experienced and qualified consultant to demonstrate, analysis and document each projects performance, results achieved, encountered challenges and lessons learned including baseline data collection.

3. Purpose of the evaluation

NLM and its back donor supported Reducing Maternal Mortality of the four Projects (in Gamo Gofa Zone and Basketo Special Woreda, Segen Area Peoples' Zone and South Omo Zone) have been operational for the last almost 5 years, since 2012. RMMP-Bale Zone intervention started in 2013 and is in 4th year intervention. All four RMMPs are greatly appreciated both by the government officials and the target area communities for what it has been achieved. Further, discussions are underway regarding smooth phasing-out of two RMMPs in Gamo Gofa and Basketo Special Woreda (RMMP-GG and BSW), and Segen Area Peoples' Zones through strengthening Zone and target Woreda health sector for an additional two more years (2017-2018). To this end, the hired consultant will be also responsible to undertake RMMP-South Omo end term and RMPP-Bale midterm evaluations. Moreover, RMMP-Bale midterm evaluation will focus on the efficiency effectiveness and results achieved for the last three (2013-2015) including encountered challenges will be assessed. However, prior to termination of the project period, a comprehensive evaluation is necessary to create better understanding of the impact, relevance and effectiveness of the interventions undertaken these far by all four RMMPs.

This evaluation will serve as both an evaluation of NLM and its back donor-supported initiatives to date, as well as provide recommended directions and strategies that will help both NLM and local Government to improve mothers and their new-borns mortality. Lessons, experiences and recommendations from the project areas, as well as from other COs operating in the same geographical area will provide a guidance for two projects (RMMP-GG and Segen smooth phasing-out, RMMP-South Omo end term analysis and new phase planning process, and RMMP-Bale to utilize remaining project period efficiently and effective utilization to achieve set project objectives.

The aim of hiring a consultant to undertake this additional evaluation to that of Government is to assess four RMMPs and demonstrate analytical work to produce quality evaluation report to the required standard.

NLM and its back donor supported RMMPs main focus is to contribute to the reduction of mothers and their new-borns mortality through human and material capacity building including monitoring and joint supportive supervisions. Past experience has shown that the

most effective way to accomplish this task is through utilizing local government structure and seconded staff.

4. Scope of the evaluation

The evaluation will employ employee participatory based approach process, promoting maximum input from all relevant stakeholders that includes Region, Zone and target Woreda government pertinent sectors, COs operating in the area and project target communities. In order to guide and inform the evaluation process, steering committee of each project will actively take part during the start-up of evaluation and debriefing. Four RMMPs duration and budget frame for the entire periodis as shown in the agreement document.

Table 1: RMMPs budget as indicated in the main PD

No	Name of the project	Duration	Total budget
1	RMMP-Bale	2013-2017	9,956,843
2	RMMP-Gamo Gofa	2012-2016	13,719,669
3	RMMP-Segen	2012-2016	8,754,179
4	RMMP-South Omo	2012-2016	11,018,967
	Total		43,449,658

The consultant will work closely with the target Zone and Woreda departments and offices in developing the evaluation methodologies to produce one compiled RMM program evaluation report with the content that illustrates each project adequate information.

The smooth phasing-out of two projects terminal evaluation, one project end term evaluation and RMMP-Bale midterm assessment will use both quantitative and qualitative methods to assess the impact and effectiveness of the projects in all four locations. The evaluation should address the following key questions:

- To what extent have the project strategies and activities supported by NLM and its back donor contributed to the project goals to achieve set objectives?
- What has been the impact of project activities? Have there been any unforeseen impacts? (positive or negative)
- What challenges were confronted by NLM and local partners during project implementation and how were these addressed?
- What lessons have been learnt by NLM and local partners through project intervention?
- Based on the existing project agreement, to what extent the local government, particularly health sector at Zone and Woreda level are ready to take over and continue to run RMMP outputs as part of routine activity and budget cycle plan?
- Among the RMMP components, which once are to be given more emphasis to be strengthened to facilitate smooth phasing-out of RMMP-Gamo Gofa and Segen?
- What recommendations can be made on the future direction of NLM and its back donor intervention support to similar project elsewhere?
- Assess the level of sustainability (financial, institutional and social) of the individual project components, and identify critical areas that may affect or contribute to sustainability?

In undertaking the evaluation, the consultant will review relevant project documents, reports, and statistics, including reviewing a sampling target locations. In addition, information tools will be designed to gather inputs from:

- Relevant sectors at the Zonal and target Woredas, including target health institutions. Interview reproductive age mothers and pertinent sectors at Zone and Woredas, besides COs operating in the area involved in the RMM services.

The following main tasks will be undertaken:

1. **Document Review:** four RMM projects documents, monitoring and joint supportive supervision reports, counterpart progress/activity reports, financial reports, relevant to Charity and Societies Agency regulations.
2. **Evaluation meetings:** with steering committee members to develop and finalise tools/methods of evaluation.
3. **Information Collection in project Locations:** Information will be collected by the consultant through key informant interviews, focus group discussions, and selected site visits through employing sampling methods.
4. **Presentation of Preliminary Findings:** at the conclusion of the field work, the consultant will give a brief presentation of preliminary findings, conclusions and recommendations to each project steering committee, Zonal and Woreda pertinent sectors including project staff.
5. **Analysis and Report Writing:** Analysis of the data and produce the evaluation report with findings, concluding remarks and recommendations.
6. **Finalization of the Report:** based on input from stakeholders and RMMP/NLM/E staff, produce compiled one program evaluation report maximum 25 pages to the required standard.

5. Project presentation

Reducing Maternal Mortality Project in Gamo Gofa, Segen, South Omo and Bale Zones are complementary intervention to the government development efforts towards saving lives, enabling reproductive age mothers and their new-born, to access improved health facilities at closer distance that contributes to the sustainable development of their societies.

Also the upcoming evaluation is expected to give more emphasis on clear recommendations that the government pertinent sector departments and offices in Gamo Gofa and Segen Zone on how to continue strengthening the sustainability of project outputs during the anticipated two years (2017-2018) smooth phasing-out process. Gamo Gofa and Segen Zones including target Woredas exercise full responsibility of taking over and running RMMP in their geographical localities as part of their routine activities without depending on external funding. Moreover, the evaluation has also to indicate that the priorities of Government at project target area health institutions and health professionals to be given emphasis to be strengthened the capacity throughout these two years of RMMP-GG and Segen smooth phasing-out.

As well known, four RMM projects approved support more focused on human and material capacity building including monitoring and joint supportive supervision, to complement local government development initiatives. The projects emphasis on (i) enhancing the capacities of health professionals (Health Officers(HOs), Aesthetician nurses, Scrub nurses and Midwives including Health Extension Workers(HEWs), and also bed side on job practical training of hospital staff. Further, (ii) Material capacity building that provided basically required medical equipment at BEmONC and CEmONC sites (Hospitals and health centers) including (iii)Monitoring and joint supportive supervision that involved local government at Zonal and Woreda level are second and third project components that contributed significantly to the target health facilities improvement.

Through target health institutions empowerment and the accompanying current effect, results ensued towards rendering improved maternal health care services. To this end, pregnant women are the main participants and beneficiaries of this projects, however other COs operating in the area also benefited from RMMP experiences. Needs, specific objectives and expected results are identified in conjunction with local stakeholders including the government. Project funds provide as committed with flexibly response to local requests and priorities. The strategic for reallocations budget twice a year is largely involving, to achieve maximum results accommodating changing dynamics.

NLM and its back donor are the sole funder of these projects in active participation of the local partners. Project funds are managed through standardized systems, as outlined in an operations manual plan, of the NLM and government, which is updated periodically whenever required. Four seconded national project coordinators by the government act as fund administrators under contractual agreement with NLM/E. Accountants, cashiers, store keeper and driver are part of the employed project staff with clear job description, besides overall RMMPs accountant at NLM/E finance office level. Approval of each project budget made annually by the NLM and its back donor. Also the projects are given a chance to reallocate/revise annual budget within approved budget frame to have more room of reliability.

The implementation of the projects was through Zonal and Woreda health structure utilizing seconded staff as project coordinator. In addition, monitoring and joint supportive supervisions of the projects made by the target Woreda and Zonal pertinent sectors including project steering committee. For detailed each project performance and financial utilization, refer to each projects five years' final summary and annual audit reports prepared to facilitate this evaluation.

As to the entered project agreement with the local government two evaluations (mid and terminal/final) of each four RMMP to be carried out by the co-signatories (BoFED and BoH from the region including the same structure at zone and target Woreda level. As co-signatory NLM/E will take part in actual evaluation of the projects

6. Questions to be answered

The evaluation will provide answers to the following questions:

6.1 Effectiveness

- To what extent have project intended outcomes been realized in the project target sites as it relates to the knowledge and skills transfer, attitudes and practices of BEmONC and CEmONC services?
- Has RMMPs led to better and equal participation in all project components?

6.2 Relevance

- Does the RMM Project contribute to the achievement of the MDGs, SDP GTP?
- Has RMMPs built human and material capacity of target health institution, besides technically support through monitoring and joint supportive supervision)?
- Does the RMMPs help target health institutions to become independently operating and actively participating as responsible development instrument?
- Does the project ensure consistent and sustained exposure to knowledge and skills-based health education?
- Have the projects increased the capacity of target health professionals and non-health professionals, through practical and theoretical short and long term trainings?

6.3 Efficiency

- Is the approach of RMMPs management and implementation cost-effective? How can we minimize cost and maximize benefit in the RMM projects implementation?
- To what extent have the projects guidelines been implemented in target health institutions in a standardized way? What factors contributed to the efficiency implementation of RMMPs as planned? What are the hindrances?
- To which extent has the RMM program managed to facilitate a learning environment between the four different RMM projects? (How has the projects learnt from one another)

6.4 Impact

- Has the Projects resulted in behavior changes in the lives of target health professionals and community, particularly reproductive age mothers?
- Has the RMM Project intervention contributed to a reduction in Maternal and their new born morbidity and mortality?
- Has the project initiative also impacted upon knowledge, attitude and practices in the health institutions outside project targets areas?
- What are the impacts of the projects on reducing material mortality performances in particular and health development of the target area in general?

6.5 Sustainability and Replicability

- To what extent are the RMMPs implementation, management arrangements and funding sustainable?
- Has local government sense of ownership built at each project target area to maintain project outputs?
- How clear is project phase-in and phase –out for all key stakeholders as indicated in the agreement document and their readiness?
- What recommendations and lessons learnt in RMMPs implementation should be considered to be replicated outside project target areas?
 - ✓ What are the barriers to replicate RMMP into other unreached geographical locations?
 - ✓ What are the challenges encountered by the staff during the implementation of RMMP and how have they been addressed?
- What changes, if any, should be made to the objectives, design and activities of the project for future interventions
- To which extent has the RMM program ensured good decision making processes, involving relevant stakeholders? Including project management, steering committee and follow up from the partners.

7. Methods

The consultant will commence the work on July 03, 2016 and by August 19(20), 2016 would have concluded and submit the final version report, which would have incorporated the recommendations after reviewed by NLM/E.

It is foreseen that the consultant will gather all relevant data information which will be obtained through FGD/IDI)or target Health institutions, target Woredas and Zonal pertinent sectors completed self-assessment questionnaires in about 20target health institutions in RMMP-Gamo Gofa, Segen and South Omo including RMMP-Bale randomly selected, where the project activities implemented. (Approximately 7days' field work for two projects (RMMP-Bale and South Omo) projects intervention geographical areas and 5 days for RMMP-Segen and, because of distance and road situation, 9 days for RMMP-GG& BSW). The consultant is expected to work closely with the officials at Zonal and Woreda level including health institution leaders. This evaluation would be qualitative and the consultant will design, conduct, and analyse participatory In-Depth Interviews (IDIs) and Focus Group Discussions (FGDs) with duty bearers and rights holders. Data will be collected from health institutions, including their target communities' members, involved project; target Health Post and Health Center leaders, target Hospital medical director, CEOs, and other key stakeholders.

During aforementioned interviews and discussions with Woreda health offices, health institutions leaders, HEWs, HDAs, 1 to 5 network group and Community conversation leaders, baseline data information on the availability, utilization and quality of maternal and newborn health care services in the selected RMMPs visited target sites will be collected by

the consultant. The main aim of collecting baseline data in combination with the project terminal and midterm evaluation serves as a point of reference against, which changes and assess activity's progress of achievements and results can be monitored, measured and evaluated using verifiable indicators presented in the logical framework during the project implementation phase.

8. Sampling and limitations/delimitations

Sampling is important in project planning and evaluation, based on the project intervention geographical and thematic areas. It is through sampling method that effective model of target beneficiaries is produced and reliable estimation, result/output and impact determined. During these midterm and terminal evaluations of RMMPs if possible all project target geographical areas will be visited and individual planned project performance and results/outputs and impacts assessed. On the other hand, the situation in some of target area may limit/delimit the consultant to visit entire project sites because of inaccessibility and other related risks as indicated in each PD to achieve as planned, where the consultant to give emphasis on target areas will be agreed on jointly by the consultant project and key stakeholders.

9. Expected product presentations

The consultant is expected to debrief each project steering committee target Zone, Woredas and NLM/E with draft level findings, conclusions and recommendations in written organizing a meeting ahead of commencing final version evaluation report writing process. A final report sums up all relevant information discovered by the consultant during the entire evaluation process will be submitted with profound recommendations in written. Ahead of final version evaluation report production NLM/E is expected to go through the intended draft report and give its comments if any, then advice the consultant to bind and submit nine hard copies in addition to the softcopy of the same evaluation report final version.

10. The utilization of the evaluation findings

NLM will learn and reflect on the documentation drawn from the evaluation capturing the expected and achieved results, outcomes and impact, achievements, lessons learnt and encountered challenges.

Also NLM back donor wants to ensure that each project implemented is in line with proposal document amended agreement.

This learning process will serve as an input resource for NLM/E 's strategic planning and future intervention project proposal development.

The learning process and documentation will also be used to strategically influence development partners at local and Regional level. The final report will be used internally and externally as one of the learning and experience sharing tools with the project key stakeholders at Zonal and target Woreda levels.

11. Timeframe for evaluation and reporting

The duration of the consultancy working days, including travel time to the project bases and sites, back and forth as indicated in the figure 1 below. This indicative timeline may be updated through written agreement between NLM/E and the consultant, as needed, during the course of the contract. The Consultant will conduct document review and the entire field work including report write up of the evaluation for 50days starting from 3rd July2016 from the inception of this ToR. Under no circumstances should the consultant invoice for more than the maximum number of days indicated above without formal in advance approval from NLM/E, along with associated amendment to this ToR. The assignment consists of 50days. Detailed indicative timeline for the evaluation and baseline data collection is as shown under here in figure 1.

Table 1: An indicative timeline for the evaluation is provided below

No	Project name	Key tasks	Duration
1	RMMP-Bale		
1.1		Travel to Gob/Robe	3 rd July 2016
1.2		Document review, submission of methodology, work plan and tools Briefing on project performance by the project staff involving project steering committee	4-5 th July 2016
1.3		Project sites visits, interviews, baseline data collection and discussions	6-8 th July 2016
1.4		Debriefing project steering committee and project staff on collected data, evaluation findings conclusion and recommendations	9 th July 2016
2	RMMP-GG & BSW		
2.1		Travel to Arba Minch	10 th July 2016
2.2		Document review, submission of methodology, work plan and tools. Briefing on project performance by the project staff involving project steering committee	11-12 th July 2016
2.3		Project sites visits, interviews, baseline data collection and discussions	13-17 th July 2016
2.4		Back to project base Arba Minch from project sites visit	18 th July 2016
2.5		Debriefing project steering committee and project staff on collected data, evaluation findings conclusion and recommendations	19 th July 2016
3	RMMP-Segen		
3.1		Travel to Gidole/Segen Area Peoples' Zone, document review, submission of methodology, work plan and tools. Briefing on project performance by the project staff involving project steering committee	20 th July 2016
3.2		Project sites visits, interviews, baseline data collection and discussions	21-24 nd July 2016
3.3		Debriefing project steering committee and project staff on collected data, evaluation findings conclusion and recommendations	25 th July 2016
4	RMMP-South Omo		
4.1		Travel to Jinka, document review, submission of methodology, work plan and tools. Briefing on project performance by the project staff involving project steering committee	25-26 th 2016
4.2		Project sites visits, interviews, baseline data collection and discussions	27-30 th 2016
4.3		Debriefing project steering committee and	31 th July 2016

		project staff on collected data, evaluation findings conclusion and recommendations	
4.4		Departure for Arba Minch to Addis Ababa	1 st August 2016
5	Evaluation Reports		
5.1		Draft report submission for NLM comments	13 th August 2016
5.2		Incorporating NLM/E comments and Final Version report submission	19 th (20) August 2016

12. Report format

The evaluation final report should include the following sections:

- Cover page
- Table of content
- Executive summary
- Body of the report:
 - Introduction
 - Purpose and specific objectives for the final evaluation
 - Methodology employed
 - Findings
 - Analysis/discussions
 - Conclusion and recommendations
- Supporting data should be included in appendices.

The compiled evaluation report of the four RMMPs will be not more than 25 pages.

13. Consultant

13.1 Profile of Consultant

The consultant will work with each project coordinator and technical advisor of RMMP as a resource persons and will be charged with the responsibility of undertaking the overall field work, baseline data and required information collection, reporting and conclusion of the evaluation.

The consultant must possess the following minimum qualifications;

- Masters or BSc Degree in economics, international development studies, community health, social sciences, or other relevant development field of study (Essential)
- Demonstrable experience minimum 8 years in conducting program evaluations, with proven analytical skills (Essential)
- Experience of institutional capacity building and participatory development project approach. (Essential)
- Experience of working with local communities, non-governmental and government organizations. (Essential)
- Experience in the design and use of participatory methods for assessment and evaluation. (Essential)
- Fluency in English and local language (Essential)
- Expertise on Ethiopia civil society and economic context. (Essential)
- Desirable knowledge of Federal Charity and Societies Agency and Charity Organization operation knowledge and approaches. (Desirable)

14. Facilitator

NLM/E development office will assign an expert with good knowledge of project evaluation to facilitate the intended evaluation of three RMMPs terminal and one midterm evaluations. All four RMMPs coordinators and technical advisers and accounts serve as a resource person.

Besides, organizing meetings with pertinent right holder's at Woreda, Zone and target sites, in addition to availing basic evaluation logistics, remain each project coordinator responsibility. In combination with projects evaluation 1-2days will be allocated for baseline data collection per four RMMPs reproducing to the total expenses. Results on as indicated in three new phase project period will be in the south and some retrospective data collection to enhance RMMP-Bale is important for upcoming new phase project planning.

15. Consultant requirement procedures

Considering efficient and effective legal way of recruiting qualified and experienced consultant, NLM/E management committee is fully responsible to advertise, screen and select required consultant for the purpose through its management committee approval. This will be done after the candidates (he/she) technical proposal that includes professional costs and daily rate per-diem before his/her selection approval process (along with any expected adjustment to a number of days required). The selected consultant, then will be compensated at rate approved by NLM/E, taking into account candidate technical proposal, and equal with experience and responsibilities of the consultant (as will be provided in the contract accompanying this ToR).

16. Budget

16.1 Evaluation fees and modalities of remuneration

Full payment will be cogent on receipt of all deliverables as indicated in the signed contract agreement between the consultant and client. NLM will provide an advance for subsistence on contract signature and 25% of the fee on acceptance of the evaluation detailed tools/methodologies and questionnaires. Partial payment of no more than 85% of total will be provided with the consultant invoice accompanying delivery of final version of compiled one program evaluation report with clear content of midterm, end term and terminal evaluations process.

Annex 2: Checklists

**Norwegian Lutheran Mission (NLM) in Ethiopia
Live International Development (LID) Consultants
Information (data) collection format
(To be completed for each Woreda by project focal person)**

Checklist # 1

1. Name of the RMMP focal person _____ Tel. _____
2. Provide brief overview of RMMP in terms of planned and achieved performance

S/N	List of project activates	UOM	Planned	Achieved	%
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					

3. Project beneficiaries

S/N	List of project components	Male	Female	Total
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

4. Financial Performance /Planned versus Accomplishment

S/N	List of project components	Planned	Actual	%
1				
2				
3				

4				
5				
6				
7				
8				
9				
10				

- 5. Did RMMP achieve its objectives? Why? How? Give measurable indicator?**

- 6. Main challenges encountered the project?**

- 7. Mention the Strategies /opportunities used/ adopted to overcome those challenges?**

- 8. Draw your overall conclusion and lessons learned?**

- 9. Draw your recommendation?**

- 10. The way forward?**

- 11. Consultant's Summary**

**Norwegian Lutheran Mission (NLM) in Ethiopia
Live International Development (LID) Consultants
Information (data) collection format**

(To be completed for each Woreda by sectoral government stakeholders)

Checklist # 2

1. Name of the person consulted _____ position _____ Telephone _____

2. Do you know RMMPs? Yes No; if yes since when?

3. What do you know about RMMPs?
4. Your level of collaboration /cooperation?
5. How do you rate the level of transparency of the project with your office?
6. What went wrong?
7. What went right/
8. What should have been done differently?
9. Does the project goes with woreda development plans? How?
10. How do you follow/ supervise the project?
11. Do you receive periodic progress reports from NLM?
12. How is (did) the RMMP support (ing) ed the community? In terms of what?
Give examples in you woreda context?
13. Your conclusions and lessons learned?
14. Your recommendation?
15. Consultant's Summary

**Norwegian Lutheran Mission (NLM) in Ethiopia
Live International Development (LID) Consultants
Information (data) collection format
(To be completed for each woreda by other KIIs)**

Checklist # 3

1. Name of the KII _____ position _____ Telephone _____
2. Do you know IWSP? Yes No; if yes since when?

3. What do you know about RMMps?
4. How do evaluate RMMps? Mention your criteria?
5. What were the key challenges of the project? How overcame?
6. Your involvement in the project panning, implementation, supervision and monitoring?
7. RMM resource utilization?
 - 7.1 Human resource utilization?
 - 7.2 Material resource utilization?
 - 7.3 Financial resource utilization?
8. Does the project facilitate stakeholders meeting? Yes _____ No _____ state why for both?
9. Rate level of transparency of the project with your organization?
Excellent ___ Very good ___ Good ___ Poor ___ Very Poor ___ Non-existent ___
10. How as the communication with the project /AFD?
11. Excellent ___ Very good ___ Good ___ Poor ___ Very Poor ___ Non-existent ___
12. Mention what main changes the IWSP brought about in your woreda context by giving examples?
13. What unique benefits/ packages the project made for community?
14. Your conclusions
15. Your recommendation?
16. Consultant's Summary

**Norwegian Lutheran Mission (NLM) in Ethiopia
Live International Development (LID) Consultants
Information (data) collection format
(FGD guide questions)**

Checklist # 4

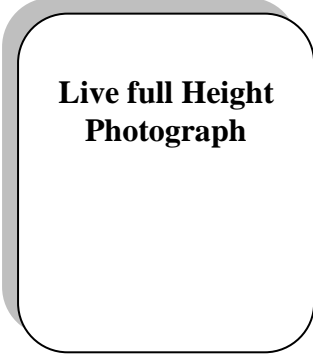
FGD center _____ Data _____ Time from _____ to _____
Woreda _____ Kebele _____ Goti _____

FGD Participants

5. Any other comments/remarks by the consultant?

**Norwegian Lutheran Mission (NLM) in Ethiopia
Live International Development (LID) Consultants
Information (data) collection format
(Documentation / Success/ Failure story)**

Checklist # 5



**Live full Height
Photograph**

1. Name of the person interviewed _____ Age _____
Date of interview _____
2. Waoreda _____ Kebele _____ Village _____
3. Mention Major Measurable changes the project brought?
4. Compare your livelihood systems before and after the project? Assets created before and after the project?

S/N	List of Assets owned /created	UOM	Before the project	After the project
1				
2				
3				
4				
5				
6				
7				

5. Consultant's Summary

Annex 3: Lists of Personnel Contacted

S.No	Contact person	Institution	Woreda /zone	Position	Remarks
1	Tesfaye Mohamed	WHO	Kemba	Representative	
2	Bele Bebis	WHO	Kemba	Planning Expert	
3	Ayele Pawloes	WHO	Kemba	HMIS Officer	
4	Abebe Buta	WHO	Kemba	Quality Regulator	
5	Webenech Yosph	HC	Kemba	Health Centre Representative	
6	Ametu Kebede	HC	Kemba	Anesthetics	
7	Biruk Alemene.	HC	Kemba	CEmONC	
8	Zerfnesh Petros	HC	Kemba	HEW	
9	Lima Desholo	HC	Kemba	HEW	
10	Wondosen Kasahun	Sawla Hospital	Demba Gofa	CEmONC	
11	Tsegreda Tesfaye	Sawla Hospital	Demba Gofa	OR Team Leader	
12	Elas Mesele	Sawla Hospital	Demba Gofa	Ethics Officer	
13	Amare Abera	Sawla Hospital	Demba Gofa	Finance Officer	
14	Demeke Yirga	Sawla Hospital	Demba Gofa	HO	
15	Zemach Zeleke	Sawla Hospital	Demba Gofa	Scrub Nurse	
16	Tegene Tesfaye	HC	Demba Gofa	CDC	
17	Amote Ajebam	HC	Demba Gofa	MCH	
18	Manderfro Shibru	Gezeso HC	Bonkie	Head of Health Centre	
19	Degent Demeke	Gezeso HC	Bonkie	MCH	
20	Almaz Kentishe	Gezeso HC	Bonkie	Scrub Nurse	
21	Dukasa Duma.	Gezeso HC	Bonkie	Emergency...	
22	Belna Bajo	Gezeso HC	Bonkie	Anesthetics	
23	Dereshe Abayne	Gezeso HC	Bonkie	HMIS Officer	
24	Bayush Bekele	Gezeso HC	Bonkie	Attendants of Mothers Village	
25	Dike Diche	Gezeso HC	Bonkie	Mid Wife	
26	Sisay Abebe	Gezeso HC	Bonkie	Planning Expert	
27	Yetmwerash Asmamaw	Gezeso HC	Bonkie	Representative of Woreda Administrative Office	
28	Mena Mayo	Gezeso HC	Bonkie	Maternal and Child Health and Nutrition Expert	
29	Dense Debela	Gezeso HC	Bonkie	Woreda Health Office Representative	
30	Asegedech Gezahign	HP	Bonkie	HEW	Yela Kebel
31	Seblewongel Bekele	HP	Bonkie	HEW	Yela Kebel
32	Dr. Ketsel	A/Minch Hospital	Arba Minch	Gynecologist	
33	Gima Gendela	A/Minch Hospital	Arba Minch	Ethical Officer	
34	Gebeyehu Getelow	A/Minch Hospital	Arba Minch	Anesthetics	
35	Serake Berhane	A/Minch Hospital	Kemba	CEmONC Trainer	
36	Meles Chelbo	WHO	Arba Minch Zuria	MCH Expert	

37	Elinsa	NLM	South Omo	ADvisor/ Coordinator of RMMP	
38	Danial Deri	NLM	South Omo	Supervisor of health extension	
39	Etago Mengeshari	Community	South Ari	Beneficiary	Shepi Kebele
40	Elo Kara	Community	Amer Gale /Airbore	Beneficiary	Goderba Kebele
41	S/r Tsegent Tamene	Jinka Hospital	South Omo	Clinical Nurse	
42	S/r Mehert Gemedo	Jinka Hospital	South Omo	public Nurse	
43	S/r Aynalem Lemma	Jinka Hospital	South Omo	Clinical Nurse	
44	S/r Martha Matheos	Jinka Hospital	South Omo	Clinical Nurse	
45	Tameru Kite	Community	Male	Key Informates	
46	Ayano Konicha	Community	Male	Key Informates	
47	Nabute Ato	Community	Male	Key Informates	
48	Bandire Dasa	Community	Male	Key Informates	
49	Zerhun Markos	Community	Male	Key Informates	
50	W/ Mewand Atenso	ZHO	South Omo	Planning and Monitoring Expert	
51	T/ Hymanot Terefe	MOFED	South Omo	Representative Fiance Office	
52	Tamerat Asefa	Jinka Hospital	South Omo	Head of the Hospital	
53	Dr.Milkias Abraham	Jinka Hospital	South Omo	Medical Director of Hospital	
54	Wesen Debela	WHO	Turmi	Head of the woreda Health Office	
55	Minyot Badeg	HC	Turmi	CEmONC	
56	Bereket	HC	Turmi	BEmONC	
57	Mulken Addis	HC	Turmi	Head of the HC	
58	Robel Kikila	HC	Turmi	Surveillance focal person	
59	Beniam Kebede	HC	Turmi	Anesthetics	
60	Tesfayesus Gebre	HC	Turmi	Scrub Nurse	
61	Abiyot Mokonen	HP	Turmi	HEW	Zerketa Kebele
62	Tsegreda Abaybehe	HP	Turmi	HEW	Dembbaiyte
63	Gebre Baysemay	WHO	Tolta	Head of Woreda Health Office	

64	Meratu Musse	HC	Tolta	Head of HC	
	Webalm Abayneh	HP	Tolta	HEW	Gumeter kebele
65	Shawel Tadess	HC	Berebre	MCH Expert	
66	Abduramine Abdulkadir	HC	Berebre	CEmONC / HO	
67	Yonas Shubese	HC	Berebre	Scrub Nurse	
68	Beyene Abebe	HC	Berebre	Anesthetic	
69	Deme Buluqa	HC	Berebre	Anesthetic	
70	Moleda Gezahegn	HC	Berebre	Anesthetic	
71	Medina Abdulkadir	HP	Berebre	HEW	Walti Dersa Kebele
72	Abiyot Asefanew	HP	Berebre	HEW	Gebe Qequ Kebele
73	Nesru Abdu	Beltu HC	Lege Hida	Head of HC	
74	Sisay Teshome	Beltu HC	Lege Hida	Head of Woreda Health Office	
75	Dametew Alemu	Beltu HC	Lege Hida	Anesthetic	
76	Aman Awo	Beltu HC	Lege Hida	Scrub Nurse	
77	Hussien Husman	Beltu HC	Lege Hida	Scrub Nurse	
78	Amine Awel	Beltu HC	Lege Hida	CEmONC	
79	Remedan Mustafa	Beltu HC	Lege Hida	Anesthetic	
80	Mitriya Mohamod	HP	Lege Hida	HEW	Ado Goro Kebele
81	Azeneme Terfe	HP	Lege Hida	HEW	Maltu Kebele
82	Margarin	Basketo Hospital	Basketo	Advisor of RMMP-Bale Zone	
83	Dr,Bekire Abdulkarim	Basketo Hospital	Basketo	Midical Director of Giner Hospital	
84	Elias Asefa	Basketo Hospital	Basketo	CEmONC, head of Hospital	
85	Tefere Zewedu	Basketo Hospital	Basketo	Representative of Woreda Administration	
86	Dr. Haile Chane	Basketo Hospital	Basketo	Medical Director	
87	Yilma Mohamed	Basketo Hospital	Basketo	Scrub nurse	
88	S/r Mahaza Fehew	Basketo Hospital	Basketo	Scrub Nurse	
89	Ato Worku Mamano	Basketo Hospital	Basketo	HMIS Officer	
90	Zelo	NLM	Arbaminch	RMMM- Gamo Goga	
91	Demise	NLM	Segen	RMMP-Segen	