Mid-term evaluation of the project
“Universal and equal access to quality health services, to meet the health needs of women and children in the Liben Zone (Somali Region, Ethiopia)”

Final Report
Object of the Evaluation

a.1_context

a.1_1 Somali region background

Somali region is one of four regions classified as a Developing Regional State (DRS) by the Ethiopian Government. These are regions where poverty incidences are higher and social indicators lag significantly behind the national averages. In addition, the region is prone to drought, floods, disease, outbreaks and inter-clan conflicts. It is a region with tremendous geographical disparities and there are visible developmental inequities within the region.

The Central Statistical Agency (CSA) based on the 2007 Population and Housing Census, estimated the total population of Somali region at 4.4 million (CSA, 2007), and projected the same at 5.5 million in 2015.

Of the total population, 44% and 56% are females and males respectively, the average household size is 6.6, and the total urban population of the region is estimated at 14%, and 86% of the population is pastoralists and agro-pastoralists.

a.1_2 maternal and child health overview

Maternal, newborn and child, health is the major public health problem in Ethiopia. According to the 2014 Ethiopia Mini Demographic and Health Survey (EMDHS), Somali region lags behind the national averages in the antenatal care attendance (24%), skilled birth attendance (10%) and postnatal care rate (3.2%).

The country has one of the highest maternal mortality ratio (MMR) worldwide. MMR was estimated at 676 deaths per 100,000 live births in the Ethiopian Demographic and Health Survey (EDHS) 2011. The latest estimates of WHO, UNICEF, UNFPA and the World Bank shows that the maternal mortality
ratio has declined to 420/100,000 live births in 2013. The total fertility rate 6.4% is the highest in the country, while usage of any modern family planning is one of the lowest in the country and stands at 1.6%.

Child mortality rate of Ethiopia is among the highest in Africa. According to the 2011 EDHS Report, Somali region had reduced under-five mortality by 122 from the 1990 estimate (from 166 to 88 per 1,000 live births). However, according to 2013 UN estimate Ethiopia has achieved its under-five mortality rate, which is 68/1000 live births, three years ahead of 2015. The Infant Mortality Rate decreased from 97 deaths per 1,000 live births in the 2000 EDHS to 59 in the 2011 EDHS.

The Health Sector Development Program (HSDP) is a key component of Ethiopia's Growth and Transformation Plan (GTP) and its primary objective is to improve the health of the population through the promotion of preventive, curative and rehabilitative health services.

The HSDP prioritizes maternal and newborn care, and the innovative Health Extension Program (HEP) serves as the primary vehicle for the prevention, health promotion, behavioral change communication, and basic curative care. The program is based on expanding physical health infrastructure and developing Health Extension Workers (HEWs) who provide basic preventive and curative health services in the rural community. The Strategy for Revitalising the HEP in pastoral areas that was released mid-2017 acknowledges the challenges of the primary healthcare in pastoral communities and advocates for a change in the management of services, taking into consideration the disparities and features of each regional context.

When the last HSDP ended in June 2015 the next five-year national health sector strategic plan, the Health Sector Transformation Plan (HSTP), which covers July 2015–June 2020, took over, and is considered the first phase of the framework “Envisioning Ethiopia’s Path towards Universal
Health Coverage through Strengthening Primary Health Care”.

a.2_ Project at a glance
The project “Universal and equal access to quality and health services, to meet the health need for women and children in the Liben Zone (Somali Region, Ethiopia)”(Project) started 1st of January 2016 and is planned to be concluded 30th of April 2019.

The specific objective of the Project is to improve the access to integrated maternal, child and reproductive health services (MCRHS) for women and children in Filtu and Dekasuftu districts, in order to make it universal and equal. It is part of the Liben Zone health system development plan and contributes to strengthening the local health system, in partnership with the Woredas Health Offices (WoHO).

In compliance with the latest HSDP and the HSTP, the specific objective is meant to be achieved through three Expected Results (ERs):

ER1: Improve the MCRHS for the benefit of the whole population of Filtu and Dekasuftu districts, without discrimination and with a special attention on the most vulnerable persons (pregnant women, women in the reproductive age, children, displaced persons and pastoralist communities)

ER2: Expand the MCRHS medical coverage through the strengthening of the reference system and the active involvement of the communities

RA3: Train the local health authorities in able to programming, supervision and management of the services provided by the Health Facilities (HF).

a.3_ available baseline analysis
The collection of baseline data was done through two exercises. The first, a Knowledge, Attitude, and Practices Survey (KAP) related to maternal health services in Filtu and Dekasufftu Woredas was conducted in 2016 and focused on the demand side of MCH services. In addition a Health Facility Assessment (HFA) was conducted in the beginning of the Project, in order to give a picture of the services available in the districts, focusing on the supply side of MCH and its quality.

Both the KAP and the HFA were purposely done to obtain a comprehensive picture of the situation in order to provide baseline data for the project upon which progress towards delivering maternal health services in the 2 Woredas should be monitored and evaluated.

**evaluation objective and scope**

After almost two years of implementation CCM commissioned an external mid-term evaluation of the Project.

In March 2018 Avanzi was contracted to perform the mid-term evaluation and it took place during the months of April, May and June 2018.

**b.1 objective of the evaluation**

The objective of the evaluation is to fully review and assess the results achieved by the Project during the period of implementation, as well as its impact and sustainability.

**a.2 scope of the evaluation**

**a.2_1 subject of the evaluation**

This evaluation has focused on stakeholders that are central elements of the Project; community influential leaders, health extension workers (HEW), health workers (HW), nurses, midwives, HFs management, religious and kabele leaders, traditional birth attendants (TBA), WoHOs, target beneficiaries, bureau and local authorities, project staff, project partners, and NGOs implementing similar activities in the intervention areas.

**a.2_2 geographical scope**
The evaluation is designed to assess the overall Project implemented in two of the seven Woredas in the Liben Zone, Somali region.

Besides the Hospital in Filtu, the Project is supporting 19 Health Facilities (HF) in Liben Zone, 13 situated in Filtu Woreda, and 6 in Dekasuftu Woreda. Out of the 13 HF in Filtu Woreda, 3 are Health Centers (HC) and 10 are Health Posts (HP). Out of the 6 HF in Dekasuftu Woreda 2 are HC and 4 are HP.

**a.3 evaluation criteria and questions**

In line with the Organization for Economic Cooperation and Development (OECD)/Development Assistance Committee (DAC) criteria for international development evaluations, this evaluation provides an independent and external assessment of the Project against the following criteria: relevance, effectiveness, efficiency, impact, and sustainability.

A set of evaluation questions against these criteria was proposed in the ToR, which during the inception phase were assessed driven by a rationale of addressing the evaluation objectives through a feasible, meaningful and solid evaluation design.

The slightly revised evaluation questions are detailed in Annex 1.

**methodology**

**c.1 methods**

An initial analysis of progress, technical, financial and activity, and monitoring reports of the Project was conducted to map existing evidence against the assessment criteria defined for the evaluation.

Before the data collection in the field the appropriate evaluation methodology/output for each criteria/key

1 Guidelines developed by the OECD/DAC Network for Development Evaluation (OECD/DAC 2010)
evaluation questions were selected, together with relevant sources used to collect data and analysis methods.

The sets of primary and secondary data have been analysed separately, and the results were then triangulated and combined to be able to fully review and assess the results, impact and sustainability achieved by the Project.

This is laid out in detail in the Evaluation Matrix in Annex 2.

c.2 primary data sources

Qualitative research was the major part of the methods used for the evaluation. A significant abstract from KIIs and FGDs is presented in Annex 3. The KIIs and FGDs were undertaken at various stages of the evaluation process.

KIIs included project staff, WoHO staff, staff of Filtu Hospital, HEWs, HWs, and partnering and non-partnering NGOs. The head consultant conducted the KIIs and translators were used to support the interview process.

In total, the lead consultant interviewed 19 Key informants in the 2 Woredas.

The FGDs were composed of 7-12 participants (sometimes with many non participant observers) and were also conducted by the head consultant with support from the translator, and following a semi-structured topic guides (see Annex 4 & 5). In total, 7 FGDs were held with HEWs or HWs, religious and kebele leaders, TBAs, and targeted direct and indirect beneficiaries. Within each FGD the mix of participants was different, and the semi-structured topic guide was used taking this into consideration.

After discussions with the PM, taking into consideration the security situation, the long distances, the availability of the focal person within the WoHO, the rainy season, and other limiting local conditions, the proposed sample size was decided to 1 HC and 2 HPs per Woreda. In addition one HP in each Woreda was visited that is not supported by the Project as well as Filtu Hospital. The visited HCs and HPs were as follows:
1. Filltu: Aynle HC
   - Lantwer HP
   - Malka Libi HP
   - Bifato HP as not supported
2. Dekasuftu:
   - Deka HC
   - Gunway HP
   - Kurabul HP
   - Higli as not supported

Non-probability sampling, in particular convenience and purposive sampling was used. Even though local conditions limited the sampling, factors such as geographical/cultural particularities and project focus was taken into account to make the sample as representative as possible.

A complete picture of the formal data collection both in numbers, time, and location is given in the Data Collection Grid in Annex 6, the Field visit program in Annex 7, and the Data collection map in Annex 8.

c.3_ secondary data sources
The main secondary data sources used for the evaluation included:

- National surveys: Demographic Health Surveys data from national surveys.
- National policies, standards, guidelines, programs and plans have been analyzed, to assess the relevance and coherence of the Project.
- Ministry of Health performance review reports, where applicable; UNICEF reports; other reports, studies, evaluations, assessments and reviews conducted in the countries.

Available documentation and reports were used for desk-based review and analysis. A list of all the documents accessed for this evaluation is presented in Annex 9.
c.4_ limitations

The findings of the evaluation might have limited generalizability beyond its immediate locality as it included a limited number of stakeholders, interviewed at a specific stage. However, by applying qualitative research methods such as KIIIs and FGDs, the evaluation team sought to get in-depth information to answer evaluation questions. Generalizability is not the main goal of good qualitative research. Purposive sampling of “information-rich” participants has been used to represent (not statistically) the broad types of informants relevant to the evaluation.

findings

d.1_ relevance and quality of project

What is the present level of relevance of the project?

- Are the project overall and specific objectives consistent with, and supportive of Partner Government policies?
- How appropriate are the project activities?
- Are the project activities the best way to achieve the objectives?
- If not, which could be the alternative options?
- Does the project still respond to the needs of the target groups?
- Have key stakeholders been involved in the design process?
- Are the project’s objectives and outcomes clear, practical, and feasible within its time frame?

Overall, the evaluation notes that there is a very high consistency of the Project’s overall and specific objectives with the Partner Government policies and they are strongly supportive of the same. The initial signed support and approval from the WoHOS, the composition of the Projects management committee and steering committee, the interventions methods, the formats and collection of health data, and the selection of author of the final evaluation are all project components to assure initial and ongoing relevance.
Key Informants within the WoHOs confirm that ongoing relevance is being assured through the partnership and collaboration and the decision to identify a specific focal person within the WoHOs for the Project improved this aspect even further.

- The project is in compliance with overarching policy documents such as the latest HSDP, the HEP, and the actual HSTP; all highlighting the importance of community participation as a milestone for development and based on expanding physical health infrastructure and developing HEWs.

- Through its activities and implementing methods, such as alignment with the Ethiopian strategies, guidelines and protocols, and community participation, the Project strongly contributes to strengthening the local health system and fits into the Liben Zone health system development plan.

- The Project is also consistent with more technical policies such as the 2005 National Standards on Maternity Home Services serving as a manual explaining briefly to standardize Services provided within MWH in the health centers.

The Project activities are highly appropriate in order to reach the specific objective and achieve the three ERs. Since the Projects ERs are covering both the health services supply side and demand side, and the WoHOs who are the final responsible actor of MCHs services in the Woredas, the possibilities of reaching the specific objective of improving access to integrated RMNCH are increased.

However the scale of the activities can be discussed. Due to the very challenging conditions in terms of distance, road conditions, vehicle conditions, the number of HFs involved could have been reduced in order to guarantee an overall quality implementation and a higher impact, something that will be discussed in further detail in the following section. In addition a cost-benefit analysis
could be part of the ongoing monitoring of the activities in order to make sure that focus and effort is concentrated on the most efficient and effective activities.

Alternative activities that could be further evaluated in order to achieve the Project objectives could be the implementation of Mobile health and nutrition teams (MHNTs). By 2009, there were 20 government run teams in Somali region, and by 2011 it increased to 24. Alongside government run MHNTs, international NGOs (such as UNICEF) have deployed additional MHNTs. According to a recent evaluation\(^2\) the MHNTs were considered relevant to the pastoralist and weak health infrastructure context of Somali region and could be considered as a transitional alternative strategy for health service delivery in the region. According to the evaluation MHNTs were effective as compared to the static facilities in creating access to previously unreached population groups for health services.

Similar activities (mobile clinics) were applied in an earlier EU-funded CCM project in Filtu (2012-2015), and it was proven an effective (despite very expensive) strategy to increase the access to care. However, this was not the case in terms of strengthening the woreda health system (i.e., community tended to access care only during the outreach activities and avoiding the HPs). A comparison exercise between the two strategies (Mobile Clinic and the standard MHNTs) could be useful in order to understand how the former one could be improved to ensure the enhancement of both the access of care and the quality of the health system.

The Project overall has during its implementation period responded to the need within MCH of the target groups. It is worth mentioning however that during the FGDs almost always MCH was mentioned as second or third major health challenge for the community overall. The first health concern raised was malaria, both among adults and children.

\(^2\) Ethiopia: Evaluation of Mobile health teams in Afar and Somali regions. Breakthrough International Consultancy PLC. 2016
The demand driven approach that is highlighted in the project proposal, as a mean to assure that the interventions serve the stakeholders needs and requirements can be put into question when related to women. The KAP survey used as a baseline for the Project revealed that the poor perceived service quality, the transportation problems and the cultural tendency to rely on traditional midwives are the three main factors limiting access to HFs.

In respect of the transportation problem, which is by far the largest barrier to access to HFs the Project do not respond to this need directly in a sustainable way. The lack of means of transport and if available the limiting cost of fuel was often mentioned during KIIs.

The evaluation also noted that regarding the cultural tendency, the Project due to cultural, traditional and religious norms do not fully respond to the expressed needs within MCH. A women during a FGS explained that she feel safe giving birth at home since if Allah could not help her and she would die she would be surrounded by all her family. It is clear that the protocol Clean and Safe Birth do not correspond to this woman's definition of safe and need. Another example is the lack of women among HEWs, due to the low level of women having the minimum education requires in order to be selected by the community to go though the training and become a HEW.

In the design process the stakeholders were involved but not to a sufficient level. This is especially true for the Project partners WoHOs and Filtu Hospital. The negative effect of this too low involvement is worsened by the high level of turnover of staff and a lack of a well-managed handover among these stakeholders.

Key informants within the Filtu Hospital requested to perform the interview without CCM presence and described the collaboration mal functioning on both a personal and professional level.

It became clear during the KII s that the Project is not fully understood among these stakeholders and this do not
only creates false expectations and a long list of requests outside the scope of the Project, but also sometimes bad tensions as in the case with Filtu Hospital. Instead of being a implementing partner facilitating the Project's activities and making sure they contribute towards strengthening the local health system, they run the risk to become a stakeholder continuously presenting both personal and professional requests, such as transportation, per-diem, and taxi-ambulances.

The Project's objectives and outcomes are both detailed and clear, however as touched upon briefly earlier, the feasibility within its time frame is questionable. This is a fact that came out very clearly from the key informants among the project staff. Due to the very challenging conditions, long distances, road conditions, vehicle and drivers quality, the workload under various activities within all ERs become too high and put the quality of the implementation at risk. The number of HFs involved should probably have been reduced to assure a higher impact and quality especially regarding community participation, and training and technical assistance.

Another aspect of the feasibility of the Project is regarding the ER1; Maternal, child and reproductive health services are improved, benefiting to the whole population of Filtu and Dekasufu districts, without discrimination. When looking at the Data Collection Map (Annex 8), the fact that the Project supports 10 out of 33 HPs in Filtu and 4 out of 12 HPs in Dekasufu, that there are large areas that are not covered, and that the most remote HFs such as Bander is rarely visited, it becomes clear that the ER1 is not feasible within its timeframe.

d.2 _efficiency_
How well is the availability/usage of means/inputs managed? How are the implementing parties’ capacities in the project implementation?

- How are the resources and budget used?
- Does the project have the appropriate financial controls, including reporting and planning, that allow
management to make informed decisions regarding the budget and allow for timely flow of funds?

- To what degree are inputs provided/available on time to implement activities from all parties involved?
- Are project resources managed in a transparent and accountable manner?
- Are responsibilities and reporting lines clear?
- Are work-planning processes result-based?
- How are the monitoring tools?
- Are there parties able to perform the responsibilities entrusted to it?

Of the Project's total budget app. half is related to human resource and app. 85% of the human resources budget is related to local staff costs. Among the available resources (financial, human and physical) which are all managed in a transparent and accountable manner, human resources is therefor by far the largest one. The evaluation has identified 4 areas with room for improvement regarding the efficient usage of human inputs. These areas are all negatively affecting the use of human resources through; unclear and changing responsibilities, reporting lines, and workload, various changes in working and team environment/dynamics, and a decreasing commitment and quality performance.

- The high turnover of the PMs and the gaps between them, which the key informants believe could be better managed from the HO in Torino
- The late, difficult and non-budgeted recruitment of a rehabilitation officer that is alone monitoring all the 20 HFs.
- The high turnover among technical staff. As per the organogram below two key technical positions within the Project were at the time of data collection vacant.
- A heavy workload in combination with challenging both private and professional conditions among all staff and a feeling of unmet/unanswered concerns both from local and national level.
One key informant believes that it should be valuable to understand why staff is leaving, and the reasons should be discussed internally. The importance of a committed and comfortable staff is very high. Other key informants believed that there is a lack of personal improvement/learning within the organization, all staff meetings (it is only taking place when important issues need to be communicated), individual staff evaluations, and national annual workshops.

In terms of the monitoring and reporting system it is in general well functioning and understood by all involved. They consist of monthly general reports to PM (narrative, financial, indicators, and result based planning) and special reports when trainings and other specific events and activities have taken place. They are often followed up by comments and clarifications on a local level. Some staff also reports on activities on a weekly level. The PM then reports internally on a quarterly basis, and that report is also sent to the region and shared with zonal authorities and partners.

One challenge is the lack of feedback from CCMs national office. When that happens it is regarding an old report and the clarifications can be hard to remember. To avoid this it was suggested that each 3 months the reports should be looked at together with the national staff to clarify unclear issue before it gets to old. However national staff has never came to Filtu for a purpose like this. Another important issue related to the reporting is with the
monthly hard copy reports that need to be sent to CCMs office in Addis. The official post service in Ethiopia is not working and no other solution has been communicated. The formats and processes developed to monitor the HEWs, the HWs, the trainings and other project activities are functioning well, but the actual co-monitoring, planning a training on the job are facing the challenges earlier mentioned regarding the long distances, the bad road conditions and the numerous HFs supported.

The second biggest budget line is Rehabilitation, Equipment and Supply, which represent app. 27% of the total budget. Apart from human resources, the first project year was low in spending (mainly only training and mobilization activities were implemented) now with the rehabilitation starting the spending becomes higher. According to key informants trainings was at the moment of data collection the largest expense.

The evaluation found that there are challenges when it comes to provide and make available the physical inputs to assure that the activities are implement on time. The main challenges are within the rehabilitation activities. There are difficulties in procuring various materials due to the long distances, the bad road conditions and the security situation. According to a key informant 90% of the materials are being transported from Addis and the rest from Awassa. The lack of experience and expertise among the counterparts complicates this situation even more. In the past, the logistic challenge has not been given enough support from CCMs office in Addis, but the situation has now largely improved. The procurement of material for communication activities was also highlighted as a barrier to assure a timely implementation of activities within communication and external relations.

When looking at the implementing parties’ capacities and ability to perform the responsibilities entrusted to them the findings are:

- Filtu and Dekaseftu WoHOs - being responsible for management and control of local health services they are the Project’s main partners. Overall, the
capacities are sufficient, but in practical due to political, economical, historical, traditional, and cultural influences the performance of their responsibilities are sometimes reduced. Examples are contradicting figures and data, discussions over per diem and other reimbursements, challenges with internal and external communication, an unclear internal structure, the perception and role of international NGO like CCM etc. One example of a lack of capacity is the limited understanding of the difference between rehabilitation and construction. One key informant argues that there is a lack of commitment among the WoHOs leading to continuous requests of material/services outside the project area, which is a result of negligence. Another key informant explained that due to earlier mismanagement by CCM and other operational NGOs in the area the expectations and understanding of the collaboration is a challenge (the use of per-diem for example)

- Filtu Hospital - the hospital is challenged by a high staff turnover and a sometimes limited handover. There seems to be a different perception regarding the Project’s objective, expected results and the role of CCM in the collaboration. This is in part explained by the change in focus from an earlier project collaboration where the Hospital received much larger direct support. Their ability to perform the responsibilities entrusted to them is sufficient, but the collaboration and consequently the expectations regarding the collaboration need to be further discussed.

- The local community based organization SOWDA (Social Welfare & Development Association) - they have with good quality contributed to the initial KAP survey. However, the collaboration is better described as an implementation support in the form of staff leasing when CCM conducts activities involving data collection.

- The volunteer based Filtu Youth Federation - they contributed to the development and execution of 2 (one
per year) dramas/theatrical shows for community awareness-rising and mobilization. They have the needed capacities and the collaboration has been efficient and with good results. The association represent and important collaboration for the quality and impact of the community mobilization.

According to the evaluation the Project has the appropriate overall financial controls, including reporting and planning, that allow the PM to make informed decisions regarding the budget and allow for timely flow of funds. During the field visit a flaw in the cash-flow management was identified. The signing of the construction contractor had to be delayed to insufficient funds available both at local and national level, and a request had to be put to Torino, delaying the start of the construction of the HP in Gunway.

d.3_ effectiveness of implementation
How well has the project achieved its planned results during this time?

- To what extent has the expected results been achieved?
- What is the progress of the project interventions towards its intended outputs in the project logical framework?
- What is the quality of the results/services available?
- Are all planned target groups accessing to/use project results available?
- To what extent has the project adapted to changing external conditions (risks and assumptions) in order to ensure benefits for the target groups?
- If any unplanned negative effects on target groups occurred to what extent did the project management take appropriate measures?
- Are the activities carried out timely and effectively?
- Are the activities practiced on good principles and ethically?

Regarding ER 1 there is a variation of degree of progress among the interventions contributing to the expected results. The largest delay among the interventions is
within the rehabilitation and construction (Gunway HP was in such bad condition that it was decided to reconstruct it) of the HPs. This is mainly due to the period without a PM, the drought emergency, and the fact that the Project had not foreseen an engineer following the planned rehabilitation of 20 HPs. The rehabilitation officer joined the team in Filtu as late as September 2017. During the First Project year only Filtu Hospital maternity waiting home, Lantwer HP and Misajid HP were rehabilitated. During the field visit the contract for the construction for Gunway and rehabilitation for Arasame, Osobey, and Lambarde were finalized but the progress towards this interventions’ intended outputs in the project logical framework is still behind.

According to the latest internal quarterly progress report (Nov 2017-January 2018) the yearly project accomplishment rate was at 71%. Besides the intervention regarding the supply of medicines and consumable materials, which is on time according to the expected outputs, the training courses and specialization courses of HWs as well as the technical support and on-the-job training are lacking behind. During the period November 2017-January 2018 only 48% of the technical assistance on the job training was accomplished. This is partly due to the fact that the data only started to be collected in November 2016, but also a result of the challenging implementing conditions; distance, road conditions, number of HF involved etc.

ER 2, which is related to the demand side of MCH services, the community mobilization activities didn’t start until November 2017, due to a non prioritization of the Project’s first PM, an underestimation of the planning and organization of the mobilisation activities, difficulties in hiring staff, and the strong focus on the KAP survey. The sensitization campaign activities were at a 6% accomplishment rate in the quarterly report ending in January 2018. With the arrival of the second PM the activities have picked up but there is still some catch up to do within some activities. The 1st KAP Survey was carried out as planned in collaboration with SOWDA and with good results, and rehabilitation of a Maternity Waiting Home at Filtu Hospital has been completed. The continuous
slight delay in the project interventions towards its intended outputs is mainly due to the challenging conditions once again. This is affecting all the mobilization, the awareness raising, and the technical support and on-the-job training negatively. Another intervention that is suffering delay is the distribution of the CCM defined Mama Baby Kit, which according to the first annual report was supposed to be distributed during the second year, but at the time of the field visit the purchase of all the components were not completed.

When assessing the Projects intention to undertake a strong institutional capacity building among the local health authorities; ER 3, the focus during the first Project year was to build a relationship of reciprocal trust. This has led to a postponement in the implementation of the evidence based planning training and slight delays in the implantation of the health service management training. The joint visits for monitoring and supervision are reaching an quarterly completed rate of app. 48% in the quarter ending in January 2018, while the supply of office equipment has reached a 100% completion.

When looking at the quality of the results/services, all 3 ERs have a general high level of quality. Of course this vary from HP to HP and from community to community, but the general impression and what data from KII and FGDs show is that when once implemented the quality is high. The actual PM during the field visit who inherited a large delay in some activities has managed to not only to catch up but also to assure the quality of the results.

To what extent the planned target groups access the Project’s results available, the major challenge lies within ER 2, where the project intends to remove barriers to access to services and to promote services demand.

As earlier discussed under the Project’s responsiveness to the needs of the target groups there are cultural, religious and traditional norms creating large barriers to access, in addition to the transportation barriers. The estimates vary a lot depending on whom you ask and in what community. A key informant within the Dekasuftu WOHO
claimed that there are no more homebirths in his Woreda, while the Medical Director in one of the HC in the Woreda said that 70% of the births in the HCs catchment area are taking place at home. Another challenge in reaching the planned target groups is related to the selection made by the WoHOs of health staff to participate in trainings. Sometimes the selected staff responsibilities are not related to the training and sometimes in the case of follow-up training different persons are being selected.

Regarding the Project’s risk management the Proposal (only in the Italian version) mention three areas of risk analysis.

- An evacuation plan
- Logistic delays in supply of medicines and consumable materials
- Socio-cultural barriers

When looking at the Project’s assumptions the relevant ones listed in the proposal are:

- The equipment, medicines and consumable materials remain available
- The safe presence and movement of staff
- Deteriorating conditions regarding water and food availability

A key informant at Dekasufu WoHO explained that there is lack of drugs/vaccinations at federal and regional level and they are unable to use private channels due to the price. He argued that the governmental Pharmaceutical Fund and Supply Agency (PFSA) is not delivering the amount of drugs that the Woreda has applied and paid for in advance. The Project’s activities regarding the purchase of medicines to avoid out-of-stock condition and ensure the disposition of essential medicines like the one used for foetal malformations prevention is working well.

The evacuation plan has luckily not been needed to be implemented, however, security challenges related to ethnic conflicts as well as political demonstrations have limited the movement of the staff and has created challenges and
delays in reaching certain communities and HCs as well as procurement and logistics from outside Somali region. Ethiopia has declared a state of emergency for 6 months both in October 2016 and February 2018. The first declaration was one of the reasons to why CCM reacted and requested a 4 months addition to the Project's time period, together with the limited time without a PM, and difficulties in recruitment of staff.

In March 2017 a suspected measles outbreak was reported in Kaljeh HP (Filtu woreda) and CCM supported both with manpower and logistic support to assist the outbreak investigation, case management, selected measles vaccine campaign and transportation of samples.

The challenge and risk of social and cultural barriers is the one that although initially analysed, being the focus of the KAP, and identified and monitored by the PM, remains an unsolved challenge.

Overall the activities have been carried out with a variation of delays, mainly due to the challenging conditions in the implementation areas (security, distance, road conditions) and the large number and geographical spread of the selected HFs. As a response to this the PM has combined various activities to be implemented during the site visits. The effective use of the vehicles at disposal is also an important factor and here it seems to be a slight lack of monitoring regarding vehicle maintenance and rented cars/drivers.

All the activities are ethically practiced and on good principles favouring vulnerable groups and disadvantaged persons.

d.4_ impact
What is the direct impact prospect of the project at Overall Objective level?
To what extent does the project have any indirect positive and/or negative impact?

- What is the overall impact of activities undertaken to target specific objective high lightening the major
contributory factors for positive and negative aspects?

- What are the threats? How have these been addressed? Could these have been addressed in a different way?
- Have there been any unplanned positive impacts on the planned target groups or other non-targeted communities arising from the project?
- Do donor coherence, complementary and coordination existed and had any indirect impact on the project?

Taking into account that this evaluation focused mainly on qualitative data and that the Project only has been implemented for two years, the data collected shows a clear direct positive impact in contributing to the general objective of the Project.

The major contributing factors/activities to the improvement of access to integrated RMNCH services as well as limiting factors to an even larger impact are as follows:

- Structural rehabilitation and purchase/maintenance of equipment – the evaluation showed that this activity do have a positive impact on the access. However, the impact is conditioned by many factors. The direct positive impact from this activity will become clearer in the end of the project. Conditioning factors are the space within the HPs, the functioning of the referral system, the success and the impact of the community mobilization, the presence of a female HEW etc. Gunway is a perfect example of a potential high positive impact. The community has been mobilized effectively and during the FGD, the participants all said that they are ready to start accessing the services provided by the HP once the construction is finished. The non-supported HP in Hgle shows very clearly how the impact from this activity is conditioned. Of all the HPs visited it was by far the best equipped, however, despite the various equipment and supplies in the facility received from other NGOs, such as soaps, malnutrition kits, and brochures, the HPs MCH services were neither promoted nor requested.
Supply of drugs and consumables - the KAP showed that one of the three main reasons limiting access to the HPs is the poor perceived service quality. The evaluation noted that increased supply of drugs and consumables have improved the perceived quality and consequently had a positive impact on access to RMNCH services. Within almost all FGDs, the women in reproductive age stated an increase in the perceived service quality related to material such as clinical gloves, scissors, clean clothes, and soaps. However, in many HPs this material was given to the TBAs by the HEWs and used to assist during home delivery, without the HEWs presence.

Logistic support of vaccines - the FGDs showed that the increased availability of vaccinations through the Project’s logistic support, have had a positive impact in terms of access to integrated RMNCH services at HPs, both in terms of more vaccinated children as well as an indirect positive impact through increasing access due to perception of a quality services offered regarding vaccinations. However, there is a challenge regarding the conservation due to the availability and functioning of the solar fridges. For example, Gunway HP has no fridge, and whereas some HPs have solar fridges it is often not functioning. The WoHOs have made requests both to regional and federal level and also to CCM, but the only ones accepted by the region (the WHO approved ones) are too expensive to fit in this project’s budget. Key informants said that the vaccination programs for children sometimes couldn’t be followed timely, since the HPs are depending of timely transportation support of the vaccines.

RMNCH and specialization course for HWs - all the HWs believed to have benefitted from the courses, that the appropriate persons had attained the courses, and that the content of the course was highly relevant. One midwife at Filtu Hospital that had participated in Basic Emergency Obstetric Care (BEmOC) training said that she especially had learned how to perform assisted delivery procedures such as Episiotomy (a
surgical incision) and vacuum extraction, and that she also had had the possibility to apply it in practice. However, the noted positive impact is being limited in the case of the HCs when the acquired capacities cannot be practiced due to lack of cases available and/or lack of materials, such as a vacuum extractor. Another limitation of impact is the fact that course participants felt that there was no system in place regarding the sharing of knowledge and expertise acquired during the course. A solution could be that together with Project partners evaluate the possibility to co-develop and support a federal format for a Training of Trainers (ToT), in order to make sure that the acquired knowledge and capacities are shared among peers and trickles down in the organization. A key informant believed that the issue of per diem is hard to manage, which represent the final limitation to positive impact from RMNCH and specialization course for HWs. He believes that half of the participants join the training only for the per diem and do not show interest in learning and having a positive impact in their communities. He suggests that this could be avoided with and even stronger focus on follow up, monitoring, and rewards of good evaluations.

- Implementation of a Maternity Waiting Home - the impact is positive but conditioned depending on the distance to the MWH. Reproductive women from communities living close to Filtu Hospital and Deka HCs testified the positive impact through the reduction in pregnancies at risk leading to fatal deliveries, however this was not the case for more remote communities, which represent the majority.

- Creation and Mobilization of community members’ group & awareness raising campaign on RMNCH health - this is where the Project has the largest positive impact. At the end of the first Project year data collected during the period November 2016-March 2017 showed that the use of ANC had increased with 11%, and the use of skilled attendance at birth with 11%. All the qualitative data show that the increase in access is
mainly due activities in this area. Also the WoHOs agrees on this point. During many FGDs it became clear that the reproductive women that now come for prenatal visit, that deliver in the HF, and that make sure that their children are vaccinated, are doing so thanks to this activity. A key informant however explained that barriers are still high when performing the community mobilization due to cultural, traditional and religious issues.

- Joint visits with TA for HC/HP monitoring and supervision - monitoring and supervision support is often needed and requested on various topics, and is also key to reach impact. Also here the non-supported HP in Higle is a showing example of how the lack of monitoring and follow up is limiting the impact. In Gunway the activity has shown a big positive impact and an informal replicable reward system (different gifts are given to high performing female and male community volunteers) used in this community improves the impact even further. Overall the activity has a positive but still limited impact to the specific objective.

- Supply of office equipment - both the WoHOs was satisfied for their new needed office equipment, and it showed to have a positive impact in terms of the collaboration, communication, and commitment etc. However, the direct impact to the specific objective is rather minor.

The biggest threats to a positive impact are the early mentioned access barriers, transportation and cultural, religious and traditional norms.

The referral system strengthening activities do little to address this threat, and to solve logistical problems and to ensure a prompt assistance. With exception from Filtu Hospital, and the HFs that are both close to a road and close to a HC or hospital the lack of transportation is a major threat to impact. The lack of resources to pay the fuel both back and forth, the lack of maintenance of the
existing vehicle, and the bad road conditions makes this threat even harder to address. This barrier was noted in the KAP and is a hard one to address.

The cultural, religious, and traditional barriers to access are being confronted within the community mobilization and awareness raising activities and improvements are seen. The lack of female HEWs came out in the evaluation as one of the strongest barriers among reproductive women. There are no women that have the minimum required level of education to be selected by the community. In order to address this threat the community mobilization could include the importance of girl education and support of the same, and collaboration with the support of the local authorities with an organization supporting education for girls could be developed.

One key informant, with a long experience, explained that CCM is the only organization in the area that is truly appreciated by the community members. The underlying factors to this are:

- Transparency of activates/administration/finance
- Output and impact is felt (which is even harder since the activities are mostly soft)

This is an example of an unplanned positive impact, since it will facilitate the operation of future organizations in the area.

Regarding any indirect impact arising from donor coherence, complementary and coordination the evaluation did no find data of sufficient importance.

**d.5 sustainability**

What is the level of ownership of the project by target groups and will it continue after the end of external support?

What is the level of policy support provided and the degree of interaction between project and policy level?

How well is the project contributing to institutional and management capacity?
- How far is the project embedded in the local structures?
- What is the likelihood that target groups will continue to make use of relevant results?
- What is the risk that the level of stakeholder ownership will be insufficient to allow for the project outcome/benefits to be sustained?
- Are there any social or political risks that may jeopardize the sustainability of the project outcomes?
- Do the various key stakeholders see that it is in interest that the projects benefits continue to flow?
- Is there sufficient public/stakeholder awareness in support of the long-term objectives of the project?
- Are there any obstacles hindering project sustainability?
- How far is the project embedded in institutional structures that are likely to survive beyond the life of the project?
- Are project partners being properly developed (technically, financially and managerially) for continuing to deliver the project's benefits/services?
- If the services/results have to be supported institutionally, are funds likely to be made available? If so, by whom?
- Are the services/results/ affordable for the target groups at this point of the project? Financial/economic viability?

In this section the findings relevant to answer the evaluation questions are presented following the points of view from which, stated in the Proposal, the Project is considered sustainable.

Financial:

From a financial perspective the positive factor is that the HF staff is integrated in the public health system, which bears the costs. However when it comes to all the others costs, purchase of medicines when PFSA do not deliver, per diems to people participating in trainings as well as focal persons when accompanying CCM staff in the field, fuel, etc. are all covered by CCM. Additional funds
to support the services are not likely to be made available on an institutional level. Key informants explained that various requests have been made regarding various expenses but without success.

The services/results are in theory affordable for the target groups since they are free, however due to lack of needed medicines at some HFs they target groups have to buy it outside the HF, which is not affordable to everyone. The for many needed transportation cost in the form of fuel and per diem for the driver is a factor that strongly makes the services/results un affordable to the target groups.

Institutional:

According to the proposal and correctly so the implemented activities respond to the needs identified by SRHB and WoHOs. However, this does not automatically mean that they will assume the commitment to maintain the project results achieved and to continue independently as stated in the proposal. The lack of a common understanding of the project and the collaboration shows that the Project is not that well embedded in institutional structures. The fact that the WoHOs sees CCM as an organization supporting the WoHOs where it is needed makes the evaluation believe that it is likely that the Project will not survive beyond the life of the project. One key informant said that it takes a long time to redefine expectations from partner and beneficiaries. The institutional sustainability is also questioned when it comes to the partners technical, financial, and managerial level for continuing to deliver the project’s benefits/services. As described before even it this is improved by the Projects activities historical, traditional and cultural aspects will still challenge the sustainability.

Social:

The proposal suggested that in order to maximize the social impact, the awareness raising and training activities are based on methodologies adapted to the local context. According to the evaluation, the Project is well embedded in the local structures within the catchment area, which
are geographically close to the HFs. However, among the many sub-kabeles the Project is less embedded and the various barriers to access are still untouched. As mentioned by one HEW during a FGS, the community volunteers would like to receive per-diem from the WoHOs when they do outreach to cover the alternative costs. This is especially true for Filtu Woreda where the distances are even longer and the HEW is often alone and therefore depending on volunteers for outreach activities.

The level of ownership of the project by target groups is very variable; in Gunway it is very high but in Malakalibi it is very low. With the late start of the community mobilization and awareness raising activities it is very hard to estimate the likelihood that the target groups will continue to make use of the services. CCM’s role in increasing the access is key and with only 1 year left of implementation there is a risk that the level of stakeholder ownership will be insufficient to allow for the project outcome/benefits to be sustained on both Woreda level as per the Project’s specific objective. An even in those communities where the level of ownership is stronger the risk is still present due to unsolved challenges such as lack of female HEW, inaccessible transportation, and lack of functioning solar fridges.

Another risk factor is the importance of not loosing your trust once the community mobilization has taken place efficiently. If factor such as materials, availability of HEW, and equipment is not in place the trust can be lost quickly which strongly reduces the long-term sustainability of the Project.

Political:

Ethiopia has been facing recurrent protests since the second half of 2016 that are mainly driven by socioeconomic and political marginalization, especially in Ethiopia’s two largest Oromia and Amhara regional states. The second proclaimed state of emergency in February this year has received a lot of criticism. Human Rights Watch says that it risks further closing the space for peaceful political activity. The directive bans all protests without
permission of the Command Post, a body led by the prime minister to manage the state of emergency. Since April this year, Ethiopia’s Somali region has seen sporadic protests directed at regional President Abdi Iley (Abdi Mohamed Omar) and his administration. The Ethiopian House of Peoples and Representatives (HPR) postponed the local elections (supposed to be held in 2018) by a margin of one year timeframe due to challenges attributed to incessant unrests.

Even though the political situation might not directly create a risk that might jeopardize the sustainability of the project outcomes, it is indirectly creating conditions that complicates the impact and the sustainability of the Project:

- Higher turnover among Project Partners (Somali Regional Health Bureau, and Filtu and Dekaseftu Districts)
- Logistic obstacles due to road blocks
- Lack of transparency, commitment and long-term perspective among the partners due to political turmoil

The evaluation found that they various stakeholders are sufficient aware and personally convinced of the benefits of a continuity of the Projects results, however various, sometimes unmanageable, obstacles are hindering project sustainability:

- The very challenging conditions in terms of distances and road condition
- The lack of proper funds at local, regional and federal level allocated to implement the HEP
- The earlier mentioned lack of commitment and neglect from the WoHOs
- Deeply rooted cultural and traditional aspects that require a long-term perspective in order to see a sustained impact from the community mobilization and awareness activities on the access
Conclusions

The following section provides the evaluation's main conclusions, i.e. the answers to the evaluation questions and hence the synthesis of the analysis produced.

Conclusions are presented here below by relevant OECD/DAC criteria.

Relevance:

- The Project is in present extremely relevant to national policies, plans, and guidelines as well as to the priorities of the health sector. From the latest HSDP, the HEP, and the actual HSTP to technical guidelines on Maternity Waiting Home and guidelines and national handbooks for HWs training, there is a logical continuum and a strong coherence in applying principles of community participations, demand driven approach, capacity building, training and technical assistance, and gender equity to the approach and design of the Project.

- All data sources show a strong appreciation for the Projects from the communities. Yet the voices of end user’s express concerns for critical issues of access and quality of service; the cultural, religious and cultural barriers, the lack and accessibility of transportation, and the lack of female HWs.

- Besides the concern regarding access and quality, the doubts in this section are regarding the full involvement of Partners and Filtu Hospital during the design process, the Project's objectives feasibility within its timeframe in terms of scale and outreach.

Efficiency:

- Overall, the Project is being implemented in an efficient way however the data collected though the evaluation has provided some evidence that is suggestive of possible areas where efficiency gains can be achieved. One major area of potential
assessment is the use of human resources. 4 areas with room for improvement were identified regarding the efficient usage of human inputs.

1. The high turnover of the PMs and the gaps between them
2. The late, difficult and non-budgeted recruitment of a rehabilitation officer
3. The high turnover among technical staff
4. A heavy workload in combination with challenging both private and professional conditions

- The Project relies on a transparent, well-structured and functioning reporting and monitoring system. Yet, example of challenges is the lack of timely feedback from a country office level and a lack of management regarding a timely flow of funds.

- Another important area where efficiencies can be gained is procurement and logistics. The main challenges are within the rehabilitation and communication activities.

- The ability among the partners to perform the responsibilities entrusted to them are sufficient, however, when it comes to the WoHOs and Filtu Hospital, political, economical, historical, traditional, and cultural influences sometimes lead to contradicting figures and data, discussions over per diem and other reimbursements, challenges of internal and external communication, and a slight misperception of the role of international NGO like CCM etc.

Effectiveness:

- Overall the activities have been carried out with a variation of delays, mainly due to the challenging conditions in the implementation areas (security, distance, road conditions) and the large number and geographical spread of the selected HFs. The largest delay among the interventions is within the rehabilitation and construction.
However, when looking at the quality of the results/services, all 3 ERs have a general high level of quality. Of course this vary from HF to HF and from community to community, but the general impression and what data from KII and FGDs show is that when once implemented the quality of the results/services available is high.

To what extent the planned target groups access the Project’s results available the major challenge lies within ER 2 where the project intends to remove barriers to access to services, improving physical accessibility, social, cultural and population acceptability, but also to promote services demand. Due to the short implementation period before this mid-term evaluation due partly to the delay in implementation the access indicators are still behind the intended outputs in the logical framework.

Finally, the evaluation has identified critical areas of attention and in need of improvement regarding the carry out of activities in a timely and effective manner.

- The lack of coordination among NGOs, local organization and WoHOs regarding outreach activities
- 1 rehabilitation officer monitoring 20 HFs
- An underestimation of planning and organization for mobilization and outreach activities
- The discussion around per-diem towards the WoHOs
- Monitoring of the selection of training and course participants (also follow up trainings)

Impact:

- Taking into account that this evaluation focused mainly on qualitative data and that the Project only has been implemented for two years (and the majority of the activities for less time), the data collected shows a direct positive impact in contributing to the general objective of the Project. However, the
evaluation found that there are many both conditioning and limiting factors to achieve a greater impact:

- Conditioning factors regarding to the impact from the activities related to structural rehabilitation and purchase/maintenance of equipment, are the space within the HFs, the functioning of the referral system, the success and the impact of the community mobilization, the presence of a female HEW etc.
- When it comes to supply of vaccinations, the highly limiting factor is the challenge of functioning solar fridges.
- The impact of the training activities are high, but slightly limited due to lack of informal systems of ToT, the motivation of joining the training/courses (per-diem), and in the case of the HCs where the acquired capacities cannot be practiced due to lack of cases available and/or lack of materials.
- Where the evaluation noted the largest impact, within the community mobilization activities, the impact is still limited due to the still high cultural, traditional and religious barriers.

Sustainability:

- Deeply rooted cultural and traditional aspects that require a long-term perspective in order to see a sustained impact from the community mobilization and awareness activities on the access.
- The evaluation found that the level of ownership of the Project by the local structures is significant, however, limited to the communities within the catchment area which are geographically close to the HFs. Among the many sub-kabeles the Project is less embedded. The revealed lack of a common understanding and perception of the Project and the collaboration within institutional structures make the evaluation conclude that it is unlikely that the SRHB and WoHOs will assume the commitment to maintain the project results achieved as stated in the proposal.
• With regard to risks of short and long term financial sustainability of the program, the evaluation concludes that there is a high dependence on CCM for costs such as purchase of medicines when PFSA do not deliver, per diems to people participating in trainings as well as focal persons when accompanying CCM staff in the field, fuel, etc. Additional funds to support the services are not likely to be made available on an institutional level.

• Throughout the analysis, it become clear that there are three main obstacles hindering project sustainability:

1. The very challenging conditions in terms of distances and road condition
2. The lack of proper funds at local, regional and federal level allocated to implement the HEP
3. The earlier mentioned lack of commitment and neglect from the WoHOs

recommendations

The logic, use, and management of the per-diem need to be revised, in coordination with WoHOs and international and local organizations operational in the area.

In order to address the importance of girl education within the community mobilization, a collaboration should be developed, with the support of the local authorities, with an organization supporting girls education for girls.

In order to avoid trainings potentially taking place at the same point in time, and not to loose out on efficiency gains regarding transportation and logistics, regular coordination meetings among the different NGOs present in the area should be organized. Compared to the ones already existing, having or a technical focus or a reporting objective, these meetings should have as objective to efficiently coordinate and plan the participating organizations activities.
Under the very challenging conditions both professionally and privately there is a need for an improved staff management both in Ethiopia and in Italy. In Italy it refers to a better planning and management of the PMs. In Ethiopia it could entail teambuilding activities locally and nation wise, analysis of why staff leave in order to prevent similar situations or circumstances, and a revision of the individual workload.

The long distances and challenging road and vehicle conditions do create barriers to access, to organization of training, to collect data, and to supervise and monitor. Since a reduction of the number of HFs targeted is counter productive cost-benefit analysis should be considered (as part of the ongoing monitoring and supervision) in order to make sure that focus and effort is concentrated on the most efficient and effective activities.

To tackle the risks related to product/service quality as well as trust (the trust created from the mobilization activities can be at risk if the services are not possible to be performed), the lack of fridge storage needs to be confronted.

A final recommendation is to perform an analysis together with Project partners regarding the possibility to include TBAs as beneficiaries in the Project, especially on a HP level. Even if the Ethiopian Health Services Extension Programme (HSEP) only calls for the TBAs incorporation into the system by serving as volunteers who work under the supervision of the HEW, the implementing partner could together evaluate, with support from regional and federal level, the possibility to target TBAs, in order to more efficiently confront the cultural and traditional barriers and not miss out on key trust, experience, and expertise. Without deployment of adequate numbers of trained health workers for delivery services, and with the relative lack of female HEWs, TBAs remain vital for the communities in need of MCH services.
list of Annexes

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