Evaluation of Maternity Worldwide Gimbie Integrated Maternal Health Programme

October 2006 – March 2009

Big Lottery Fund

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Glossary

BLF	Big Lottery Fund
GAH	Gimbie Adventist Hospital
NGO	Non-governmental organisation
PSG	Project Steering Group
SBF	Safe Birth Fund
SBV	Safe Birth Vouchers
UN	United Nations
WHO	World Health Organisation

Executive Summary

Maternity Worldwide is an NGO whose purpose is to help reduce the number of women dying or injured in childbirth in resource-poor settings in line with the millennium development goals. Its mission is to identify and develop appropriate and effective ways to decrease maternal and newborn mortality and morbidity, facilitate community access to quality skilled maternity care and support the provision of quality skilled care.

This is the final evaluation report of the Maternity Worldwide Gimbie Integrated Maternal Health Programme in West Wollega, Ethiopia from October 2006 – March 2009, supported by the Big Lottery Fund. This programme has been based on the WHO Three Delays Model which emphasises that deaths during pregnancy and childbirth are, in the main, due to delays at community and health facility levels.

Maternity Worldwide worked in partnership with the Gimbie Adventist Hospital and the programme targeted 40 kebeles (villages) situated in 3 woredas (districts), including 15 kebeles in the first year and 25 in the second year. The programme worked at all levels including:

- women's income generating projects at community level
- a community health education project for women, men and children
- upgrading the facilities and equipment at four associated rural clinics
- upgrading the facilities and equipment of the Gimbie Adventist Hospital to make it a comprehensive emergency obstetric unit
- recruitment of new professionals and upgrading the skills of existing professionals where needed.

The women's income generating projects originally targeted 1200 poor vulnerable rural women, and the community health education project aimed to hold a total of 200 health education sessions attended by 10,000 women men and children.

Other activities supported by Maternity Worldwide (but not funded by the Big Lottery Fund) included an expansion of the existing Safe Birth Fund voucher system where subsidized maternity care was provided for all women in the programme kebeles.

The programme achieved outstanding results in a relatively short time frame. There was a substantial year on year increase in the number of women attending Gimbie Adventist Hospital for deliveries, which included those with obstetric complications. Antenatal attendance also increased substantially during the programme life. Maternity Worldwide established an obstetric database to support the hospital's monitoring system and all details of maternity admissions were subsequently recorded. It has also developed a successful maternal death tool used to audit maternal deaths and, with improved procedures by Year 2, the case-fatality rate had fallen.

The women's income generating project was extremely successful. The main activities selected by women beneficiaries were animal rearing, petty trading, gardening and a small number undertook cotton spinning and other activities. Nearly 80% of those women who started activities in Year 1 of the project have paid their original loan back and most had made a profit. Before the project many of these women had collected firewood for a living. The loans which were paid back were revolved so that new women's groups could be established.

Much of the success of this programme was due to the implementation model used by Maternity Worldwide which comprised of three steering groups to oversee the various activities. and whose members comprised of different governmental departments, NGOs and faith based organisations. The steering groups included representatives with a wide range of technical skills including health, agriculture, vetinary and social services. Representatives from the Woreda Women's Affairs department were particularly committed and active in the steering committees.

These committees oversaw the implementation of programme activities including monitoring activities. This was the first time that such an integrated way of working had been undertaken in West Wollega and its members were very enthusiastic to reproduce this way of working in the future with other health-related programmes.

It is clear from the visits to a sample of programme kebeles during the evaluation that the programme has had a positive and beneficial impact on the status, financial security and rights of women beneficiaries. The impacts were wide-ranging with benefits relating to family health, children's schooling, women's economic status (including increased income and savings), social standing and peace of mind. The profits made from the income generating activities had had a clear positive effect on women's ability to travel to hospital for delivery and pay a contribution for any medical procedures necessary. In several of the kebeles visited beneficiaries reported that they had started up other women's savings and credit associations drawing on the skills provided by the project.

A community health education programme was also rolled out to community members in the programme kebeles and was undertaken by the government health extension workers with support from Maternity Worldwide. Health education was given to groups of community members at a range of different venues and also carried out from house to house. Activities significantly over performed against the original targets including the number of sessions given and the number of community members attending these sessions. Focus group discussions undertaken during the evaluation visit to a sample of programme kebeles showed a noticeable change in the knowledge, attitude and behaviour of beneficiaries.

At the end of the programme period responsibility for the ongoing implementation of the women's income generating groups and community health education project was handed over from Maternity Worldwide to the relevant government zonal departments. This will help promote the sustainability of the programme.

It was clear that there was high participation at all levels of the programme: from the steering committees right down to the communities.

Capacity building has taken place throughout the programme including building the capacity of those who participated in the three steering committees, health staff at the maternity unit at Gimbie Adventist Hospital and the rural clinics, and women beneficiary and kebele leaders in the communities (who received training on income generating projects and community health education).

The Maternity Worldwide programme has successfully upgraded the requisite equipment at Gimbie Adventist Hospital so that it can now function as a comprehensive emergency obstetric care facility. The equipment was purchased and installed in the face of many logistical difficulties.

The strengths of the programme include the huge achievements made in a short period with a limited number of personnel. This is the only safe motherhood project in this zone providing hospital lbased emergency obstetric care in addition to community activities. The programme has been well implemented in spite of many obstacles faced including the remote and mountainous programme area, the difficult journey to Addis Ababa and the difficulty of attracting qualified obstetricians to this area. The hospital and clinics are now fully equipped with the relevant equipment. The formation and management role of the three programme steering committees in the programme implementation is unique in this zone and provides a good future model and will contribute to the programme's future sustainability. The involvement of kebele leaders at the community level has helped to tap their invaluable experience of their own communities when planning the programme and to later mobilise communities. The women's income generating projects and the community health education project have had a wide reach.

The programme weaknesses and constraints include the short time frame originally allotted, the shortfall in real spending money due to the recent worldwide economic downturn, the high turnover of programme staff, the weak link of the rural clinics in the three delays model and the need to adopt a behaviour change communication model to improve health education delivery and make it more participatory.

1. Background

This is the final evaluation report of the Maternity Worldwide Gimbie Integrated Maternal Health Programme supported by the Big Lottery Fund from October 2006 – March 2009**.**

This programme has been based on the Three Delays Model which emphasises that deaths during pregnancy and childbirth are in the main due to delays at community and health facility levels.

The WHO **Three Delays Model**[1] is as follows:-

1. Delay in deciding to seek care when problems arise due to
- *Low status of women*
- *Financial barriers*
- *Poor understanding of maternal health problems*

2. Delay in reaching health care once the decision to seek treatment has been made due to
- *Poor roads*
- *Mountains, rivers and difficult terrain*

3. Delay in receiving effective, good quality treatment when the health facility is reached due to
- *Poorly equipped facilities*
- *Lack of skilled professionals*
- *Shortage of essential drugs*

West Wollega in the west of Ethiopia is a mountainous area with remote kebeles (villages), unmade roads, a lack of transportation, high levels of poverty and poor access to health services. There are insufficient health facilities and many are substandard with low utilisation rates, and high case fatality rates among pregnant women who access health care. Women are particularly disadvantaged in this zone as a result of high illiteracy rates, limited access to contraceptives and unsafe water and sanitation. Women mostly deliver babies at home and many maternal deaths are avoidable and have a large impact on child health and development.

Prior to support from the Big Lottery Fund, maternal health activities had been implemented in Gimbie on a small scale for a number of years. In 2005[2] Maternity Worldwide undertook a situation analysis which confirmed the need to scale up these activities to reach a wider population. The analysis also revealed a great enthusiasm among community leaders and community members to improve maternal health and they welcomed this proposal to scale up. The Big Lottery Fund awarded a two year grant which commenced in October 2006 and supported Maternity Worldwide to work in partnership with Gimbie Adventist Hospital (GAH) in 40 kebeles situated in 3 woredas (districts) of West Wollega (which has a total of 21 woredas). The 3 woredas included Gimbie, Lalo Asabi and Guliso, and the programme focussed on Gimbie Woreda in Year 1 and Lalo Asabi and Guliso in Year 2 ***(see Appendix 1 for Map of Woredas of North West Oromia Region)***

In Year 1 4 of the 15 kebeles were in Gimbie Town and 11 in Gimbie Rural. In Year 2 5 of the 25 kebeles were from Gimbie District, 15 from Lao Asabi and 5 from Guliso Woreda.

This Big Lottery Fund programme set out to work at all levels taking the three delays model into account, and planned activities included:-

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[1] Thaddeus S, Maine D. Too far to walk: maternal mortality in context. Soc Si Med 1994; 38; 1091-1110

[2] Maternal Health in West Wollega, Ethiopia. A description of the context, evaluation of service provision and recommended action to reduce deaths in pregnancy and childbirth. Maternity Worldwide. May 2005.

- woman's income generating projects
- a community health education project for women, men and children
- upgrading the facilities and equipment of the Gimbie Adventist Hospital (GAH) to make it a comprehensive emergency obstetric unit
- upgrading the facilities at four associated clinics
- recruitment of new professionals and upgrading the skills of existing professionals where needed.

Other activities supported by Maternity Worldwide which were separate to the Big Lottery Funding included an expansion of the existing Safe Birth Fund voucher system where subsidized maternity care was provided for all women in the programme kebeles. In addition, it also funded the treatment for common complications following childbirth including obstetric fistula and utero-vaginal prolaspe.

A time-line of activities and significant events during the life of this programme has been mapped out ***(see Appendix 2 for Time Line of the West Wollega Maternal Health Programme)***.

A mid-term evaluation of the programme was undertaken at the end of Year 1 in January-February 2008.

A no cost extension to the programme was agreed between the Big Lottery Fund and Maternity Worldwide from September 2008-March 2009.

2. Programme Targets

Total number of beneficiaries targeted

The programme proposed to target[3]
1) 1200 rural women disadvantaged by poverty, limited education and low status and unable to command resources.
2) 2117 poor pregnant women disadvantaged by high mortality and ill health and unable to access and influence reproductive and maternal health services.
3) children and families disadvantaged by high maternal death rates resulting in loss of the family unit and inability to break the cycle of poverty (this included 5,187 men and 5,398 women).
4) rural communities disadvantaged by poverty and poor knowledge of and access to preventive health measures including maternal and reproductive health (this included 58,800 men and 61,200 women).

The specific programme targets are included in Table 1 below.

Table 1: Programme targets and achievements, October 2006 to March 2009

	Programme Targets	Year 1	Year 2	Total	Programme Achievements
Women's Groups	Number of new women's groups established	15	25	40	40
	Number of women attending groups	450 women	750 women	1200 women	1200 women
Health Education	Number of kebeles to receive health education	15	25	40	40
	Number of sessions to be held*	75	125	200	Year 1: 225 Year 2: 1268
	Number of attendees (including women, men and children)	3,750	6,250	10,000	Year 1: 14,087 Year 2: 97,694
Health Service Capacity Building	Number of facilities equipped to provide Comprehensive Emergency Obstetric Care[4]	1	0	1	1
	Number of facilities equipped to provide Basic Emergency Obstetric Care[5]	0	4	4	3 clinics equipped & 1 clinic accidentally burnt down*
	Number of nurses trained as 'skilled birth attendants'[6]	12	12	24	Year 1: 6 trained Year 2: 10 trained By November 2008 a total of 16 trained
	Number of practical workers trained as 'assistants to the skilled birth attendants'	11		11	Year 2: 11 trained

[3] Maternity Worldwide International Grant Application to the Big Lottery Fund.
[4] Definitions of Comprehensive Emergency Obstetric Care are given in Appendix 3.
[5] Definitions of Basic Emergency Obstetric Care are given in Appendix 3.
[6] Definitions of Skilled Birth Attendants are given in Appendix 3.

3. Kebeles selected to be included in the programme

Table 2 Kebeles selected to participate in Year 1 of the programme

	Name of Kebele	Woreda	Population per Kebele
1	01	Gimbie Town	14,586
2	02	Gimbie Town	7,232
3	03	Gimbie Town	9,296
4	04	Gimbie Town	6,742
5	Tole	Gimbie Woreda	2,023
6	Jogir	Gimbie Woreda	2,773
7	Inango Dambali	Gimbie Woreda	1,601
8	BikiltuTokuma	Gimbie Woreda	2,787
9	Chuta Gochi	Gimbie Woreda	2,123
10	Chuta Georges	Gimbie Woreda	1,954
11	Chuta Qaki	Gimbie Woreda	1,998
12	Dalo Sewa	Gimbie Woreda	4,696
13	Bonaya Asabi	Gombie Woreda	4,819
14	Wara Sayo	Gimbie Woreda	2,262
15	Kombo Michael	Gimbie Woreda	1,392
	Total		**66, 255**

Table 3 Kebeles selected to participate in Year 2 of the programme

	Name of Kebele	Woreda	Population
1	Hore Mariam	Gimbie Woreda	1436
2	Gachi Galel	Gimbie Woreda	1685
3	Marache Michael	Gimbie Woreda	2552
4	Wadesa Warka	Gimbie Woreda	1809
5	Malole Gachi	Gimbie Woreda	985
6	Kurfessa	Guliso Woreda	2373
7	Bokke	Guliso Woreda	3119
8	Mogga	Guliso Woreda	2386
9	Wara Jiru	Guliso Woreda	1836
10	Seedar	Guliso Woreda	1500
11	Buko Asabi	Lalo Asabi	5433
12	Warago Arsama	Lalo Asabi	4553
13	Bako Dalati	Lalo Asabi	2801
14	Garjo Siban	Lalo Asabi	1471
15	Lalo Wanjo	Lalo Asabi	2505
16	Amaru Garu Aba ware	Lalo Asabi	2139
17	Kelay Birbir	Lalo Asabi	3264
18	Jarso Damota	Lalo Asabi	4560
19	Batoro Chokorsa	Lalo asabi	1759
20	Alee Hiwa	Lalo Asabi	2269
21	Aroji Argamsa	Lalo Asabi	1313
22	Wara Jiru Bacho	Lalo Asabi	2366
23	Alee Bareda	Lalo Asabi	2774
24	Dongoro Kata	Lalo Asabi	1188
25	Gombo Hiwa	Lalo asabi	1734
	Total		**59,810**

Reference: Ethiopia Government district population figures.
Note*:* kebeles included in Year 1 of the project were semi-urban kebeles and therefore had higher populations than those included in Year 2 which had mainly rural populations.

4. Methodology

The end of programme evaluation was undertaken by reviewing the relevant documents ***(see Appendix 4 for list of references),*** holding key participant interviews, as well as holding focus group discussions with women beneficiaries in project kebeles.

Interviews were held with Maternity Worldwide staff (both in the UK and in Gimbie, Ethiopia), as well as with programme stakeholders including members of the Women's Affairs and Health Education Committees and health extension workers implementing the programme.

Visits were made to a sample of five of the 40 project kebeles where focus group discussions were held with women beneficiaries as well as kebele men and other women leaders. The kebeles visited included:
Woreda: Gimbie (Dalo Sewa and Wara Sayo)
Woreda: Guliso (Mogga and Bokka)
Woreda: Lalo Asabi (Kelay Birbir)

Several of these kebeles represented those furthest from GAH, a distance of 60 km which were remote and only accessible on dirt roads. The evaluator also attended the formal handover ceremony of the women's income generating and community health education projects to the government Woreda Women's Affairs Department and the Woreda Health Department respectively.

5. Programme Goal and Objectives

Programme Goal for West Wollega:

'Reduced maternal mortality and morbidity among all ethnic groups and consequent improvements in the health, well-being and economic stability of families and children'.

Programme Objectives

1. To ensure stakeholder commitment and participation in all aspects of programme development and implementation through the establishment of programme steering groups with widespread representation from stakeholders and communities.

2. To establish income generating women's groups through which women gain knowledge and influence within their communities, and increase their financial resources.

3. To establish a community health education programme addressing women's status and rights, preventive health measures, and in particular education around reproductive and maternal health issues.

4. To improve access to high quality maternal health services, that are locally appropriate and informed by community engagement, contributing to reduced pregnancy related deaths a and long-term illness.

6. Programme outcomes and achievements

6.1. Outcome 1:
A reduction in deaths during pregnancy and childbirth among women living in West Wollega, Ethiopia

Indicators
- Increase in number of women attending GAH and clinics for childbirth to 1,200 in the period October 07 - September 2008.

Achievements
The number of women attending GAH and the clinics for deliveries has increased from 859 (in 2006-7[7]) to 1297 (in 2007-8[8]). This represents a substantial increase of 51%. GAH has become the main provider of comprehensive obstetric care in the zone, and this substantial increase in deliveries in Year 2 of the programme is in line with the expansion of the project in 25 new kebeles.

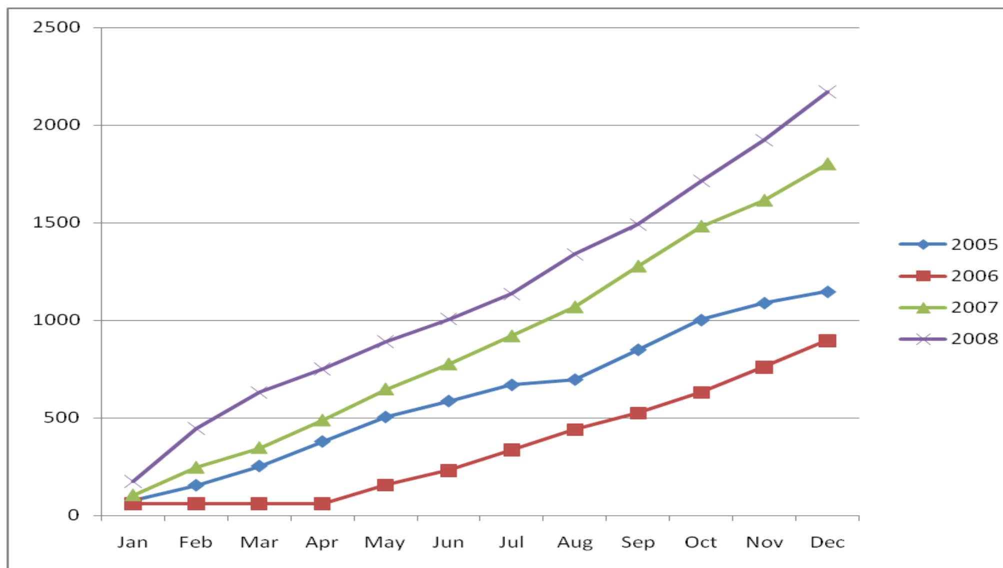
This is in line with a steady year on year increase from 2005-8 in the number of women attending GAH for maternal health issues including for childbirth and general gynaecological services.

The driving force behind this increased demand on the GAH maternity services is likely to be a combination of the distribution and use of the safe birth voucher (SBV) along with the community health education project implemented in the programme kebeles. The SBV scheme and the 'general subsidy' both offer a large subsidy and make it affordable for women to deliver at GAH with complications. This SBV component has not been supported by the Big Lottery Fund.

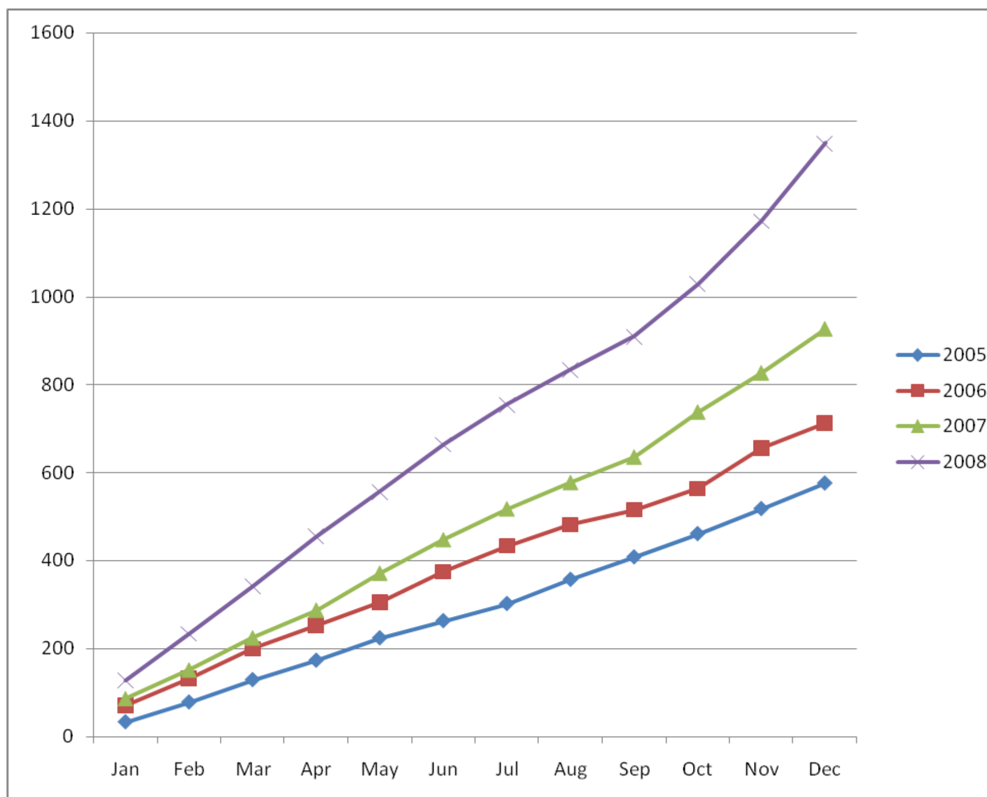
The following graphs show the increasing year on year antenatal attendance for 2005 – 2008, however there were less attendances in 2006 than in 2005. There has also been a year on year increase in deliveries at GAH during this period.

[7] Maternity Worldwide Annual Report and Draft Financial Statements. Maternity Worldwide. 2006-7.
[8] Maternity Worldwide Annual Report and Draft Financial Statements. Maternity Worldwide. 2007-8

Graph 1:
Antenatal (cumulative) attendance at Gimbie Adventist Hospital 2005 - 8[9]



Graph 2:
Deliveries (cumulative) at Gimbie Adventist Hospital, 2005 to 2008



[9] as in 10 below

Table 4: Types of delivery at Gimbie Adventist Hospital in Years 1 and 2[10]

Mode of delivery (nos of women)	Year 1 October 2006 - September 2007	Year 2 October 2007 – September 208
Spontaneous First Vaginal Delivery	526	764
Vacuum Extraction	77	109
Caesarian section	214	245
Forceps	8	20
Assisted breech		13
Destructive operation	15	15
Laparoptomy	16	41
Abortion	3	
Total	**859**	**1207**

This table shows that there was a high proportion of women delivering at GAH who had complicated births and the types of complications, and that in Year 2 the caesarean section rate was 20% of all births. The number of women delivering with complications increased from Year 1 to Year 2.

[10] Gimbie Integrated Maternal Health Programme. Annual Report. December 2008. Maternity Worldwide.

6.2 Outcome 2:
A maternal death audit performed for all pregnancy related deaths which occur in women attending Gimbie Adventist Hospital and associated clinics supported by BLF

Achievements
Maternity Worldwide set up an obstetric database to support GAH's monitoring system which became operational in 2007 and all details of maternity admissions were recorded. Regular audits have been undertaken examining the number of patient attendances and outcomes of maternal and neonatal health care.

Maternity Worldwide has also developed a maternal death tool which has been used to audit the maternal deaths which took place in GAH. It was originally planned that this audit tool would also be used in the clinics.

Programme Year	Women who delivered at GAH	Women with obstetric complications	Maternal Deaths	Case fatality rate
Year 1	859	145 (17%)	9	6.2%
Year 2	1,297	285 (22%)	7	2.4%
Year 3 (October 19 2008 - April 19 2009)	930	328 (35%)	2	0.6%

In ***Year 1*** of the programme there were 9 maternal deaths at GAH[11], of which seven were due to direct[12] obstetric causes and which could potentially have been prevented if the women had arrived for medical treatment earlier. The remaining two deaths were due to indirect[13] causes. This case-fatality rate of 6.2% was high compared to the standard set by WHO of less than 1%,

A detailed audit of all maternity cases was undertaken from August – November 2007. This revealed that 61% of all obstetric admissions were for women who had developed a complication during pregnancy and childbirth, or were women who had a high risk pregnancy. Hence the GAH provided care to a high proportion of complicated cases where skilled care is needed.

In ***Year 2*** of the programme there were 7 deaths, of which 4 were due to direct obstetric causes, and 3 due to indirect causes. This represented a case fatality rate of 2.4%. The case-fatality rate at GAH had fallen considerably from Year 1 to Year 2 of the programme, but in Year 2 it was still higher than the project target of less than 1%.

In Year 2 there were a total of 1348 births with 151 perinatal deaths (defined as still births plus neonatal deaths), giving a mortality rate of 112 per 1,000 deliveries. Note that the number of births is higher than the number of women who delivered at GAH as this figure includes a number of multiple births.

In ***Year 3*** there were considerably more women with complications presenting and a lower case fatality rate than in previous Years 1 & 2.

[11] Evaluation of Maternity Worldwide's Gimbie Integrated Maternal Health Project. Sally Monkman. February 2008.
[12] Direct causes of maternal deaths are defined as resulting from obstetric complications of pregnancy, labour or puerperium.
[13] Indirect causes of maternal deaths are defined as resulting from pre-existing diseases or diseases aggravated by the physiological effects of pregnancy.

In addition to obstetric care, the MW staff provide general gynaecology and obstetric consultations and surgeries. The majority of the consultations are antenatal, as well as for ultrasound scanning, post-op follow-up and abnormal uterine bleeding.

During Year 1 of the programme the maternal death audits were not conducted straight after the deaths occurred as they should have been. However, by Year 2 the recording procedures had improved and it is now the responsibility of the resident obstetrician to co-ordinate these reviews immediately after maternal death.

The following changes have been instigated as a result of the lessons learned:

- improved access to operating theatres, with the hospital now providing 'on-site' theatre assistants.
- the development and implementation of a protocol for the management of seizures using the most appropriate drug.
- consistent and regular observation of patients.
- Improved documentation.

At the initiation of the project in October 2006 it was planned that maternal deaths should be reviewed with the relevant communities with the aim of helping them to identify problems and prevent them in the future. However, given the high turnover of staff and their large workload this was not viewed as a priority activity when perhaps it should have been.

6.3 Cross cutting outcomes:

6.3.1. Outcome 3: Gender and Diversity

Reduced inequalities affecting the most disadvantaged women, men, girls and boys in their access to resources, participation in decision-making processes and exercising of rights.

Supporting outcomes to reach project outcomes

Project start: A pilot project of 7 women's groups completed, with total membership approximately 250 women. Women's rights promoted and financial empowerment of participants through income generating projects

Year 1
- Approximately 450 women learn income generating skills through membership of a woman's group
- Women's rights promoted and community health improved in 15 villages through participation in a community education programme

Year 2
- An additional 750 women learn income generating skills through membership of a woman's group
- Women's rights promoted, and community health improved in a further 25 villages through participation in a community education programme

Project end
Women's status and financial security improved and women's rights promoted through a network of income generating women's groups and a community education programme

Achievements

Women's Income Generating Activities

The original programme targets for the women's income generation were all met *(see original programme targets on page 7 of this report)*, with the proposed number of new women's groups actually being established in both Years 1 and 2.

- In Year 1: 15 women's groups each comprising of 30 women (a total of 450) took part in income generating activities, and in
- Year 2: 25 women's groups participated (a total of 750 women).

The women selected to be included in these groups were chosen by the kebele leaders who considered them to be among the most vulnerable women in their communities. Each women's group had an elected group leader and secretary.

In **Year 1:** each of the 450 women received a loan of 325 ETB (£18.05) and these loans were distributed in October 2007, with expectations that the first loan repayments would be made in April 2008, and the final repayments made by April 2009.

The main activities selected by women were
- animal rearing (60%)
- petty trading (32%)
- gardening (7.4%)
- a small number undertook cotton spinning and other activities (0.6%)

Table 5: Type of income generating activities undertaken by women in Year 1.

	Name of Kebele	Number of women in group	Distribution of Resources (Main Resource for each woman)				
			Animal Rearing/ fattening	Petty Trading	Gardening	Cotton Spinning	Other Specify
1	01	30	9	20	0	1	0
2	02	30	5	25	0	0	0
3	03	30	11	19	0	0	0
4	04	30	4	26	0	0	0
5	Tole	30	28	2	0	0	0
6	Jogir	30	23	7	0	0	0
7	Inango Dambali	30	25	4	0	0	1 Chicken
8	BikiltuTokuma	30	27	3	0	0	0
9	Chuta Gochi	30	28	2	0	0	0
10	Chuta Georges	30	21	8	0	0	1 Chicken
11	Chuta Qaki	30	16	7	7	0	0
12	Dalo Sewa	30	23	7	0	0	0
13	Bonaya Asabi	30	30	0	0	0	0
14	Wara Sayo	30	15	12	3	0	0
15	Kombo Michael	30	6	1	23	0	0
TOTAL		**450**	**271**	**143**	**33**	**1**	**2**

For the ***Year 1*** women's groups - 79% of the women had paid back their loan completely and 24% were still in the process of repaying them by April 2009. Some of the women being recorded as still owning money for loans may in fact be in a position to pay the loans back. However, government staff responsible for collecting the repayments had not been able to go to the kebeles to collect payments.

It was reported that some women had faced difficulties with their livestock dying and were concerned about being able to make their repayments in particular seasons.

In **Year 2:** 90% of women involved in the groups selected to trade in coffee, as it was the coffee season when they started activities, but later changed to other activities such as livestock rearing. The women made a lot of profit by trading in coffee as they sold it for a high price, however this is only seasonal.

Loans were distributed between January to March 2008, and the first payments were expected to be made from October 2008 onwards and completed by October 2009. In Year 2 a smaller number of women received a greater amount of seed money (it was increased from 325 to 485 ETB), due to the increased rate of inflation in Ethiopia which had pushed prices up.

Overall, 90% of women had made profits, with sheep rearing being one of the most profitable activities. There was a better repayment rate from those women living in rural areas compared to those in urban areas (who were employed mainly as daily workers and had less land available for livestock rearing). This was a huge achievement given that it is known from focus group discussions undertaken by Maternity Worldwide programme staff that before the project started the average monthly income of these women was 1- 4 ETB.

By the end of Year 2 the repaid loans had been revolved, and been redistributed to a total of 155 women in newly formed women's groups in the programme areas.

The Woreda Women's Affairs Department were responsible for submitting quarterly reports to Maternity Worldwide with details of income generating activities and loan repayments. Monitoring reports included details of each woman in the groups, the kebeles where they lived, the type of activity they were undertaking, and profit or loss made.

There was extremely good cooperation between the local government and the Maternity Worldwide programme and Maternity Worldwide staff made sure that government staff participated at every stage of the programme cycle. The good functioning of the project steering committees overseen by Maternity Worldwide ensured that there was good governance and that all activities were well implemented.

The following table shows the total amount of loans paid back by the women from each kebele and the profits made.

Table 6: The amount of loans distributed to each of the 40 project kebeles for the women's income generating project, the amount repaid and the amount still outstanding

No	Name of Kebeles	Amount ETB Received/kebele	Amount ETB Repaid/kebele	Amount ETB Outstanding	Net Profit Made
1	O1	9,750.00	6,026.00	3,724.00	11,750.00
2	O2	9,750.00	3,871.00	5,879.00	4,300.00
3	O3	9,750.00	2,827.00	6,923.00	1,502.00
4	O4	9,750.00	3,182.00	6,568.00	2,650.00
5	Bikiltu tokuma	9,750.00	4,029.00	5,721.00	7,695.00
6	Bonaya Asabi	9,750.00	5,612.00	4,138.00	6,436.00
7	Chuta Gochi	9,750.00	6,680.00	3,070.00	11,425.00
8	Jogir	9,750.00	8,260.00	1,490.00	5,805.00
9	Chuta kaki	9,750.00	7,487.00		

				2,263.00	6,915.00
10	Dalo Sewa	9,750.00	7,150.00	2,600.00	14,030.00
11	Tole	9,750.00	8,265.00	1,485.00	7,710.00
12	Chuta Georgis	9,750.00	8,400.00	1,350.00	17,461.00
13	Kombo Michael	9,750.00	7,963.00	1,787.00	16,833.00
14	Wara sayo	9,750.00	8,105.00	1,645.00	13,475.00
15	Inango Dambali	9,750.00	9,587.00	163.00	8,676.00
16	Ore mariam	9,750.00	-	9,750.00	5,415.00
17	Marache Michael	9,750.00	-	9,750.00	5,410.00
18	Gachi Gelel	9,750.00	-	9,750.00	5,960.00
19	Malole Gachi	9,750.00	-	9,750.00	6,575.00
20	Wadesa warka	9,750.00	1,640.00	8,110.00	2,860.00
21	Wara jiru Sobir	9,750.00	8,950.00	800.00	27,275.00
22	Kurfesa Birbir	9,750.00	8,775.00	975.00	11,315.00
23	Seda Birbir	9,750.00	9,695.00	55.00	9,225.00
24	Boke kada	9,750.00	9,025.00	725.00	41,750.00
25	Moga Kobera	9,750.00	8,960.00	790.00	16,650.00
26	Buko Asabi	9,750.00	4,564.00	5,186.00	12,300.00
27	Warago Arsama	9,750.00	4,557.00	5,193.00	8,060.00
28	Dongoro Kata	9,750.00	3,967.00	5,783.00	5,410.00
29	Batro Chokorsa	9,750.00	4,626.00	5,124.00	11,975.00
30	Aroji Agamsa	9,750.00	1,473.00	8,277.00	5,260.00
31	A/G/A/Ware	9,750.00	2,882.00	6,868.00	4,195.00
32	Lalo Wanjo	9,750.00	6,292.00	3,458.00	13,875.00
33	Barko Dalati	9,750.00	5,512.00	4,238.00	6,661.00
34	Jarso Damota	9,750.00	1,685.00	8,065.00	5,130.00
35	Kelay Birbir	9,750.00	4,248.00	5,502.00	8,345.00
36	Gombo Huwa	9,750.00	5,105.00	4,645.00	10,515.00
37	Ale Huwa	9,750.00	5,228.00	4,522.00	4,080.00
38	Ale Bareda	9,750.00	2,456.00		

				7,294.00	6,965.00
39	Wara Jiru Bacho	9,750.00	4,236.00	5,514.00	3,915.00
40	Garjo Siban	9,750.00	5,276.00	4,474.00	4,035.00
Total		**390,000.00**	**206,596.00**	**183,404.00**	**379,819.00**

Note: *where net profit is the profit after deducting the original loan.*

The above figures show that of the total loans distributed to the 40 project kebeles in Years 1 and 2 of the project, 53% has been repaid so far and 47% remains outstanding. Over the two years of the programme the 40 kebeles reported a combined profit of 379, 819 ETB, which is almost as much as their original loans.

Of the total amount of loans repaid, 80% was repaid from Year 1 projects.

In Year 2 the same amount of money was distributed to each kebele, with a smaller number of women beneficiaries. This meant each women received a higher initial start up fund than in Year 1.

Impact on women's status, financial security and rights

There was a clear positive impact on the status, financial security and rights of women beneficiaries as result of the programme.

The following are some of the positive impacts and benefits that were observed during the consultant's evaluation visit to the sample of 5 kebeles in the programme area in March 2009

During the evaluation visit focus group discussions were held with women beneficiaries from the groups over the course of two days in 5 of the kebeles where income generating projects had been implemented, and community health education undertaken. Two of the villages were among those furthest from GAH (60 km away), reached in part by dirt road and quite isolated. Interviews were also held with the male kebele community leaders (responsible for leadership for the whole kebele) and some of the women's leaders (representing just the women of the kebele).

The women beneficiaries were in the main illiterate and did appear to be among the poorest of the poor and the most vulnerable. One women's group had a large number of widows (5 of the 30 members) who were head of their household, and many had a large number of children (on average from 4 - 6 children each).

Women in all the groups visited were emphatic that the project had made significant changes to their lives and stated that fewer women in their kebeles appeared to have died of complications during childbirth since the project started. The positive impacts reported were wide-ranging, with benefits relating to family health, children, economic abilities, social standing and peace of mind.

The following are some of these impacts:

- the kebele leader in Kelay Birbir concluded that it was obvious to him that at least 6 of the 30 women in the group in his kebele had improved their economic status and social standing as a result of the project. He estimated that they had moved from category 1 to category 2 of the three economic categories he had classified in the kebele *(see page 26 for this classification).* This is against an economic backdrop where inflation in Ethiopia has reportedly risen from 10% to 68% in a six month period as a result of the global recession. Women may therefore have sold livestock at considerably higher prices than they purchased them.

- all women in the groups visited were now employed in full time activities promoted by the project including rearing animals, farming (including vegetables and coffee) and gardening. One women reported using the loan to expand her existing business of brewing alcohol, and another used the loan to start up a new business brewing alcohol. Many reported that before the project they had depended on collecting wood for a living as well as farming activities.

Most women in the focus groups had made a profit from their income generating activities and now had savings compared with before the project (when they had none). Significantly, they no longer had any debts as before.

Many of the goats originally provided by the Maternity Worldwide project had given birth and the women had kept or sold the kids. One woman said she had eventually traded up and bought an ox which she was able to hire out for ploughing and, for those rearing livestock, this appeared to be their highest aspiration. The organisation FARM-Africa supports the use of goats for income generating projects as they produce milk to both feed children in the family and sell, as well as producing manure which is good for the soil.[14]

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[14] Website of FARM-Africa: www.farmfriends.org.uk

- women in all groups visited reported they had control over their own profits and were free to spend their profits without their husbands controlling their spending (it was hard to actually verify the truth of this). A number reported their husbands had begun to help them with their new businesses and they were now working together. They said their husbands had accepted their new role as income generators due to the initial training sessions provided by the programme on women's rights including their right to work, how to save money and have control over this money earned. Some husbands had attended this training as well.

- beneficiaries are able to now pay for school uniforms and books for their children. Attendance at government primary and secondary schools is free in Ethiopia, but parents are required to buy children's uniforms and books.

- women reported being able to buy a greater variety of foods for their children to eat, and they remarked this had been one of the messages of the community health education.

- a few women reported that they are now able to afford soap for the first time, and one woman was able to buy better quality soap. This is a very important as the use of soap for hand washing at key times is one of the most effective interventions in the reduction of diarrhoeal diseases.

- some women were spending more money on fuel for light at night.

- most women in the groups visited felt they were now able to afford and therefore access health services including for themselves (including maternity services) and for their children

- some women reported they had been able to make repairs to their houses as a result of the project.

- one group member in her early twenties was an orphan, and as a result of the loan and her new business was able to support her grandmother with whom she now lived. She was the only literate member of that particular women's group visited and her aspirations were now to save her profits and go to university or college.

- women also reported they could now afford to take food to coffee ceremonies during funerals, which helped their social standing. In one kebele they had set up an association to help bereaved people to pay for funeral costs, and held discussions on how they could best help, with each contributing 5 birr per month.

- as a result of beneficiaries gaining business acumen and increasing confidence from the project, many have also set up separate communal initiatives. These have included a separate Women's Association for savings and credit whereby group members can borrow money interest free - it currently has a total savings of 2000 ETB and includes 45 women (including additional women from outside the original group of 30). In another kebele visited women had set up a savings scheme after the project started with 200 women members. Another initiative included a group fund with 180 women members who had each contributed 20 ETB a month – pay outs were rotated and each member eventually received a lump sum. Some of the savings schemes set up could be accessed for emergencies and one group mentioned funds could be used for transport to hospital when maternal complications arose. In one kebele visited the woman's group there had set up a small shop and are selling powered chilli, ground teff, maize, peas and beans which had all been packaged up in plastic bags and were for sale on the shelves. The consultant was given a tour of this shop.

- there was clear interest from other women in the kebele's to join the income generating project and become recipients of the revolving loan fund. During a visit to one kebele the consultant witnessed a gathering of 30 women having a meeting and who had come to learn from the original women's group about how the project worked and how to get involved.

- other spin offs since the project were evident. Women from the kebele nearest to Gimbie which was visited reported they had formed a group whereby each member contributed 15 ETB per year for the ambulance service for emergencies (including delivery). They were not able to afford this before the project, when they were carried on men's shoulders if they needed to go to GAH. Those who were not part of this syndicate reported since the project they could afford a taxi to go to GAH to deliver.

- when asked what they considered the most important of the project benefits to be, women unanimously reported the importance of no longer having to borrow money from their neighbours during an emergency – whether to pay for transport to deliver when complications arose or to access other health services. Loans borrowed from neighbours were invariably at very high interest rates (some reported to be up to and over 100%), and women reported being constantly anxious about their ability to make repayments and have to face their debtors on a day to day basis. It also took them a considerable time to visit different lenders to obtain a loan which was difficult during an emergency.

  The impression of a Maternity Worldwide staff member was that husbands of rural women in the area are reluctant to sell the family ox (their only asset) to pay for hospital admission during delivery complications.

- women in the focus groups also reported to be empowered by the project which had helped to improve their confidence, and were no longer afraid to speak in the regular kebele meetings in front of their husbands and other men. Women were also were more likely to challenge their husbands should a disagreement occur.

- During the focus group discussions women also reported that as a result of the programme:-

- They no longer worried about undergoing childbirth.
- a greater number of women in their kebelas were delivering in GAH.
- they no longer worried about not being able to afford treatment for fistula and collapsed uterus.
- also nobody had reported problems with access to the Safe Birth Voucher (SBV), and in one kebele visited the group estimated that 128 women had used the SBV, and 5 women had received free services for 'treatment of the uterus'. Women stated they felt the project was saving women's lives during delivery. In one kebele women estimated that between 1989 - 2008 about 100 women had died there due complications during pregnancy and a lack of awareness.
- some of the reported barriers to safe delivery were said to be: not enough money for transport where it exists, lack of transport, being carried on a stretcher to the nearest place where they could hire a private car, "gynaecological problems", not enough spacing between delivering children.

On average each kebele was said to have 300-400 households.

To sum up – the income generating project appears to have been very successful due to the close supervision and monitoring from both Maternity Worldwide and government staff throughout the project. Factors included - help with buying the original livestock and seeds, technical input and support from other stakeholder government departments (e.g. agriculture), beneficiaries who were well trained in the initial start up stage on women's rights and acquiring business skills and saving, (training for this also sometimes extended to their husbands), and they were also supported by enthusiastic kebele leaders. Women reported they are now able to make a living which has improved their economic well-being, as well as their skills to save and manage their

money effectively (both individually and collectively) including their bank accounts. This project also appears to have adapted flexibly throughout its life-span as needs arose, including increasing the amount of the initial loan seed money in Year 2 as inflation increased (by including fewer women in the group). Activities also appeared to help women beneficiaries improve their planning skills, ability to work together in a group and negotiate with their husbands more easily as well as with other woman outside the group.

This project was the first of its kind in the zone and, although women have in the past had access to credit schemes, this is the first interest free scheme linked to a health programme, and where women have been so closely supported and monitored.

Many stakeholders participated in this well planned and implemented women's income generation project which will contribute significantly to its sustainability in the future. The consultant witnessed the hand over of this project at a ceremony during her visit to Gimbie in March 2009, attended by 200 people who appeared very committed to its success.

(See Appendix 7 for detailed findings of above focus group discussions in five keels)

The project implementation steps and strengths are as follows:-

Women's Steering Group Committee and management of project
In the initial stages of the project a Women's Income Generating project steering group was set up in February 2007 and chaired by Maternity Worldwide's Programme Manager. This steering group provided a good representation of all was relevant stakeholders and sectors including:

- different government departments (Woreda Women's Affairs, Woreda Social Affairs, Gimbie Town Council, Gimbie Worked Agriculture Office, Gambia Worked Health Department)
- Women's Income Generating Group leaders/secretaries
- a partner NGO linked to the Catholic Mission
- a Women's Association

This steering group oversaw the implementation of the women's income generating activities and met regularly every six weeks and was well attended. The Programme Manager took and circulated meeting minutes. The Steering Group members were very engaged in the process and their enthusiasm manifested in a high meeting attendance rate.

Selection of project Kebele's and women participants
The steering group were themselves responsible for selecting the most disadvantaged kebeles to be included in the programme. The elected male kebele leaders (for the whole kebele) and women's leaders (for women in the kebele) along with steering group members selected the women beneficiaries included in the project. The selection criteria were as follows:

- Selection of participating kebeles: *(included those that were not benefiting from any other project, kebeles with greatest poverty levels and a willingness of the kebele and kebele leadership to be involved in the project)*.
- Selection of women beneficiaries*: (included poor women, those who were not benefiting from another project, and those willing to participate in the project).*

The kebele leaders had the main responsibility at the local level for deciding the women beneficiaries to be included and this increased their participation and buy-in to the project. It was evident that those kebele leaders visited as part of the evaluation had a clear view of the different economic groupings in their kebeles, including those community members who they considered to be the poorest of the poor. An example of such a categorisation from one kebele leader in Kelley Briber is:-

1) Category 1: people with no income
People who work for others doing farming, may eat food left over from people in categories 2 & 3, may use the remaining part of the crop tiff and mix it with mud to sell as a building material, and have houses with open walls and grass on the top.
2) Category 2: people with a little income
People who have got their own house with walls that are covered with mud and a grass roof. Those with some land to cultivate (either individually or collectively with a share of the income from the land).
3) Category 3: people with a good income
People considered to be rich and have their own home with walls covered with mud and a metal roof, as well as owning their own land and livestock.

Training of women participants and group leaders and selection of activities
Women's group leaders received training on the overall objectives of the project, leadership responsibilities, loan repayment, how to save effectively and use a bank account and how to facilitate group meetings.
All women's group members received 3 days of training on the project objectives, the different types of income generating activities (including animal husbandry, farming and gardening), loan repayments and savings.

Training was provided by Maternity Worldwide, the government departments of Women's Affairs, Social Affairs, Agriculture and Gimbie Town Council.

After the training women selected the activity of their choice. Maternity Worldwide staff and Woreda representatives helped many women to buy healthy livestock and choose good quality seeds.

Loan Repayments

Each woman involved in the project signed a loan agreement with the Department of Women's Affairs or Gimbie Town Council. The terms of the loan were that it was interest free, there was a six months grace period before repayments were due, full repayment of the loan was to be made over a period of one year after the end of the grace period (and by monthly instalments).

The Department of Women's Affairs and Gimbie Town Council were responsible for the collection of the loan repayments, and bank accounts were set up with a sub account for each kebele. The aim of the project was to rotate the repaid loans and create new potential women's groups.

Each kebele kept a log book and recorded the name of each woman member, the kebele from which she originated, the amount of profit she made and the amount of money which she paid back. There are a total of 4 bank accounts housing all beneficiaries' savings.

Monitoring

Women beneficiaries received regular and supportive monitoring visits from both the Maternity Worldwide Programme Manager and Woreda government representatives e.g. for checking up on the well being of livestock and farm produce and offering technical advice where needed. Quarterly reports from Year 1 indicated good profits from the activities and over 90% of women had had profits of up to 1000 ETB.

Community Health Education Project

Achievements

The following table shows the community health education targets and achievements in Year 1 and Year 2 of the programme.

Table 7: Community education targets and achievements

Year 1 BLF Planned Targets	Achieved
15 Kebeles receiving health education	15 selected kebeles received health education sessions (100%)
75 sessions given to communities	225 sessions conducted (300%)
3,750 beneficiaries attend the sessions	14,087 beneficiaries attended the sessions (375%)

Year 2 BLF Planned Targets	Achieved
25 Kebeles receiving health education	25 kebeles selected received health education sessions
125 sessions given to communities	1,268 sessions
6,250 participant session attendance	97,694 participants

Ref: *Gimbie Integrated Maternal Health Programme. Annual Report. 2008. Maternity Worldwide*

Note: the number of attendees were calculated by adding the total number of people who attended each session in each village (the sessions were attended on different days). In Year 2 each kebele group were taught 20 topics, and each topic taught twice. Session delivery began in June 2007.

The project has therefore held a total of 1,493 sessions and participant session attendance was 111, 781.

Table 8: Summary of people attending community health education sessions in Years 1 and 2

No of Sessions	Average duration of each session (range)	Men	Women	<12 Years	Total Participants
Year 1					
225	20-120 minutes	3,868	9,203	1,016	14,087
Year 2					
1268	20-120 minutes	42,989	48,736	5,969	97,694

Ref: Gimbie Integrated Maternal Health Programme. Annual Report 2008. Maternity Worldwide.

In ***Year 1*** the programme activities significantly over-performed against the targets. There were three times as many community health education sessions given than planned (75 sessions planned).
There were almost four times as many beneficiaries attending the sessions than originally planned (3,750). Three times more women attended than men.

In ***Year 2*** the 1268 sessions actually given exceeded the planned number by 100 fold, and the actual number of 97,694 beneficiaries who attended were approximately 1563% more than planned. In Year 2 the number of attendees had jumped hugely and the numbers of women and men attending were almost equal.

The attendance of the sessions by men was higher in the rural kebeles compared to Gimbie Town.

These results show the project to have had a very large reach and been hugely successful. This can be attributed to the great enthusiasm of the participating communities, as well as those implementing the programme. The Community Health Education Steering Group more than fulfilled its terms of reference and offered communities great support during the implementation of the programme. The community health extension workers, employees of the government health department, have showed great dedication during their visits to the programme kebeles.

The health education project had a slow start, but this was to be expected given the need to set up the Community Health Education Steering Group, mobilise communities in the project kebeles, prepare the training manual, and train the community health extension workers. Throughout its lifespan the project was adapted to suit the needs and demands of the communities including broadening the curriculum to include new topics such as gender, female genital mutilation, road safety, appropriate technology and obstetric complications. A KAP (knowledge, attitudes and practices) base-line survey was not undertaken in the community before the project started.

During the evaluation visit to a sample of five project kebeles in March 2009, it was evident that beneficiaries had improved their knowledge and that the project had affected behaviour change. Women beneficiaries were able to recall the topics taught during the sessions and some knowledge from the individual sessions. Behaviour change was evident as many women beneficiaries reported that they now went to GAH to deliver if complications occurred and were mindful of the objectives of the Maternity Worldwide programme. They had also learnt about the importance of child spacing and the use of contraception and mentioned that their husbands were also beginning to support them in their desire for fewer children.

Some of the kebeles visited had never received any health education before the project started, while others had been visited from government health extension workers in the past.

The programme implementation steps and strengths are as follows:

<u>Community Health Education Steering Group</u>
At the beginning of the project a steering group was set up dedicated to the community health education component. Steering group members have shown much ownership in the project with a high participation in committee meetings – they have overseen the project, guided implementation from the onset and provided on-going monitoring. It was the first time that such a diverse range of stakeholders had worked so closely together in West Wollega, which has resulted in the different departments integrating this model of good practice into their every day work.

This Steering Group was chaired by the Maternity Worldwide Programme Manager and had a wide representation of relevant stakeholders and sectors including:

- Government departments - (Zonal and Woreda Health, Social Affairs, Women's Affairs), Zonal Agricultural Department, Department of Food Security and Disaster Prevention & Preparedness Committee, Woreda Administration
- Other health services (Gimbie Adventist Hospital, Aira Hospital, Denbidollo Hospital)
- NGOs & other organisations - Family Guidance Association of Ethiopia, Red Cross Society of Ethiopia.
- Religious organisations - Ethiopian Orthodox Church, Catholic, Adventist, Lutheran and Muslim.

Health education materials

A community health education manual was prepared with input from steering committee members. During the life of the programme the number of topics was increased at the request of community members ***(see Appendix 5 for content of health education manual).***

Implementation of project

The Maternity Worldwide initiative has built on existing health structures in the programme area and used the health extension workers to carry out its health education programme. These extension workers are part of a new government community health extension package and drive which started in the last few years. The Maternity Worldwide programme has revitalised the work of these health extension workers to provide a greater focus on, and boost to, the project kebeles and has provided workers with allowances in addition to their salaries. These extension workers have been jointly trained, supported and monitored by the Maternity Wide programme staff and the woreda health department. Health education sessions have also been undertaken by other sectors represented on the steering committee.

The government community health extension package has concurrently been installing water and sanitation facilities (including latrines) in a number of the project kebeles, which has helped to reinforce the Maternity Worldwide programme.

Community education sessions have been carried out at a range of venues and often to large gatherings of people including at kebele meetings, church meetings, political meetings, the women's income group meetings and house to house visits. The sessions were interactive with questions and discussions. These community health extension workers are attached to nearby health posts and their remit is to cover clusters of kebeles.

In some of the programme kebeles visited the community health project was still being implemented at the time of the evaluation, and not all topics of the curriculum had yet been taught.

The project has undertaken some monitoring of the delivery of health education, including the name of the kebele, date of session, venue, person giving the session, duration of session, topics, questions and discussions (used for future planning), number of people who attended the session (including the breakdown of numbers of women, men and children aged 7-12 years and the name of the kebele representative).

However, the health education project has delivered messages in a rather didactic fashion, and there is definitely room for improvement and this is discussed in the later section on 'constraints'.

The women's income generation project and community health education project were handed over successfully from Maternity Worldwide to the Woreda Health Department at the end of March 2009 with a formal handover ceremony attended by the consultant during the evaluation visit. These projects will now be integrated into, and supervised and monitored by, the existing Ethiopian government health programme (as agreed in the legal handover agreement). This will

contribute to the sustainability of the programme. Maternity Worldwide can request progress reports if needed.

6.3.2. Outcome 4: Participation

Increased participation of the most disadvantaged people in all aspects of development projects to ensure that the benefits are long term and shared fairly.

<u>Supporting outcomes to reach project outcome</u>

Project start
Communities, in particular women from rural locations, have little influence on the development of services and programmes that affect them.

Year 1
- Community participation initiated through the establishment of steering committees which include representatives from the communities, in particular women from rural locations
- Communities have participated in end of year Dissemination Forum to give feedback and influence project development

Year 2
- Community members, in particular women from rural locations are key members of steering groups where they participate in decision making processes in relation to the Safe Motherhood Programme
- Community members have attended end of project Dissemination and have shared their views on the project

Project end
- Community members, in particular women from rural locations, have participated in decision making processes related to the Safe Motherhood Programme and thus have developed skills and the confidence to influence future projects and service developments that affect their health and well-being.
- Communities have participated in annual dissemination forums to give feed back and influence project development, thus gaining confidence to engage in decision making processes for future projects in West Wollega.

<u>Indicators</u>

Year 1
1. Health Education Committee established, Women's Group Steering Committee established, Health Service Development Steering Committee established and Project Management Steering Committee established. In total, at least 20 community representatives are members of these steering committees
2. Three meetings held of each steering committee
3. Attendance rate of >80% for community representatives at steering committee meetings
4. End of year Dissemination Forum attended by at least 50 participants including community members, local government, health care providers and local NGOs

Year 2
1. Community membership of steering groups increases to a minimum of 30 community participants
2. Three meetings held of each steering committee
3. Attendance rate of >80% for community representatives at steering committee meetings
4. End of project Dissemination Forum attended by at least 50 participants including community members, local government, health care providers and local NGOs

Indicators

Year 2

1. Additional 25 women's groups established with membership of approximately 30 participants each
2. Chairwomen of 25 women's groups receive training in animal husbandry or equivalent
3. Increase in knowledge, confidence and financial independence of women's group participants as compared to baseline (measured by qualitative survey)
4. Health education programme delivered to additional 25 villages

Year 1

1. Fifteen women's groups established with membership of approximately 30 participants each
2. Chairwomen of 15 women's groups receive training in animal husbandry or equivalent
3. Increase in knowledge, confidence and financial independence of women's group participants as compared to baseline (measured by an interviewer-administered quantitative survey supplemented by focus groups)
4. Health education programme delivered to 15 villages. 10 community health educators identified and trained

Achievements

There has been great participation by stakeholders and beneficiaries in all aspects of programme planning and implementation and monitoring. Four steering committees were originally set up to promote participation in the programme including the Programme Steering Group, the Women's Group Committee, the Community Health Education Group and the Health Service Development Committee (which was disbanded as many members were also members of the other committees)

The purpose of the ***Programme Steering Group*** was to oversee the programme as a whole and steer all its components. This group was established in January 2007 and comprised of a wide range of representatives from government zonal and woreda departments, local NGOs and organisations, hospitals, and those from faith-based organisations. The representatives were as follows:-

- Zonal and Woreda Administration
- Zonal and Woreda Health Departments
- Zonal and Woreda Social Affairs Departments
- Zonal and Woreda Women`s Affairs Departments
- Zonal Department of Food Security and Disaster Prevention and Preparedness
- Zonal and Woreda Agriculture Departments
- Gimbie Adventist Hospital
- Family Guidance Association of Ethiopia
- Red Cross Society of Ethiopia
- Aira Hospital
- Denbidollo hospital
- Representatives from religious organizations (Orthodox, Catholic, Adventist, Lutheran, Muslim)

The Steering Group took all decisions related to programme planning and implementation including the selection of the project kebeles and the initial planning of the community health education programme. This group established a sub-committee which was tasked with selecting kebeles to be included in Year 1 and Year 2 the programme using given criteria.

It was the first time in West Wollega that such a range of diverse stakeholders had participated and worked together in such an integrated way for a maternal health programme at zonal level.

This way of working has promoted good buy-in and high stakeholder involvement throughout the life of the programme. In addition to planning activities, stakeholders have also been involved in training beneficiaries and monitoring their progress.

The Steering Group was chaired initially by the Maternity Worldwide Country Director and later by the Maternity Worldwide Programme Manager who replaced her. She wrote the terms of reference for the group, managed the meetings, took minutes and distributed them to each of the stakeholders. Targets were met as the committee met every six weeks with a reported high attendance of between 30-40 participants at each meeting and with a high level of engagement.

Under the guidance of the Steering Group, two other sub-committees were later set up including the Women's Group Committee *(whose composition and function is described earlier in this report)*. From Year 2 onwards women beneficiaries attended this committee (in particular the women's group leaders who rotated their attendance so that all could have the opportunity to attend).

The second subcommittee was the Community Education Committee *(whose composition and function is described earlier in this report),* and which has overseen the community education programme. During Year 2 of the programme this committee met every 6 weeks with an average attendance of 10 members per meeting.

The evaluator attended the final handover meeting of the women's income generating project and community health education project to the respective government departments. This was hosted by Maternity Worldwide and was attended by approximately 200 people from different woreda and zonal government department, as well as women beneficiaries from the project communities. Certificates were distributed to acknowledge people's contribution to the projects. The ceremony was televised and covered by the local media.

To summarise – programme targets were met as committees were formed, more meetings were held than originally planned and with a good attendance rate. Targets exceeded the plans for the end of project handover forum when a range of 200 stakeholders attended this event.

Participation can also be shown to have taken place with the establishment of the requisite number of women's groups in Year 1 and Year 2, each comprised of 30 participants. The chairwomen of these groups were trained.

A base-line survey was not undertaken at the beginning of the programme. However, focus group discussions undertaken during the mid term review of the programme in 2008 and the final evaluation in 2009 showed the high level of participation in this programme by beneficiaries.

6.3.3 Outcome 5: Influencing Opinion

Improved responsiveness of decision and policy makers to the needs of disadvantaged people.

Supporting outcomes to reach project outcome

Project start:
Local, national and international policy makers have no information about effective interventions maternal deaths in West Wollega

Year 1
Local policy makers receive information about the project and improve their understanding of 'what works' to reduce maternal deaths in West Wollega

Year 2
National and international policy makers receive information about the project and improve their understanding of 'what works' to reduce maternal deaths in West Wollega

Project end
Local, national and international policy makers (including the Ethiopian Government Departments of Health and Social Affairs, the Safe Motherhood Alliance, other international NGOs and the World Health Organisation) receive information about the West Wollega Safe Motherhood Project and hence increase their understanding of 'what works' to reduce maternal deaths in resource poor settings.

Indicators

Year 1
1. Quantitative and qualitative end of year evaluation completed by external evaluator and distributed in written +/- verbal form to local policy makers including health care providers, Government Departments of Health, Women's affairs and Social Affairs

Year 2
1. Quantitative and qualitative end of project evaluation competed by external evaluator and distributed in written +/- verbal form to relevant policy makers at local, national and international level including the Ethiopian Government Departments of Health and Social Affairs, the Safe Motherhood Alliance, other international NGOs and the World Health Organisation

Achievements
At the end of Year 1 the end of year evaluation was completed by an external evaluation and the findings fed back verbally to the stakeholders on the three programme committees. This contributed to raising awareness of the lessons learned in implementing this maternal health programme among stakeholders. It was particularly important in raising awareness among those stakeholders whose work was not directly related to maternal health but had an indirect influence e.g. representatives of the Woreda Agriculture Department who were working closely with the Women's Income Generating Groups.

In March 2009 a final programme evaluation was undertaken by an external evaluator. At the time of the evaluation the Maternity Worldwide Programme Manager had been asked to present a paper at an Ethiopian national conference on Safe Motherhood in May 2009 on the activities of the Maternity Worldwide Programme.

6.3.4. Outcome 6: Capacity Building

Improved capacity of partner organisations, local communities and other stakeholders to tackle the causes of poverty effectively, efficiently and in a sustainable way.

Supporting outcomes to reach project outcome

Project start:
No health care providers at Gimbie Hospital and associated clinics supported by BLF are fully proficient in the management of obstetric emergencies

Year 1
Four national doctors and 12 national nurses employed at Gimbie Hospital complete 'competence based' knowledge and skills programme

Year 2
Eight additional national nurses employed at clinics supported by BLF complete 'competence based' knowledge and skills programme

Project end
All health care professionals at Gimbie Hospital and associated clinics are fully competent to manage obstetric emergencies

Indicators

Year 1
1. Twice monthly maternal healthcare training seminars provided at Gimbie Hospital with attendance rate of >90% by four physicians and 12 nurses
2. Practical Skills Workshop (3 days duration) attended by four physicians and 12 nurses
3. Completion of competence based log book by four physicians and 12 nurses
4. Four physicians and 12 nurses achieve score of >70% in evaluation examination

Year 2
1. Twice monthly maternal healthcare training seminars provided at Gimbie Hospital with attendance rate of >90% by 8 nurses
2. Practical Skills Workshop (3 days duration) attended by 8 nurses
3. Completion of competence based log book by 8 nurses
4. Eight nurses achieve score of >70% in evaluation examination

Achievements
This programme has made a lot of investment in building the capacity of stakeholders, and undertaken training at a number of levels. This has included for those who participated in the three committees, health staff at the Maternity Unit at GAH and in the clinics, and women beneficiary and kebele leaders in the community (who received training on income generating projects and community health education).

Training of health staff at GAH
Before the Maternity Worldwide programme started GAH was only staffed by two midwives and six nurses and the hospital surgeon or physician managed obstetric complications. The Maternity Worldwide programme aimed to help make improvements to this situation by recruiting a full time obstetrician and increased numbers of midwives in addition to midwife trainers in Years 1 and 2 of

the programme. Maternity Worldwide has also initiated a rota of short term expatriate obstetricians from Europe, USA and Australia.

The obstetrician and midwife have three roles which include:
- to provide patient care
- to train local healthcare staff as skilled birth attendants; and
- to introduce evidence based protocols and guidelines for the management of pregnant women and the newborn in order to raise the standards of clinical care in GAH and clinics.

In order to improve training procedures in Year 1 Maternity Worldwide developed a full curriculum for training the nursing staff at GAH to become skilled birth attendants. This curriculum was based on guidelines of best practice produced by WHO/UNFPA, and was reviewed in Year 2 of the project to ensure all competencies were being adequately addressed.

In Year 1 a total of six nurses completed the training programme and are now working in the obstetric department of GAH. This is lower than the original target of 12 nurses. An additional 11 practical workers received training as assistants to the skilled birth attendants. It was reported hard to motivate staff to attend training in the first year of the programme, but this was easier by the second year.

In Year 2 a second group of nurses (10 from GAH and 2 from affiliated clinics) started their training at the end of March 2008, and ten finally completed the training and became skilled birth attendants (as well as being able to provide comprehensive family planning services). A greater number of nurses were trained than was originally planned.

The Maternity Worldwide programme reoriented the training, and rather than being trained while off duty, the new curriculum was comprised of blocks of theory and clinical practice, and GAH agreed to release nurses to attend training during their working time. Trainees continued to be supervised whilst working and were provided with textbooks. A module on family planning was also included and training was facilitated by Marie Stopes International and Engender Health Staff based in the zone. This training by NGOs was not originally planned and is positive evidence of the strong partnerships which Maternity Worldwide has forged.

Assessment of those trained was rigorous using Jhpiego[15] assessment guidelines for skilled attendants training. Each nurse was able to record their practical experience in their own log book and were supervised by Maternity Worldwide midwife trainers and obstetricians. This rigorous and improved training has been borne out in an improved quality of care in GAH.

However, the programme has suffered from a high turnover of staff ***(see Appendix 2 for Time Line of the Programme)***. It has been particularly hard to recruit Ethiopian obstetricians due to the remoteness of GAH and poor communications in Gimbie, and there has been some degree of friction between some of the Maternity Worldwide obstetricians and GAH. There have therefore been periods when GAH did not have an obstetrician. However, by Year 2 the programme was able to tackle these recruitment issues and Ethiopian obstetricians stayed in post longer. Lessons have been learned from these difficulties, and Maternity Worldwide has investigated the possibility of recruiting expatriate staff as a way of solving the problem and has consulted with the Royal College of Obstetricians (UK). Maternity Worldwide (Denmark) continues to send volunteer obstetricians to GAH for short periods. This has helped to provide a service when no local obstetrician is in post, share workload when one is in post, and enable him to take vacation.

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[15] The organisation Jhpiego is an affiliate of Johns Hopkins University

It has not been possible to train Ethiopian physicians working at GAH to work as skilled birth attendants as outlined in the original programme proposal. This is due to the gaps in staffing and high turnover of obstetric staff.

The training of nurses and midwives by midwife trainers was shown to improve the quality of care in the maternity unit[16]. A patient user satisfaction survey has been undertaken whereby women who delivered at GAH were interviewed when they left the hospital. A GAH staff member received training to undertake this survey. Results showed that 80% of those interviewed were satisfied with the care they had received at GAH. Recommendations to improve the service included – a need for hot water after delivery, a clock to be installed on the wards so nurses were able to check the time to administer medication to patients and that the obstetrician should be encouraged to continue his employment at GAH which reflects local knowledge that there was a high turnover of medical staff ***(see Appendices 6 for example of patient user satisfaction questionnaire format).***

Training of others

The programme also provided training and ongoing support for those who undertook community health education in the community and for those members from the Women's Affairs government department. Those based at community level also received training including the women's group members, women's group leaders and kebele leaders. Some training was provided by members of the Steering Committee.

[16] Evaluation of Maternity Worldwide's Gimbie Integrated Maternal Health Project. Mid-term evaluation. Sally Monkman. February 2008.

6.3.5 Outcome 7. Alliances, collaboration and networking:

Developed alliances, collaboration and networks at all levels, both in the UK and overseas to bring about sustainable development initiatives for the most disadvantaged people.

Supporting outcome to reach project outcome

Project start:
Maternal health services and community development programmes in West Wollega are uncoordinated and lack a common vision.

Year 1
- Partnership work initiated through the establishment of steering committees composed of representatives from local government, health care providers, local NGOs and community members
- Networks strengthened through end of year Dissemination Forum

Year 2
- Partnership work enhanced through ongoing participation in all steering groups
- Networks strengthened through end of project Dissemination Forum

Project end
- Local stakeholders and partners have worked collaboratively to implement a Safe Motherhood Programme, thus setting a foundation for the collaboration on future health related projects in West Wollega.

Indicators

Year 1
1. Health Education Committee, Women's Group Steering Committee, Health Service Development Steering Committee and Project Management Steering Committee established
2. Three meetings of each steering committee held
3. Attendance rates of >80% at each meeting of steering committees

End of project Dissemination Forum attended by at least 50 participants including community members, local government, health care providers and local NGOs

Year 2
1. Three meetings of each steering committee held
2. Attendance rates of >80% at each meeting of steering committees
3. End of year Dissemination Forum attended by at least 50 participants including community members, local government, health care providers and local NGOs

Achievements

Project steering committees have been established and have been successful in ensuring collaboration and networking at a local level (this is described in detail earlier in this report). This has provided a model of a completely new way of working in West Wollega and has been successful beyond the original programme expectations. There are strong possibilities that this model of working will be replicated in the zone in the future for other health initiatives. A number of the government stakeholders belonging to these steering committees were interviewed during the evaluation visit and were very positive about their relationship with Maternity Worldwide. In particular they were impressed with the manner in which Maternity Worldwide had endeavoured to engage and include them at all stages of the programme to increase their ownership. They

contrasted this to other NGOs in the zone who were often “quite secretive about their activities and stayed away from government bodies as much as possible”. In addition they mentioned that they considered the regular six week meetings to be very valuable for keeping up the programme implementation momentum.

The Maternity Worldwide staff in Ethiopia have during the life of the programme met with local and national NGOs and international organisations in Gimbie and Addis Ababa, e.g. WHO, UNFPA has expressed particular interest in the skilled birth attendant training programme and asked to be kept up-to-date with the Maternity Worldwide programme.

Maternity Worldwide also has close links with the Royal College of Obstetrics and Gynaecology and Midwifery in the UK and the Chairman of Maternity Worldwide was a member of the International Board for three years. Maternity Worldwide was one of two NGOs in May 2007 which took part in the Women’s Parliamentarians Congress attracting representatives from over 30 countries. This Congress advocates for improved women’s representation and highlights the issues around Millennium Development goal 5.

In addition a Maternity Worldwide staff member in the UK is a member of the UK Sexual and Reproductive Health and Rights and Maternal Health Working Group. In 2007 Maternity Worldwide was involved in Dfid’s Independent Development Committee review of Maternal Care, as well as having a strong presence at the Women Deliver Conference. These links provided opportunities to raise the profile of Maternity Worldwide and advocate for its objectives.

6.4 Outcome 8: Other: Provision of services/facilities

Supporting outcome to reach project outcome

Project start: Gimbie Hospital and 4 associated clinics lack sufficient equipment and supplies to provide emergency obstetric care to WHO standards

Year 1
Gimbie Hospital and 4 associated clinics fully equipped to provide basic (clinics) and comprehensive (hospital) emergency obstetric care

Project end
Gimbie Hospital and 4 associated clinics fully equipped to provide basic (clinics) and comprehensive (hospital) emergency obstetric care

Indicators

Year 1
1. Inventory of equipment and supplies at Gimbie Hospital and clinics shows that the health facilities hold all the necessary items, in good working order, for the provision of emergency obstetric care (as specified by WHO).

Achievements
A comprehensive audit has taken place and Gimbie Adventist Hospital has been upgraded with the requisite equipment so that it qualifies to be a comprehensive emergency obstetric care facility. The programme originally tried to purchase this equipment from Ethiopian suppliers, but the quality was poor. The equipment was finally purchased from UNICEF from abroad and, although this was better quality, it took a long time to arrive and Maternity Worldwide was obliged to pay high customs tax and storage costs ***(see Appendix 3 for list of equipment).***

Maternity Worldwide's partner GAH have had problems managing the staffing of their rural clinics attached to the hospital. Due to these problems, Maternity Worldwide has only been able to include one functioning GAH clinic as part of its programme.

7. Summary of the programme strengths

- This programme has achieved an enormous amount in a short period of two years in a remote area of Ethiopia and with a limited number of personnel. The staff members have developed close links with stakeholders from government departments and demonstrated dedication, commitment and a great deal of tenacity. This is the only safe motherhood project in the zone providing hospital based emergency obstetric care in addition to other community activities.

- The programme has been well implemented in spite of many difficult obstacles. These include the remote mountainous terrain, the long and difficult journey to Addis Ababa the capital city, lack of a nearby airport, the difficulty of attracting qualified obstetricians to this region, the fact that the different stakeholder government departments in this zone have never worked in such an integrated way before and the high turnover of staff both in MW Ethiopia and in the UK.

- The Maternity Worldwide programme used a multi-pronged approach based on the three delays model. Efforts were made at all levels including providing GAH and its associated clinics with appropriate emergency obstetric equipment, recruiting obstetricians to work at GAH, training nurses and midwives, and implementing community heath education and income generating projects at community level.

- Distribution of the Safe Birth Voucher (SBF) backed up by the community health education project appears to have been the driving force behind women's improved access to GAH maternity services. Women beneficiaries visited during the evaluation in March 2009 appeared to feel more confident to use health and maternity services, with the backing of the savings they had made from their income generating activities. The programme has created a noticeable demand for the use of GAH maternity services and figures show significant year on year increase in demand for these services.

- The programme has ordered and received equipment for emergency obstetric care both for GAH and the associated clinics which are now fully equipped. Procuring this equipment was a huge challenge and success for Maternity Worldwide staff. It was a long and protracted process and required much effort and tenacity on the part of the staff. The equipment was ordered from the UN and took a long time to clear through customs at the port.

- This programme is unique in the zone whereby a number of government stakeholder departments are working together in an integrated way for the first time to plan and implement a health improvement programme (including the Departments of Health, Finance, Women's Affairs, Social Services). Stakeholder committees have been established which meet regularly every 6 weeks to discuss programme activities, problems and lessons learnt. Women beneficiaries are also members and attend these meetings. Maternity Worldwide programme staff have managed to achieve strong buy-in from the relevant government departments. One stakeholder from the Women's Affairs Department commented that this programme has been so successful because Maternity Worldwide has actively sought to collaborate and involve stakeholders, compared with other NGOs in the zone who have been reluctant to involve the government and are often quite secretive about their activities. Stakeholders warmly welcomed this collaboration with Maternity Worldwide and the strong and close bonds between its staff and stakeholders is obvious. The programme has also built on previous small scale activities undertaken by the Department of Women's Affairs in the zone such as empowerment activities for women including self-help activities and sensitizing women about their rights. Beneficiaries in the project areas therefore were already receptive to these issues when the project started which has contributed to their enthusiastic participation.

  All the stakeholders were involved and participated from the very inception of the programme which greatly contributed to its sustainability. Government stakeholders interviewed appeared

enthusiastic about this new integrated way of working, and said it was a useful way of providing mutual support and would help to improve the capacity of the zone, woredas and kebeles. They hoped to use this model as a catalyst to work with new projects. This model also made for a smooth handing over process of the Women's Income Generating Projects and Community Health Education projects in April 2009. The establishment and inclusiveness of the Steering Committees (including the general overseeing committee, women's income generating and community health education) contributed to this buy-in. Minutes of these committee meetings were religiously recorded by the Maternity Worldwide Programme Manager. The Department of Women's Affairs seems to be particularly strong and active in the zone.

These above mentioned committees themselves selected the target kebeles to be included in the programme (rather than just the Maternity Worldwide staff).

The involvement of kebele leaders in the programme (including both men and women) was an empowering experience for them, and a recognition by the programme of their knowledge of and involvement in their own communities and local areas. At the beginning of the project these leaders themselves chose the women beneficiaries to be involved in the income generating projects who then received a comprehensive three day training.

- The community health education has had a large reach at different venues, has undertaken more sessions than originally planned, adapted flexibly throughout the life of the project, broadened the curriculum according to need, used existing health extension workers for implementation and has been closely monitored. During the evaluation it was evident that beneficiaries were able to recall knowledge regarding of some of the health education they had received and had changed their behaviour by seeking GAH maternal health services.

- Much training has been undertaken by Maternity Worldwide to improve the skills of staff at the GAH and clinics. A full training curriculum has been developed, and in the first year of the programme 6 nurses were trained who were already working in the hospital and in the second year 12 nurses received training. Midwife trainers from Kenya trained GAH staff in full-time blocks including for theory and clinical work. This was well organised so that staff were rotated between GAH and the clinics and there appeared to be no staff shortages on the wards. Log books were developed so that progress could be charted.

  Training schedules and guides were also developed and clinical protocols adapted in line with Ethiopian practice.

- Maternity Worldwide has strengthened delivery reporting at GAH and developed and introduced for the first time a database of women who have been admitted to the maternity unit. Prior to this delivery recording had been poor at GAH. Using this database the programme has been able to undertake clinical audits and review all maternal and neonatal deaths as well as reviewing documentation to discuss individual cases.

- The programme has built houses in the grounds of the GAH compound where Maternity Worldwide staff are currently living (this was not funded by the Big Lottery Fund).

- A patient user satisfaction survey at GAH has been facilitated by Maternity Worldwide. A survey form was designed and administered by an independent employee of GAH and those women who had delivered in the hospital were interviewed when they were discharged. Staff received training to undertake this survey. Results showed that 80% of those interviewed were satisfied with the care they had received at GAH. Recommendations to improve the service included – a need for hot water after delivery, a clock to be installed on the wards so nurses

were able to check the time to administer medication to patients and that the existing obstetrician should continue to be employed and work at GAH.

- A comprehensive and extensive situation analysis was undertaken in 2005 before the programme started.

8. Summary of the programme weakness and constraints

- The evaluator considers that the two year time frame which was originally allocated for the programme was too short to implement all the planned activities. This has meant that the Year 2 activities are currently still being implemented in 25 kebeles at the same time as the project is winding down and the income generating and community health education components being handed over to the government. Also the programme was still being implemented at the time of the evaluation. The programme had a six month no cost extension. The programme would have benefited had it ideally been a 3-4 year programme. Like many NGOs, the Maternity Worldwide programme did not have a long enough start up period, which could ideally have been six months, in order to engage the participation of the many stakeholders and establish the main steering committees. Following the actual implementation of project activities, the final six months winding down phase would benefit if it were free of any implementation of activities.

- Developing relationships with the necessary government agencies in Addis Ababa was difficult at the start of the programme. This was in part due to the remoteness of the Gimbie programme and the difficulty of engaging with them.

- The recent economic downturn world-wide has meant that the programme has had a shortfall of spending money for activities due to poor exchange rates. There has also been very significant inflation in Ethiopia and a further decrease in the real value of funding in sterling.

- Although Maternity Worldwide partnerships with the local government agencies have been excellent, its partnership with GAH has suffered from limitations due to the high turnover of Maternity Worldwide staff, in particular the difficulty of recruiting local obstetricians. At the beginning of the programme the delineation of responsibilities between the Maternity Worldwide Country Director (part-time non-BLF funded role) and Programme Manager was not optimal.

- The clinics have been a weak link in the three delays model and suffered from staffing problems.

- The community health education component of the project could benefit if it adopted a less didactic approach just delivering messages, and focused on using a behaviour change communication model including participatory methodologies. This is more likely to promote the desired behaviour change in illiterate communities. This model helps people to identify and understand their problems and the barriers to effecting change and take a communal approach to solving them.

  The participatory games developed by other safe motherhood programmes could usefully be adapted and piloted by the Maternity Worldwide programme. Materials could usefully include flip charts, posters and tools such as cards with drawings representing the barriers to safe delivery. These need to be developed locally and made culturally specific.

  It is worth investigating whether it is possible to create another level within this project whereby

a member of the existing group of 30 women in the women's income generating group can have responsibility for promoting some of the key messages from the curriculum on an informal basis during their regular basis. This may help to improve the long term sustainability of the project.

- A logical framework was not produced for the programme, nor was a KAP base-line survey undertaken at community level before the project started.

- The training of the community health extension workers appears rather short and could be improved by extending it to a longer time five day period, and to include how to train trainers. It could also benefit from regular and ongoing short follow up refresher training every six months.

- The programme could have benefited if the results of the maternal death audits had been shared with the relevant communities.

9 Recommendations

This two year phase of the maternal health programme in Gimbie which has been funded by the Big Lottery fund has now come to a close. All the programme objectives have been achieved (and a number have exceeded original targets), apart from those related to the rural clinics. Maternity Worldwide has now handed over the women's income generating project and community health education projects to the relevant government departments who will continue to support and monitor them ensuring their sustainability.

Ideally the programme should have been implemented over a longer period of 3 - 4 years. This would have allowed for a longer initiation phase to start up the programme and the steering committees, as well as a longer exit process. As the programme stands the exit period was too short, as actual activities were still being implemented at the time of the evaluation. More time is also required for the exit period to hand over the programme activities to the government and monitor and support them for a while.

The SBF and 'general subsidy' will continue to be supported by Maternity Worldwide (Denmark) for the short term, as there is evidence that this has been successful in reducing the barriers to access maternity care. However, this will not be a sustainable in the long term and this support needs to be reviewed as soon as possible.

There is a need to continue to strengthen the clinics associated with the programme.

The women's income generating project and the community health education project can continue to be initiated in other nearby kebeles in the three project woredas in the future subject to Maternity Worldwide successfully obtaining funding.

The income generating aspects of the programme could benefit by a strengthened monitoring system and some of the following indicators could be included:-

<u>General</u>

- improved ability of beneficiaries to work with others closely in groups
- improved planning and organisational skills
- improved ability to manage own finances including recording savings and participating in a joint bank account with others.
- improved economic position with increase in earnings, savings and no debt.
- improved ability to contribute towards household income (or support household where woman headed household)

- improved skills from project activities such as animal rearing, farming and gardening.
- improved confidence to start up other community initiatives with others such as community financing schemes (including for transportation to hospital during obstetric emergencies and for ambulance transportation where available).

Empowerment
- improved ability and confidence to speak at community meetings and in front of men
- improved ability and confidence to negotiate with husband over financial issues
- improved control over own earnings and savings
- improved ability to work alongside husband on project activities
- improved confidence from having own income generating activities

Other potential benefits
- decreased need to borrow money from neighbours at high interest rates during obstetric emergencies and for other emergencies.
- decreased anxiety as a result of having to borrow money from others at high interest rates.
- more access to general health services because of savings
- more access to maternal health services because of savings
- increased ability to buy more food as well as a greater variety of food for family
- increased ability to buy soap to improve family hygiene
- increased ability to buy more fuel for household (or other household items)
- increased ability to buy school fees, uniform and books
- increased ability to repair family house

It is recommended that Maternity Worldwide considers expanding the three delays model of safe motherhood to other government hospitals in West Wollega in the future, as working with government structures will be a more sustainable approach.