Transform: Primary Health Care Project

Cooperative Agreement No: AID-663-A-17-00002

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1 General Information

Project Title:	USAID Transform: Primary Health Care
Prime Partner:	Pathfinder International
Sub Partners:	JSI, Abt Associates, EnCompass, Malaria Consortium, & Ethiopian Midwives Association
Cooperative Agreement Number:	AID-663-A-17-00002
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Name & contact address of the COP:	Dr. Mengistu Asnake Tel.: (251-11) 320 35 01, Fax: (251-11) 320 35 72; E-mail: masnake@pathfinder.org P.O. Box: 12655, Addis Ababa, Ethiopia

2 Background

The Transform: Primary Health Care is a USAID-funded health project under cooperative agreement AID-663-A-17-00002. The project is implemented by a consortium of organizations led by Pathfinder International, including JSI Research and Training Institute Inc. (JSI), Abt Associates, EnCompass, Malaria Consortium (MC), and the Ethiopian Midwives Association (EMA), in collaboration with local governmental and non-governmental partners.

Transform: Primary Health Care will contribute to Ending Preventable Child and Maternal Deaths (PMCD) through supporting the implementation of the Health Sector Transformation Plan (HSTP) of the Government of Ethiopia (GoE). Transform: Primary Health Care will support attainment of the four HSTP transformational agendas, namely: (1) Woreda Transformation; (2) Caring, Respectful, and Compassionate (CRC) providers; (3) Quality and Equity in Health Care; and (4) Information Revolution.

It also supports GoE's strategic initiatives through the provision of phased, adaptive technical assistance (TA). Overall success will result from achievement of four high-level results:

1. Improved management and performance of health systems;
2. Increased sustainable quality of service delivery across the PHCU's continuum of care;
3. Improved household and community health practices and health-seeking behaviors; and
4. Enhanced program learning to impact policy and programming related to PMCD.

Achieving these results in turn leads to significant contributions to Preventing Maternal an Child Deaths (PMCD) while ensuring sustainable progress towards the ultimate HSTP goal of healthy, productive, and prosperous Ethiopians.

The project focuses primarily in the areas of maternal, newborn, and child health (MNCH); family planning (FP), reproductive health (RH); and malaria within Ethiopia's four major regions (Amhara; Oromia; Southern Nations, Nationalities, and Peoples' (SNNP); and Tigray).

This report refers to quarterly report for the period October to December 2017 which is the first quarter of year two (FY2018) of the project.

3 Accomplishments during the reporting period

3.1 Result 1: Improved management and performance of health systems

The project continued providing demand driven and tailored technical, and financial support to all intervention regions in this fiscal year. Based on principles of the World Health Organization (WHO) for strengthening Health Systems at the district level, the project is supporting the improvement and enhancement of six building blocks namely; (1) Leadership, Management & Governance; (2) Services; (3) Health Information System; (4) Supplies, Technologies and Pharmaceuticals; (5) Human Resource; and (6) Finance. This is being done by supporting the implementation of LMG team trainings; use of Data for Decision Making Trainings; Revised Health Information System Trainings; facilitating Integrated Supportive Supervisions; and measuring performance against standards (EHCRIG, EHSTG; CSC; EPAQ). Details of the accomplishment is presented below.

3.1.1 Sub-Result 1.1: Established and strengthened innovative processes to sustainably enhance health system management and performance

3.1.1.1 Performance Management & improvement

Performance improvement and management support provided. The Ethiopian Federal Ministry of Health in collaboration with development partners developed and started to implement performance improvement and performance management tools. The standards endorsed to measure performance of primary health care facilities includes: Ethiopian Primary Health Care Alliance for Quality (EPAQ) which measures and share experiences among networks of Primary Health Care facilities. Ethiopian Health Sector reform standards: Ethiopian Hospital Service Transformation Guideline (EHSTG); Ethiopian Health Center Reform Implementation Guidelines (EHCRIG); Community Scorecard (CSC); and Woreda Management Standards (WMS). Description of and achievement against each standard are presented in the tables below:

Description of standards

Ser no	*Standard*	*Target*	*Reporting period*
1	WMS: has 5 chapters and 26 standards	Woreda Health Office	Monthly
2	EHSTG: has 20 chapters and 191 standards	Hospitals	Quarterly
3	EHCRIG: has 10 chapters and 87 standards	Health Center	Quarterly
4	CSC: has 6 standards to measure HC & hospitals	Community (kebele)	Quarterly
5	KPI: primary health facilities (Woreda & HC have 30 KPIs and hospitals have >36 KPIs)	Primary health facilities	Monthly
6	EPAQ: Alliance of Woreda HO, HC & Primary & Hospital	Experience sharing and Performance review meeting	Quarterly

Woreda Management Standards implementation supported. Leadership and Governance related performance of Woreda Health Office should be measured against Woreda Management Standards (WMS). This has five main chapters: (1) Structure & governance; (2) Services; (3) Community Engagement; (4) Coordination with other sector; and (5) Performance management. In action, it consists of 26 standards and 81 indicators/validation points. During year one, the project supported 34% of targeted Woredas in the intervention regions to implement WMSs. Specifically, the project orients the Woreda Health Offices on the implementation of standards that can contribute for improving quality and equity of resources.

Woreda Management Standards (WMS) Jan 2017

Regions	# of Woredas in the cluster	# and % of Woredas Conduct WMS		WMS Score (%)					Average Score of WMS
		#	%	Chapter 1 (%)	Chapter 2 (%)	Chapter 3 (%)	Chapter 4 (%)	Chapter 5(%)	
Amhara	76	63	83%						47%
Oromia	135	80	59%	28%	24%	24%	25%	34%	25%
SNNP	70	46	66%	37%	33%	3%2	41%	46%	39%
Trigray	19	18	94.7%	85.1%	44.3%	18.4%	59.7%	70.6%	55.6
Total	**300**	**189**	**63%**	**31%**	**19%**	**13%**	**25%**	**29%**	**57%**

Ethiopian Hospital Service Transformation Guidelines (EHSTG) & Ethiopian Health Center Reform Implementation guidelines (EHCRIG)

The Federal Ministry of Health Developed Ethiopian Hospital services Transformation Guidelines which has 20 chapters and 197 standards. The performance review team of the hospital should measure performance of their hospital against this standard on quarterly bases. Similar, The Health Centers has Ethiopian Health Center Reform Implementation guidelines (EHCRIG) which out of 1h has ten chapters and 87 standards to be measured on quarterly bases.

During the reporting quarter out og 87 hospital close to half 43(55%) had trained staffs on the principles of the standards. And little higher than half of hospitals with trained staff 20(58&) measured their performance against the standard. The average met standard was 58% (Table). In addition, out of 1433 project target heath center 1404 (98%) had trained staff on the implementation the reform. While 1301 (91%) of oriented health centers measured their performance against the standard. The average score met the standards was 49.7%.

EHCRIG-EHSTG Jan 2017													
Regions	# hospital in Woredas	Number& % of Hospitals trained on EHSTG		Number& % of Hospitals Measured trained EHSTG		Number of Health Center in the woreda	Number and % of Health centers trained on EHCRIG		Number and % of HC Self assessed using EHCRIG		Number of HC Validated for Qt	Average score of EHCRIG in those woredas
		#	%	#	%		#	%	#	%		
Amhara	**20**	**8**	**41%**	**1**	**57%**	443	443	100	427	96%	0	0
Oromia	**23**	**5**	**22%**	**0**	**54%**	538	538	100	471	88%	193	71
SNNP	**24**	**14**	**58%**	**3**	**58%**	347	318	91%	298	93.7	108	60
Trigray	**16**	**16**	**100%**	**16**	**61%**	105	105	100	105	100	105	68
Total	**83**	**43**	**55%**	**20**	**58%**	1433	1404	98%	1301	91%	406	49.75

Key performance indicators: are set of selected indicators to monitor performance of the health system. Therefore, the health system would be informed with essential information useful to decision making. KPIs are tracked and monitored on monthly bases, During the reporting quarter out of 1422 project supported health centers 1283(90%) had trained staff on KPI. And more than toe third 1017(71%) measured against the standards. The average score was 23.3%

Key Performance Indicator (KPIs)						
Regions	Number of Health Center in the Woreda	Number and % of Health centers trained on KPI		Number and % of HC Self-assessed using KPIs		Average score of the KPIs
		#	%	#	%	
Amhara	443	443	100	340	77%	45%
Oromia	537	527	98%	392	73%	35%
SNNP	347	313	90%	285	91%	58%
Tigray*	105	0	0	0	0	0%
Total	1432	1283	90%	1017	71%	23.36%

***NB: unlike Amhara, Oromia and SNNP, the KPI of Tigray region can 't be rated out of 100**

Community Scorecard implementation supported. The Community Scorecard (CSC) is an important tool that is recommended for implementation at community level to increase community participation, accountability and transparency between service users, providers and decision makers. The community measures the primary health care services against six major evaluation parameters: (1) Caring, Respectful and Compassionate Health Workforce (CRC); (2) Waiting time; (3) Availability of medical supplies and commodities; (4) Ambulance services and community engagement; (5) Clean and Safe Health Facility (CASH); and (6) Access to health facility infrastructure (e.g. electricity, safe and clean water supply).

In Year 1, Transform Primary Health Care project provided technical and financial support to over 82 Woredas to introduce and implement Community Scorecards to enhance health

service governance. The project continued to provide its technical and financial support for all intervention regions. In this reporting period, the project further supported to scale up the implementation of CSC in demonstration sites in the four regions. The following major results were achieved:

During the reporting period, out of project targeted 7344 kebele to implement CSC, 2321 (32%) had started the initiatives through establishing the client counsel. In addition, 1536 (42%) communities (kebles) had measured their nearest 128(31%) of the health center against the six standards.

Community Score Card (CSC) Jan 2018									
Regions	Number of Kebeles in the woreda	Number and % of Kebeles established client counsel		Number and % of Kebeles with client counsels which conducted CSC measurement		Number & % of Health Center measures with CSC		Number of Health Center arrange Town Hall Meeting after CSC	# of HC used the townhall meeting feedback for Quality/performance Improvement
		#	%	#	%	#	%		
Amhara	1864	1266	67.9	786	42%	0	0	0	0
Oromia	3065	497	16%	357	72%	84	20%	0	0
SNNP	1986	129	6.5	207	10	37	11	4	0
Tigray	429	429	100	186	43	7	7	2	0
Total	**7344**	**2321**	**32%**	**1536**	**42%**	**128**	**31%**	**6**	**0**

The project provides technical support to primary health care facility managers in using the CSC report for performance and quality improvements. In Amhara Region, East Gojjam Zone, Machakel Woreda, a high performing Woreda, used the result of the CSC and feedback of the client council to address quality issues and derive positive results. Those health centers evaluated by the community benefited from using scores of CSC for performance improvement. The input from Primary Health Care project helped a lot to do so and this support was appreciated by the public sector.

The Head of Amanuel Health Center says: "The Amhara regional State Health Bureau in collaboration with Transform Primary Health Care project has oriented us on the principles and implementation of Community Scorecard. Our Health Center [Amanuel Health Center] has exercised the full package and received reports from the community based on six domains of the community scorecard. In addition, some qualitative information was supplemented by the client councils. The community scored waiting time the lowest. To identify the gaps, the health center conducted client flow and waiting time analysis. The baseline assessment revealed 1 hour and 30 minutes waiting time i.e time spent by clients to make first contact with health workers. We identified some practical solutions and got them implemented. Some of the interventions were: ensuring availability of services from 6:00 AM up to 8:00 AM; preparing and opening additional outpatient clinic room and discussion with

staff. The second client flow and waiting time survey showed significant improvement with 25 minutes average waiting time and higher client satisfaction." (Head of Amanuel Health Center)

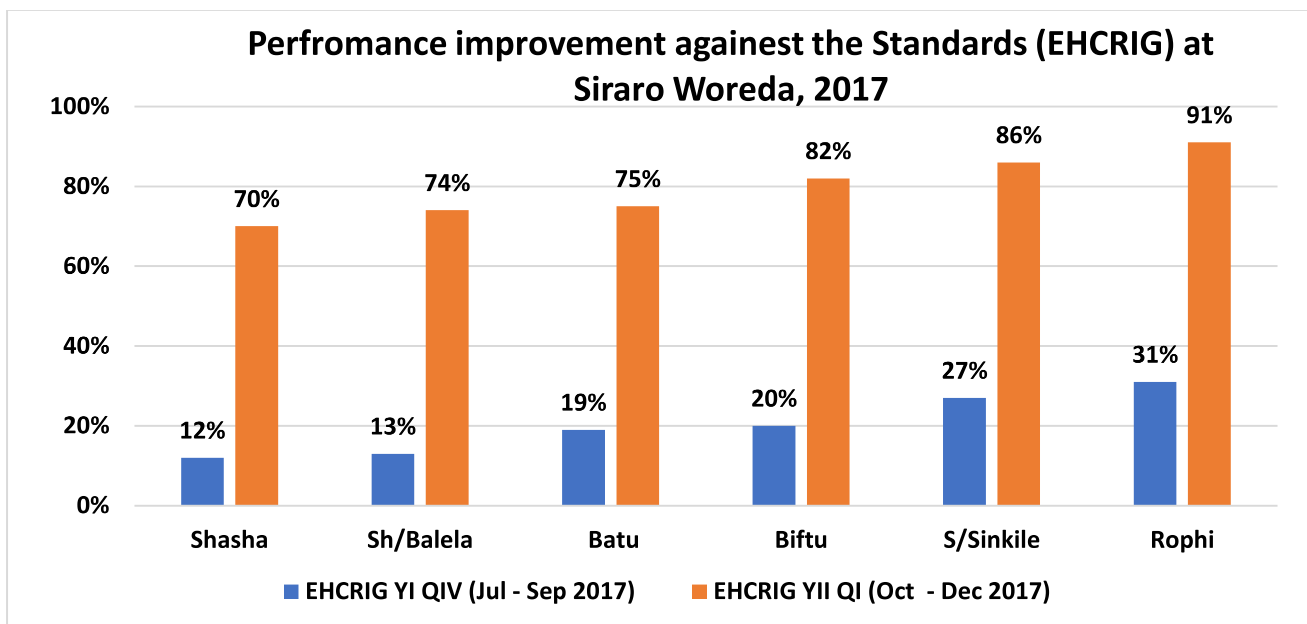
Ethiopian Primary Health Care Alliance for Quality (EPAQ) implementation supported. EPAQ is a collaborative relationships established by primary health care facilities (i.e. Woreda Health Office, Primary Hospital and Health Centers. Exercising EPAQ helps member organizations to measures and share experiences in implementations of health sector reforms among networks of Primary Health Care facilities

During the first year, the Ethiopian Primary Health Care Alliance for Quality (EPAQ) was implemented in three of the four regions, namely; Amhara, Oromia & SNNP. Collaborative networks of primary health care facilities in four Woredas were exercised. The EPAQ performance review meeting agenda was focused on EHCRIG, KPI, WMS, and change packages. Tigray postpone the activity due to competing priorities in the region.

Ethiopian Primary Health Care Alliance for Quality (EPAQ) which

EPAQ, Jan 2018			
Regions	Number of HC in the Woreda	Number and % of Health centers conduct EPQAs	
		#	%
Amhara	443	16	4%
Oromia	538	85	16%
SNNP	348	32	9%
Tigray	105	30	28.6
Total	1434	163	11.4

During this reporting period, the project monitored the implementation status of action plans in Aleltu and Siraro Woredas of Oromia region; Boreda Woreda of SNNP region and Tehuledere Woreda of Amhara region. According to the follow up report, the average EHCRIG standards met by facilities in Siraro Woreda of Oromia Region has significantly improved as shown in the chart below. EHCRIG has 81 standards in ten chapters some to name: PHCU Management & Governance; Health Center & Health Post linkage; and PHCU client flow and service Organization.



The project provides technical and financial support for the facilitation of EPAQ exercises in seven Woredas, in the three regional states i.e. Sululta & Gimbichu Woredas of Oromia, Woreillu Woreda of Amhara; Dara and Boricha Woredas in Sidama zone, Demboya Woreda in Kembata Tembaro zone and East Badwacho Woreda in Hadiya zone of SNNP.

Fig: Site visit during EPAQ meeting at Sululta Woreda of Oromia, Dec 2017

Furthermore, 221 participants (148 from SNNP, 51 from Oromia and 22 from Amhara) attended the EPAQ Performance Review meeting workshops in this reporting period.

EPAQ meeting Woreillu Dec. 2017 *HFs visit during EPAQ meeting Woreillu Dec. 2017*

Primary Health Care Unit Capacity Enhancement (CE) and Performance Review Meeting (PRM) supported. The project conducted Primary Health Care Unit (PHCU) capacity enhancement and performance review meetings in four PHCUs in Oromia, Amhara and Tigray regions. According to the

guidelines, a well-developed Integrated Supportive supervision checklist should be used to provide technical support to Health Extension Workers.

The following key steps are developed and should be implemented:

1. Orientation of PHCU staffs on approaches, objectives and tools of PRM & CE workshop.
2. Conduct Integrated Supportive supervisions at Health Post level. Identify knowledge and skill gaps. Propose capacity enhancement agendas.
3. Communicate PRM & CE workshop participants; Capacity enhance session facilitators; prepare the necessary materials; prepare facility to be visited; agenda and presentation formats.
4. Conduct PRM & CE workshop; and Recognize best performers.
5. Develop action plans on identified gaps.
6. Document the process.

Two of the four PHCUs completed the steps and procedures of this innovative capacity enhancement and performance management guides. The participants of the Capacity Enhancement and Performance Review Meetings were the PHCU director, Health Center – Health post Focal person, Health Extension Workers, Catchment Kebele Leaders, Sector office (eg. School) and HC Board Chairperson and representatives of WorHO and partners. Data obtained from ISS should be analyzed by Performance Review Team before facilitating PRM 7 CE Workshop. The preparation enables the PHCU team members to wisely use their time for PRM & CE, onsite facility visits and action plan development. All actors express their feelings for the technical support they received from Transform Primary Health Care project. The integrated approaches save times, costs and improve the competencies of Health Extension Workers.

Twinning partnership established. Twinning or pairing high and low performing Woredas is a central strategy to building sustainable capacity toward Woreda transformation. The project is dedicated to improving the capacity of partners by promoting quality standards and sustainable health services for individuals, families, communities and population in general through clinical and non-clinical mentorship programs, professional training and use of data for decision making. In Amhara region, East Gojjam Zone Health Department has facilitated the pilot exercises of twinning partnership through sharing important information between the high Performing Woreda of Machakel and Bibugn which is low performing Woreda. The twinning partnership was started with orientation on concepts and launching of the partnership in the zone. The participants of the meeting includes East Gojam Zone Health Department head and experts, heads of Bibugn and Machakel Woreda Health Offices, Machakel Woreda Administrator, and heads of PHCUs of the two Woredas, experts from both Woreda Health Offices and Transform: primary health care project staffs.

Machakel and Bibugn WorHOs heads and E/Gojjam ZHD while signing the MOU (Left) and Twinning Partnership Sensitization Workshop (Right), Machaleke woreda Amauel, Dec 2017

Memorandum of understanding (MoU) was signed by the three parties, Bibugn and Machakel Woreda Health Offices and E/Gojjam Zone Health Department. The MoU captures the roles and responsibilities of each party. Finally, based on the action plan developed during the sensitization workshop, a three day training for both Woredas and two Health Center Experts on systematic problem solving, health information system and indicators, coaching and mentorship was facilitated. At the end of the training, trainees were divided into two groups and they developed team vision: "To see a high performing Bibugn Woreda." Detail one year twinning action plan was developed for easy implementation that will be monitored by project and health sector staffs at lower levels.

Integrated Supportive Supervision supported. During this reporting period, the project has provided demand driven Technical, Financial and Logistics support to targeted Woredas. Details of technical support and its description are presented below:

In Amhara region, technical and financial support were provided for a 3-day Integrated Supportive Supervision (ISS) checklist revision workshop. A total of 55 participants (11 female) from the regional health bureau and partners working in the region attended the workshop.

In SNNP region, 27 Woredas and 10 Zones conducted integrated supportive supervision. The project provides technical support to all Zones & Woredas. However, only 7 Woredas and 3 Zones received financial support and the rest uses their own sources of budget.

In Tigray region, the project supported the region-wide ISS by deploying four technical staff, a vehicle and partly covered per-diem of some public-sector staffs. This session took nearly 40 days and covered all health facilities (HFs) and a considerable number of health posts (HPs) and households. Prior to the regional ISS, one of our regional staff (LMG officer) was assigned to review the checklist as a member of the regional review team. In addition, 4 Woredas have received financial and technical support to conduct ISS. Through these sessions, several HFs, HPs, WDA teams and households were visited. Support also provided to Amhara and Oromia regions for 11 and 17 WorHO, respectively, to conduct ISS.

Performance Review Meetings supported. In Oromia region, three zonal level review meetings (Bunobedel, East Hararge and Guji) were supported financially, logistically and technically and 203 participants attended these review meetings.

In SNNP region, 16 Woreda Health Offices and 7 Zonal Health Departments conducted quarter based performance review meetings. The project provided technical and financial support for 6 Woredas and three Zones.

3.1.1.2 Heath Care Financing

Through the health care financing (HCF) interventions, the Transform: Primary Health Care project provides technical support to alleviate financial barriers to health care, mobilize additional domestic resources to the health sector, encourage community participation, and ultimately improve health service utilization. It mainly addresses major activities such as: strengthening public financial management (PFM) at the PHC level, improving HCF reform implementation for retaining and using revenue at health facilities for priority interventions, and strengthening CBHI implementation in the intervention Woredas.

Public Finance Management (PFM) guidelines adapted. The adaptation process to develop the final draft of the Public Financial Management (PFM) guidelines tailored for the PHC level was completed. These are the first guidelines of its kind in Ethiopia, previously no PFM guidelines existed in the country for the PHC level. They fill a significant gap and therefore represent an important step for the Transform: Primary Health Care project in providing meaningful technical support at the regional and PHC level in HCF. The near-final draft is undergoing final technical review, editing, and formatting. Once finalized, the project's regional teams will customize the guidelines as needed for use in their contexts and use them for planned PFM training and coaching activities. The guidelines will ultimately be used by Woreda Health Office, primary hospitals and health centers.

The PFM guidelines were finalized through a collaborative process whereby the project team gathered and synthesized inputs from federal, regional and local (PHC level) finance and health system representatives and senior experts from the FMOH and MOFEC and all four project regions.

A consultative workshop was held with the objectives of: 1) creating awareness amongst key stakeholders on the draft PFM guidelines, and 2) obtaining feedback and perspectives from government counterparts and key partners to further improve and finalize the draft. A total of 30 participants attended the workshop. The most appropriate, experienced and senior Ethiopian authorities and specialists in PFM were also represented. The final draft addresses and incorporates all relevant comments and feedback provided by workshop participants.

During the workshop, the objectives of the overall project and the HCF thematic area were introduced. The challenges and opportunities in the health facilities that led to the need for PFM guidelines were also outlined. It is also underscored that the guidelines can be helpful

to an array of stakeholders involved in supporting the health system to move towards Universal Health Coverage (UHC) by bringing PFM and health financing systems into better alignment. Eight components (planning and budgeting; cash management and payment procedures; revenue retention and utilization; accounting and reporting procedures; procurement of goods, works and services; property/asset management and procedures; and internal control and auditing) of the draft guidelines were presented. Workshop participants discussed the guidelines in small groups formed based on participants' institutional arrangement and their background or experience.

Critical health facility readiness assessment checklist developed for provision of health services to CBHI beneficiaries. Health facilities provide health services for CBHI beneficiaries. Therefore, their preparedness or "readiness" to provide quality health care services to CBHI beneficiaries is paramount, as CBHI members must be able to access services with satisfaction. Readiness is determined by assessing the availability of essential drugs, laboratory services and skilled manpower at facilities. The project developed a standardized tool – a checklist – to equip the Ethiopian Health Insurance Agency (EHIA) branch offices, Zone and Woreda Health Offices, and CBHI schemes, with a systematized instrument for their quarterly and annual facility readiness assessments. The checklist can also be used by health facilities to assess their readiness in providing quality health services for CBHI beneficiaries. The checklist provides a means to identify gaps and review health facility performance plans. In the coming quarter, the checklist will be shared with the RHBs, EHIA branch offices and CBHI schemes for further refinement and assessment can be conducted thereafter.

TA to HFs on RRU budgeting and relationship between HCs & HPs in use of RRU. To use health facility resources in effective and efficient ways, expenditure budgets must prioritize core areas of health care service delivery. During the reporting quarter, onsite technical assistance was provided to HFs to improve their RRU budget prioritization practices and to efficiently allocate and utilize retained revenues. Assistance was also provided to improve the relationship between health centers and satellite health posts in using RRU. A total of 79 HFs (16 hospitals and 63 HCs) located in Oromia (30), Tigray (26) and SNNP (23) were provided technical assistance in collaboration with Zone and Woreda finance and health institutions. Topics mainly emphasized during the visits were assumptions to consider, formats to use, and justifications to support with evidence. It also covered how and in what way the WorHO should participate in and involve HFs in budget allocation/sharing, and showed the HFs SMTs what items should be recorded, documented and evidenced during budget hearing. Facilities were also shown how to prioritize and allocate budget for high impact and priority areas, transfer and request additional budget from Woreda finance offices for very significant expenditure items. In addition, HFs and their SMTs were advised to systematically support HPs by budgeting retained revenue to pay for items that couldn't be filled by specific program support (e.g. cleaning materials, stationaries, specific antibiotic drugs, and reagents). Lastly, technical teams discussed with WorHO and WoFED on the need

for them to reinforce and exercise participatory and decentralized planning and budgeting across the Woreda finance system.

Supportive Supervision Conducted. In Oromia region, regular thematic-specific supportive supervision was conducted in collaboration with the RHB, EHIA, and ZHDs, to 2 hospitals, 28 HCs, 12 HPs and 8 CBHI schemes. The main objective of the supportive supervision visit was to identify major implementation gaps related to HCF, PFM and CBHI and propose corrective measures to be taken by concerned bodies. The major findings of the supervision included: lack of regular community-facility forums at health facilities, appropriation of the Revenue Retention and Utilization (RRU) work plan and budget without it being reviewed by the health facility governing board, improper management of community contributions collected in cash and in kind to encourage institutional delivery, low CBHI enrollment and renewal rates, lag in ID card preparation and distribution, low quality service delivery for CBHI members in the HFs, and in taking measures based on identified bottlenecks by health facility SMTs. The supportive supervision team provided technical support and feedback during their visit to HFs, WorHOs, ZHDs to improve on these gaps and assisted them in setting up an action plan. Supervision findings were also presented and discussed in the Zonal performance review meeting held in two Zones of Oromia region.

3.1.1.3 Sub-Granting

Based on the roles and responsibilities listed in the sub-grant management manual of the project, one of the major responsibilities of the grant team is to establish national and regional sub-grant management committees and start the grant process. To ensure that this process is started in a way the grant objectives are met, the following major activities were accomplished during this reporting period:

After having a thorough discussion with the project senior managers and giving the required orientation to the Federal Ministry of Health Resource Mobilization Directorate, MCH Directorate and the grants team; the National Sub-Grant management committee was established. One of the responsibilities of the National sub-grant management committee was setting PMCD related priority areas for the grant applications and sharing this priority areas to the regional sub-grant management committee so that they can develop their region-specific priorities. To set the priorities there was a brainstorming session and then the priorities were developed and shared with the regional sub-grant management committee of each region.

After reviewing the Terms of Reference for the sub-grant committee, the national sub-grant management committee endorsed it and the document was shared to the regional sub-grant management committees. Orientation/update was provided to the four regional health bureau management staffs focused on:

- ✓ Transform: Primary Health Care Project grant objectives, types of grant and eligibility.

- ✓ Sub-Grant management and the roles and responsibility of Sub-grant management committee.

Grant training was provided to the regional and cluster USAID Transform: Primary Health Care Project staff in the reporting period. After the training, the cluster offices developed action points to cascade and orient to their respective Zones and Woreda Health Offices on the nature of the grant, grant application process, formats to be used or basic eligibility criteria' and unallowable activities for this project.

After reviewing and customizing the sub-grant application announcement document with the regional team, the regional sub-grant management committee announced the application to eligible Government of Ethiopia entities. During the application process the senior management team of the project, regional managers and cluster office coordinators and officers were providing onsite technical support to all Woredas in developing their Performance improvement fund grant applications. Here the focus was supporting the Woredas in identifying critical gaps in relation to PMCD, introducing and supporting the Woredas to comply with the application format requirements and so on.

After collecting applications from government entities, the regional sub-grant management committee of each region critically reviewed the performance improvement grant applications and selected Woredas as indicated in the table below for the 1st cycle of the 6-month period. The submission of applications for further approval by USAID started during the reporting quarter.

Region	Applications received
Oromia	86
SNNPR	83
Amhara	68
Tigray	16
	253

The following challenges were observed during the process:

- ➢ The Project was unable to get all the regional sub-grant management committee members at one time due to various competing priorities and took more time to complete activities as per the plan.
- ➢ Woreda performance level during the project proposal development stage of the award and the current actual situation on the ground is not the same. As a result Woredas labeled as high performing were submitting their application as a low or mid performing Woredas.
- ➢ Inconsistency in planning the activities as per the standard and lack of similar experiences of the Woredas has increased the number of comments and back and forth in finalizing the applications.

3.1.2 Sub-Result 1.2: Enhanced functionality of the health system within the context of primary level care

3.1.2.1 Use of Data for Decision-Making

Training provided on UDDM. The national health information strategy has two pillars and one foundation, namely, (1) Pillar 1: Cultural transformation for health data use, (2) Pillar 2: Digitalization and scale-up of priority HIS and (3) HIS Governance. The project directly supports two of the three categories i.e. the Governance and culture of data use for decision making.

During this reporting period, the project conducted five sessions of UDDM trainings (i.e. 2 in Amhara, 2 in Oromia and 1 in SNNP region) in Health Science training institutions. 154 (32.5% were females) Health Information Technology (HIT) professionals attended the training. In-service training centers and HIT computer laboratories were selected as venues for these skill based training. Trainings were facilitated by capable regional health bureaus, Health Science Colleges and University personnel.

UDDM training at Kombolcha Polytechnic College (left) and Bahir Dar Health Science College (right)

The four day UDDM training was dedicated mainly to addressing the revised HMIS indicator definitions, information revolution pillars, and information use culture. HIT professionals are the one who collect, analyze, triangulate, and generate facility based HMIS report and other health related data in the facility. Hence, they should be equipped with the necessary competence to understand, interpret and utilize integrated HIS (including HMIS, LMIS, Census, Surveys and Population based data) including Health reform packages (WMS, KPI, EHCRIG) for program and policy decisions. In SNNP region, four Health Science College tutors and two university instructors attended the basic UDDM training.

Coaching provided on UDDM. Coaching is a key part of the connected Woreda strategy and UDDM training for the successful implementation of information revolution at PHC level. The project understood the benefit of connected Woreda strategy and adopted Connected Woreda Strategy assessment tool for HIT professionals. Three sessions of coaching were

conducted in collaboration with Universities and Health Science College staffs. The coach visited each service points, review documents, observe the implementation of the tools to exercise information revolution strategy and use of data for decision making process based on the following perspectives: (1) HIS implementation and infrastructure, (2) Data Quality at all level (Tally Registry, Report), (3) Administrative Data Use, (4) Clinical Data Use. Based on the result obtained from the assessment, WorHO and Health facilities will be categorized as emerging (<65% of the assessment criteria); candidate (65% to 90% of the assessment criteria), and model (> 90% of the assessment criteria and at least used one eHealth system).

During the reporting period three session of coaching were conducted. The three targeted Woredas were in SNNP and Oromia regions. All primary health care facilities were categorized as emerging facilities (scored <65% of the assessment criteria). The following major challenges were observed during coaching based on four major perspectives.

- HIS structure and implementation:
    - I. Don't have standard Chart Room;
    - II. No budget for HIS activities;
    - III. Poor M&E system (in terms of HIS-Regular Monitoring and follow up);
    - IV. No standards formats patient cards;
    - V. No HIT professionals in the facilities (Boreda Woreda Health Office).
- Data Quality:
    - I. Representative and content completeness not checked;
    - II. Data verification not performed regularly (Lot Data Quality Assurance Sampling (LQAs) and Routine Data Quality Assessment (RDQA)).
- Administrative Data Use:
    - I. PMT not properly functional;
    - II. Brochure or newsletter that shows the health facility performance and disseminated every quarter;
    - III. No Information in the form of table, chart, etc. based on selected indicators that has presented to the society and other concerned bodies;
    - IV. No research conducted by the health facility to improve health service and presented or disseminated research/assessment findings in the last six months.
- Clinical Data Use (only for Health Centers):
    - I. Patient-level data records are not complete and accurate (Not routinely reviewed).

Based on the coaching, the identified gaps were discussed with each health facility and Woreda health Office including USAID Transform Primary Health Care Project Cluster officers. Based on the agreed identified gaps, 2 WorHO and 1 HC developed agreed action plan to improve their performance.

3.1.2.2 Revised HMIS rollout

Training provided on revised HMIS rollout. The previous HMIS indicators (2014) were revised due to driving forces that have resulted in the need for indicator revision. Some of these are the need for more quality and equity indicators requirement by the HSTP, introduction of new health initiatives, the need to align with international indicators and other factors. The revision of the HMIS in 2017 has resulted in the selection of 131 indicators. Based on the request from Amhara regional health bureau, the revised HMIS training was provided to 28 (8 female) participants selected from health centers and WorHOs in 5 intervention Woredas and Zonal health department of Waghimera.

Sub-Result 1.3: Strengthened transformational leadership, governance, and management at the Woreda and PHCU level

3.1.2.3 Leadership, Management and Governance

Senior alignment meetings supported. USAID Transform Primary Health Care has been working towards building LMG capacity by initiating an orientation on LMG concepts and processes specifically in the health transformation agenda for key senior government officials who have direct/indirect decision making authority for improving health outcomes. Head or representatives of Zone Health Department, Woreda Health Office, Woreda administration, BoFED, Women Affairs, Education and other sectors would be expected to attend this important meeting at the beginning of the very first LMG training and at the LMG projects result celebrations by the end of six month.

In this reporting period, a half day Senior Alignment Meeting prior to the beginning of the first LMG training was facilitated in 4 sessions in Amhara and Oromia regions for 128 participants (14% were females).

LMG training supported. LMG training is one of the capacity building activities for health system strengthening and it has followed a team based and experiential learning approach. USAID Transform Primary Health Care project is implementing LMG trainings by using three modalities for Woredas and PHCUs.

- ✓ LMG block course: During this quarter, 2 sessions of a six-day LMG block course trainings were organized for 4 high performing Woredas covering 87 (11% were females) PHCU directors and health workers from Amhara (37) and SNNP (50) regions. As an output 26 LMG projects were developed for improving WMS, ANC 4, EHCRIG, SBA, PNC, HDF, EHSTG, LAFP and CAR.
- ✓ A three-day LMG 1st workshop was also conducted in 4 training sessions for 3 mid-performing and 3 low-performing Woredas. Accordingly, 163 (15% were females) participants attended from Amhara (37), Oromia (52), and SNNP (74) regions. Participants were WorHOs experts, PHCU directors and health workers. They built their leadership, management and governance skills and developed 45 LMG projects that focus on improving SBA, ANC4, Immunization, model Kebeles, TB and HIV.

- ✓ As a continuum of the 1st LMG workshop conducted in the previous quarter, the follow on LMG 2nd workshop was organized for 1 mid-performing and 3 low-performing Woredas. A total of 114 (17% were females) participants attended from Amhara (28), Oromia (29) and SNNP (57) regions. Participants were WorHO experts, PHCU directors and health workers. They have enriched their existing LMG project which was designed during LMG workshop in the previous quarter.

In general, in this reporting quarter, LMG trainings were conducted in 14 Woredas (10 of them are New) in Amhara (5), Oromia (3) and SNNP (6) regions. A total of 364 (15% were females) health workers were trained and working on 103 LMG projects (71 of them are new). As a result, LMG intervention coverage has increased to 20 Woredas and 141 LMG projects.

Coaching provided on LMG. Coaching is a key part of the leadership, management, and governance (LMG) training, and should take place between training sessions at work sites of the trainees. Coaching greatly enhances the participants' ability to apply what they learned during training and make this new knowledge a part of their daily work experience.

The regional program offices and cluster offices in collaboration with the country office LMG advisor, LMG facilitators from regional universities and zonal health department have conducted post LMG training coaching in all four regional states. During the quarter, 70 Leadership project teams were coached and given proper guidance.

Halaba sp Woreda LMG coaching team, Oct-3-7, 2017

Dara Woreda LMG projects Coaching Teferi Kela HC, Oct 3-7/2017

3.2 Result 2: Increased sustainable quality of service delivery across the PHCU's continuum of care

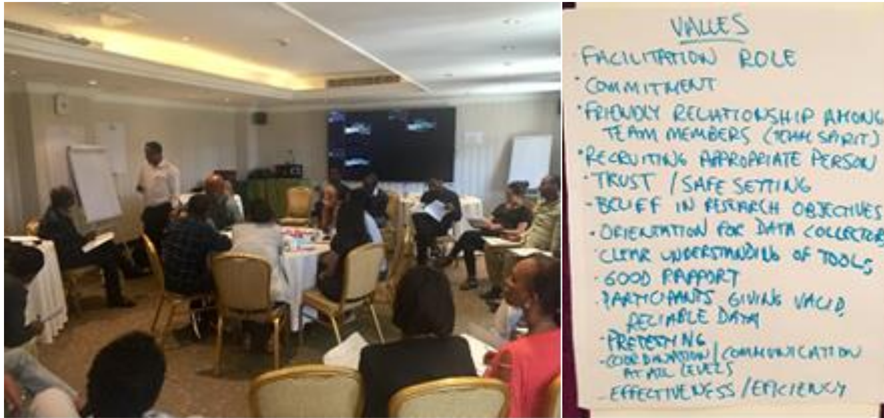
3.2.1 Sub-result 2.1: Strengthened skills for delivery of quality and integrated RMNCAH-N services

3.2.1.1 Gender

Transform: Primary Health Care Project recognizes gender as one of the key social determinants of health. It is set to contribute to the existing Ministry of Health gender integration efforts by addressing multi-leveled power hierarchies and ensuring that policies, practices, and behavior at all levels of service delivery management and provision are examined, challenged, and transformed towards perspectives that promote women's leadership and enable gender equitable access to and delivery of services. For this reason, the project focuses on conducting Gender Analysis to identify key gender gaps and opportunities across its four result areas and based on the findings of the analysis the design of Gender Strategy will be developed to guide the project's gender integration support in systematic ways. During this quarter, the following important steps have been accomplished in relation to the gender analysis as well as other planned activities focusing on capacity enhancement to address gender issues.

Gender Analysis Data Collection Training conducted. A four-day gender analysis data collection training for 16 qualitative data collectors and 6 Transform staff was conducted in Addis Ababa. The training was focused on enhancing the capacity of data collectors to articulate the value of gender analysis and practice qualitative data collection procedures, ethical issues and techniques of probing, capturing and producing quality transcripts. A field guide was also prepared and distributed to harmonize the overall field level data collection procedures and clarify the expected roles and responsibilities of each of the data collection team members.

On the third day of the training, participants went to Finfine Zuria cluster to pilot the data collection tools and practice interviews with health care providers. After the field practice reflection session was held, the team finally achieved confidence and clarity in the gender analysis data collection tools and process.



Gender analysis data collectors during the training and the values the team agreed to share during data collection

Gender Analysis Assessment. The full Gender analysis research protocol was submitted to four Regional Health Bureaus for ethical clearance and approval received in this same quarter. Data collection was conducted in 16 Woredas using techniques of participatory group discussions and key informant interviews. There were ten types of data collection tools prepared for adult men and women community members, married and unmarried adolescent boys and girls, health service managers and providers, and health extension workers. A total of 176 data collection events were completed successfully in 16 Woredas in the four regions of which 96 were participatory group discussions and 80 key informant interviews. A review of HMIS and administrative reports were also completed through on the spot document checklist. Overall the gender analysis data collection process went smoothly in terms of logistics and coordination and recruiting the right participants with the cooperation from Woreda Health Offices, maintaining required ethical standards and timely completion of field activities.

Gender analysis data collection in Tigray region, Mriena Kebele

Gender Analysis data transcription. Upon the completion of the data collection, data transcription has started immediately and complete transcriptions are now being reviewed and uploaded to Dropbox where the gender analysis teams at EnCompass HQ and in Addis Ababa have started coding the data.

Gender and health training. In this quarter, one session of gender health training was provided for 22 health professionals selected from Benatsemay and South Ari Woreda from

South Omo Zone and Kemba Woreda of Gamo Gofa Zone in SNNP region. Experts from these Woredas were selected for the training because they were identified by the RHB since they are labeled as high performing Woredas and need to complete capacity gaps related to identifying and addressing gender issues. Trainees include three from district health office (head or deputy of district health office, MNCH focal and WHO gender officer), one from health center (head of the health center) and one from each Zone MNCH department. The training was provided in collaboration with the RHB gender experts as a lead facilitator. The training focused on introducing participants with basic concepts on gender and health, existing FMOH approaches, strategies and tools to mainstream gender. In addition, participants were able to conduct gender analysis exercise using gender analysis matrix and become familiar with gender integration process.

At the end of the training, each Woreda identified gender activities and prepared action plan to be accomplished for the next six months. In addition, participants pledged to integrate gender lens in every of their activities.

16 days of activism against gender based violence commemorated at Tulu Bollo hospital. Every year the world commemorates November 25 to December 10 as 16 days of activism against gender based violence also known as White ribbon campaign. Worldwide different activities organized to communicate the message that gender-based violence is a violation of fundamental human rights. During this quarter, in collaboration with Oromia Regional Health Bureau, Women and Youth Affair Department Transform Primary Health Care Project organized a field visit to Tulu Bollo Primary Hospital which is providing comprehensive one-stop service for survivors of gender based violence. The hospital has started the service six months ago and served more than 14 sexual violence survivors.

The visit was followed by panel discussion where the regional justice office head, the medical director of the hospital and service provider from the one-stop center discussed the journey to establish the center and the challenges faced in terms of limited trained practitioners, supplies and awareness gaps among the community. Finally, it was emphasized that multi-sector action is very critical to save the lives and the future of many women and girls who need critical support in the prevention and response of gender based violence. In this regard, the initiative taken by Tulu Bollo primary hospital needs to be further strengthened, scaled-up and promised the RHB support to further enhance health sector response readiness and response. Elders or Abba Gedaa’s also blessed the event and expressed their stand against gender based violence. The event was attended by 64 (27% were females) participants.

For Transform Primary Health Care project, important lessons have been drawn from the experience sharing visit to inform objective and scope of its upcoming Land Scape Analysis on GBV at PHC level. The event was concluded by raising hands to promise to stand with

women and girls who are suffering from gender based violence and as a sign of this commitment white ribbons pins were also distributed.

Participants visiting the one-stop center

Abba Geddaa's pledging to stand against GBV

A panel discussion organized to commemorate International Disability Day. Worldwide, December 10 is commemorated as disability day to recognize and call for solving the multi-faceted challenge disabled people face every day. This year Transform Primary Health Care Project collaborated with Ethiopian National Disability Action Network (ENDAN) to commemorate the day and recognize the resilience of six disabled individuals who become successful in their lives and giving back to their communities. More than 150 participants were in attendance and the State Minster of Labor and Social Affairs, Tadelech Dalecho opened the event by highlighting the double burden women and girls with disability suffer particularly in terms of their increased vulnerability to GBV. She urges also for all state and non-state actors to give due attention to disabled women and girls to be responsive in services catered to the general population. Transform Primary Health care project supported the event and echoed that GBV is a serious public health concern and strives to support the health care system to be responsive to disability and GBV issues.

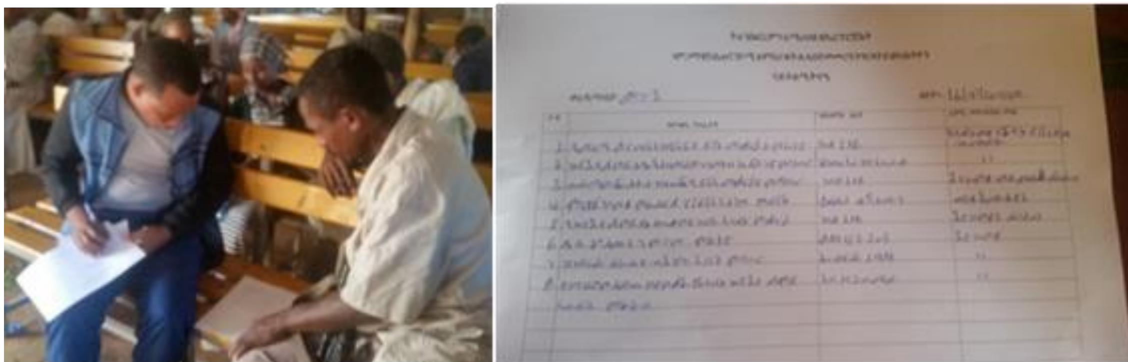
(Left) State Minister of Social and Labor Affairs, W/ro Tadelech Dalacho during opening remark and (right) Presentation of key messages on disability and GBV

Early marriage and FGM prevention review meeting and refresher training. As part of intensifying the Government of Ethiopia effort to eliminate FGM and Early Marriage practices by 2025 Transform Primary Health Care Project has prioritized hot spot Woredas with high prevalence of FGM and early marriage to provide tailored support. Accordingly, in Tigray region five Woredas namely; Wolkait, Tsegde, T/Adiabo and Tselmti have been

identified as hot spots and based on the discussion with Woreda Women and Children Affairs office key community and sector representatives from priority Kebeles participated in the review meeting and refresher training. Key focus of the event was assessing the functionality of HTP committees and increases the familiarity of stakeholders about existing FGM an Early Marriage elimination strategy. Sessions were also integrated on obstetric fistula case identification. A total of 200 (Female - 100) participants have attended in four sessions. The following are key findings from the discussions and agreed way forward:

- ✓ Three Woredas out of five have already Kebele level HTP prevention committees but not functioning well and participants agreed to take actions;
- ✓ The status of the situation and the efforts being made widely vary among Woredas and the gaps are due to limited awareness on the health consequence of these practices and the law in this regard for eg. religious leaders in the review meeting from Tegede Woreda still believe and promote a girl should get marry between the age of 12-15 according to Fetha Negest
- ✓ Despite the region is said to be with very low FGM prevalence and soon to achieve elimination in some Kebeles for eg. Mentebteb Kebele type 3 FGM which is the worst in terms of the girl's labia minora being fully stitched is still practiced.
- ✓ There is wide practice of gender based violence other than FGM and early marriage for eg females are not totally allowed to participate jointly in any of kebelle level meetings e.g. Mentebeteb Kebelle and Ziban Gedena from T/Adiabo Woreda.
- ✓ Finally based on the problems identified by representatives of each Woredas action plans were developed to establish and/or strengthen HTP committees, make high level discussions with religious leaders, identify fistula cases and clandestine practices of early marriage.

Furthermore during the quarter 213 arranged early marriages were canceled in Amhara (54), Oromia (8) and Tigray (155) regions.



Participants of review meeting from Wolkaite Woreda during action planning session

3.2.1.2 Family Planning (FP)

The goal of the FP/RH thematic intervention is to create enabled PHC facilities which can provide quality and appropriate FP/RH services and finally promote Woreda graduation. To

achieve this goal, the FP/RH activities are organized as a package of activities to be functional in the primary health care level. The package consists of three categories; First strengthening the existing FP/RH services and establish FP/RH services which are not available in the health facilities, Second integration of FP services in the service outlets of Primary Health Care (Delivery room, ART clinic, YFS clinics and Child health units) and lastly to improve and support the health service delivery system through innovative interventions (including capacitating the Woreda health office and PHCUs to provide capacity building trainings, peer to peer education/learning for skilled FP services and on-site training of HEWs at the PHCU level).

Implementation of the full FP/RH package will be initiated in a limited learning Woredas of each cluster areas and after testing it will be expanded to other areas. During this reporting quarter, the focus of the FP/RH thematic area was establishing the FP/RH learning Woredas and preparatory activities were performed to initiate the permanent family planning program.

Implanon Insertion capacity enhancement trainings. The skilled-based training on Implanon insertion was provided through a combination of theoretical lecture session in a class room followed by simulation video show and demonstration and practice on anatomical arm model using a competency assessment checklist. Following the three days of theoretical and simulated model practice training, participants were deployed to health centers to be exposed to the actual client demonstration and practice under supervision by the assigned health center FP service providers and trainers.

Pic. Implanon next roll out orientation model and Clinical practice, SNNPR

Depending on the gaps identified on Family planning–LARC services in the project target facilities during the previous quarter, Implanon insertion TOT was provided. The training was provided in 7 sessions for 136 (25% Females) health care providers in Oromia (one session), Amhara (four sessions) and SNNP (two sessions) regions.

Following the Implanon TOT trainings, Implanon roll out training was provided for HEWs. Accordingly, 14 sessions of rollout trainings were provided for 321 HEWs in Oromia (11 sessions), Amhara (2 sessions) and SNNP (one session) regions.

During the Implanon TOT and roll out clinical practical attachment sessions, clients were served with different FP services according to their method choice. As a result, 902 clients received Implanon insertion service, 152 clients received short acting family planning services (25 Depo Provera and 127 oral pills), and 72clients obtained Implanon removal service. Those trainees who didn't practice the minimum of five clients during the practical sessions will be coached by health center service providers at their health post until they acquire the insertion skill.

Comprehensive long acting reversible contraceptive training. Comprehensive long acting reversible contraceptive (LARC) training primarily focuses on Implant and IUCD insertion and removal skills but also include topics which refresh provider's knowledge on short acting FP methods. Shortage of skilled providers on Implant removal is one of the major reasons for the gap in the Implant removal service provision at the public health facilities. Prior to the trainings, facilities were identified with shortage of providers on Implant removal skills including IUCD skills in the targeted project areas.

The skilled-based training on Comprehensive long acting reversible contraceptive were provided through a combination of theoretical lecture session in a class room followed by simulation video show and practical demonstration and practice on anatomical pelvic/arm model using competency assessment checklist for six days. Following this theoretical and simulated model practice training, participants were deployed to health centers and primary hospitals to be exposed to the actual client demonstration and practice under supervision by the assigned service providers at the facilities and trainers for a minimum of five days. Clinical competency check list was used during the clinical practice to maintain and ensure quality of services.

LARC trainings were provided for those facilities identified to have a gap in trained providers. In this reporting period, five sessions of LARC training provided for 97 health service providers in Amhara (3 sessions), SNNP (1 session) and Tigray (1 session) regions.

During the LARC trainings clinical practical attachment, trainees were able to provide different contraceptive methods for their clients after proper individual counseling and client's choice. In general, 755 clients served during these trainings of which 164 were removal service. Looking at the methods received, 113, 285 and 141 clients received IUCD, Implanon and Jadelle insertions respectively, and 73 clients were served with short acting methods.

Permanent family planning services. Permanent family planning is one of the interventions supported by the project. The major objective of this activity is to establish static permanent

FP service at the primary hospital level as a center of excellence and later encourage a provision of outreach service at the health center level. Ultimately this initiative (learning) is to increase the FP method mix at the PHC level and establish a practical learning center for permanent method skill trainings during scale-up and avail a potential team of providers who can provide outreach permanent FP services within the public FP/RH service delivery system.

Following the partnership discussion, MSI country office communicated with the regional MSI offices to work together with USAID Transform Primary Health Care project offices in SNNPR and Amhara on detailed implementation of providers' skill training and orientation of HEWs who will be involved in demand creation, counseling and follow-up of permanent method clients. Based on this, Amhara regional project office have conducted two orientation sessions for HEWs, health center heads, Woreda health office staff and providers from health centers on demand creation and facilitators of the skill training for providers selected from Mekaneyesus and Farsebet primary hospitals. 76 participants attended the two orientation sessions (56 HEW and 20 health care providers). This demand creation and orientation session was technically and financially supported by Marie Stopes international Ethiopia (SIFPO2 project). Oromia and Tigray regions have selected the learning facilities for permanent FP services. Oromia region selected Gundo-meskel and Dodola Hospitals, while Tigray region selected Mehoni and Adidaero primary hospitals.

Review meeting. In Tigray, review meetings were conducted in five HFs (two PHLs and three HCs) operating in new project woredas. Following the review meeting the following issues were identified: relatively low uptake of long acting family planning, PPFP not being offered by the trained health workers in most of the HFs; low level of support to HPs to respond to demand for FP methods; challenges in integrating family planning to post- partum activities and youth friendly services; and poor documentation of long acting family planning users in the labor and delivery room. Continuous health services catchment based monitoring and technical support is one of the key agreed action points to address the raised issues.

FP/RH planning exercise. Low capacity for developing evidence based budgets for FP/RH services is a major challenge to FP/RH service delivery particularly in addressing recurrent stock-out of commodities and consumable. This could be due to poor utilization of service data for planning, quantification and procurements of commodities and consumables.

The ultimate objective of this exercise is to capacitate the health facilities to prepare evidence based budget documents and request decision makers for appropriate resource allocation for FP/RH. The planning exercise on FP/RH services is designed to enable providers to generate and compile monthly and annual FP/RH service data from their service registration book, prepare list and quantify supplies and commodities required for each FP services for a single client, and learn how to prepare budget request and procurement plan using the service data compiled from the registration book.

At the end of this exercise each facility will have evidence based budgeting document and quantified lists of supplies and equipment for FP/RH services required for a year. Finally, the Woreda health office receives evidence based budgets from all the PHCUs in the Woreda to compile and prepare the FP/RH budget and quantity of supplies and commodities. The decision makers will be more comfortable to allocate resources for FP/RH services if the Woreda presents data based budget in place of the usual traditional budget. Furthermore, this planning exercise will capacitate the Woreda health office to know the actual quantities of consumables, equipment and supplies required for the FP/RH services and also facilitates the distribution and re-distribution of the available Woreda resources (from the public sector and partners) to the health facilities according to their actual plan.

To pilot the utilization of local data use for service planning, quantification and procurement of family planning commodities and consumables, a two-day workshop on FP/RH planning exercise and orientation was held in Amhara and Tigray regions. Este Woreda in Amhara region and Tahetaye Maichew wereda in Tigray region are selected as a learning woredas. The orientations were provided for 20 and 31 participants in Amhara and Tigray regions respectively. Health center heads, primary hospital heads, WorHO heads, ZHD staff, RHB staff and cluster coordinators attended.

Participants were oriented on the project FP/RH intervention including the role and responsibility of each partner, the FP/RH intervention packages discussed in the introduction part of this FP/RH report above. A gap identification exercise for each health facility in the learning woreda was conducted as a baseline data and a gap analysis was conducted to ascertain the kind of support to be provided.. At the end of the session, action plan including a follow-up plan was developed to cascade the planning exercise and orientation session and implement across the health facilities in the woredas.

3.2.1.3 Maternal Health (MH)

The major supports rendered to the public sector on maternal health were enhancing capacities of service providers and program managers by filling skill and knowledge gaps through trainings, mentorship-coaching and supportive supervision, and providing necessary job aids and client education materials. During the quarter significant support was provided to maternal health services by the project in collaboration with RHBs and their lower structures (WorHO, PHL, HC and HP).

Gap filling trainings on BEmONC + RMC + Preventive Medical Equipment Maintenance. To enhance the capacity of service providers on emergency obstetric and newborn management, five sessions of trainings on BEmONC integrated with respectful maternity care/RMC and preventive medical equipment maintenance were organized for service providers in collaboration with Ethiopian Midwives association (EMwA), RHBs and ZHDs. The trainers were experienced BEmONC trainers who have BEmONC TOT and were selected from nearby universities, health science colleges, hospitals and EMWA using the EFMOH's in

service training guide. Accordingly, 81 (54% were females) providers from different health centers were trained.

After each of the BEmONC training finalized participants received three days of respectful maternity care (RMC) training to learn about how to provide respectful maternity services. Participants prepare action plans at the end in the presence of respective zonal health department officials. A training on preventive medical equipment maintenance coupled with BEmONC training was conducted at one of the trainings in Oromia region which will be scaled based on the lessons learned. This sequential training of BEmONC with RMC and preventive medical equipment maintenance saves money and reduces the number of days the health care providers have to stay away from their respective health institutions.

Pic. Practicing New born resuscitation at Bishoftu town

Pic. BEmONC training skill demonstration practice at Gondar University

All the participants of the training were selected from labor and delivery units of health centers as per the need assessment that was conducted by the project in consultation with the public sector. Some of the facilities were selected based on accessibility (hard to reach) in addition to the needs assessment findings. Trainers were selected in collaboration with RHBs and EMwA strictly using the FMOH in-service training guide (ISTG) and were invited from Universities, Regional Health Science Colleges, EMwA, and different hospitals.

Health managers' orientation on BEmONC. To effectively monitor proper implementation of BEmONC by trained service providers, health managers at different levels must have necessary skills and knowledge on mentoring of BEmONC. The objectives of the training were to enhance the capacity of health managers on basic knowledge and skill to conduct regular integrated supportive supervision (ISS), follow-up and mentoring support from the Zonal and Woreda health offices to respective health centers, equip health managers with basic knowledge and skill on clinical mentoring for the continuous improvement of maternal and neonatal health service quality. Based on RHBs demand to build the capacities of program managers on mentorship skills, five sessions (Oromia 3 sessions, Amhara 1 session

and SNNPR 1 session) of BEmONC orientation trainings were conducted for program managers from zones and woredas, but no planned activity in Tigray during the reporting period. A total of 147 participants received the trainings. These orientation trainings had both theoretical sessions and facility visits. The orientations were conducted in collaboration with RHBs and respective zonal health departments. The trainers are same trainers who deliver the basic BEmONC training. This managers' orientation on BEmONC is a 4 days training where the first 3 days are used for theoretical session to cover all BEmONC topics in short form as it is orientation. The 4th day is supervisory visit to health facilities using a prepared checklist for the purpose.

During the two rounds of BEmONC orientation in Oromia region, participants were assigned in five different health centers for field visit using the standardized checklist. Participants were fully engaged in supervision using both a checklist and observation of the facility and during service provision of midwives at those health centers. During the visit, they observed and identified strengths and gaps. Immediately after the visit they presented field reflections and discussed on the issue. Gaps and strengths were identified and on-site feedback was given to the respective health centers. During feedback, head of health centers, midwives and health informatics professionals participated. At the last day of the training, an orientationwas provided by ZHDs and WorHO staffs on BEmONC and effective MNH service provision.

Safe child birth checklist (SCBCL) introduction and scale up. SCBCL introduction was started at Oromia region during last quarter of the first year and scaled up in this reporting quarter. It was introduced at Amhara (three clusters including South Wollo where baseline assessment was done before the introduction) and SNNP (Hosana cluster where baseline assessment was conducted) regions during this reporting period. In all the regions the project aimed to develop a systematic approach that would enable health care workers to get oriented and use the safe childbirth checklist during their provision of childbirth care. This will empower health workers to identify, understand, and ultimately resolve barriers they might face in using the SCBCL to deliver quality maternal and newborn care, with follow up and coaching as the main strategy. Safe childbirth checklist orientation was conducted by RPO under Hosanna cluster for all 19 intervention woredas. One day orientation was given in six sessions. After completion of the orientation, baseline data was collected from a total of 88 PHCUs in order to study the impact of the checklist after implementation. The following comments were raised during orientation:

- The checklist lacks identification part like name, age, date and Maternal Registration Number (MRN) of clients. (Which was corrected during subsequent prints, but the remaining comments need discussion with FMOH before inclusion and noted for same).
- Chlorohexidine for cord care and watch were not included in the checklist
- Availability of the checklist might not be sustainable for SCBC implementation
- It is better if there is a review meeting after the implementation of the SCBC checklist

- Dose of Vitamin K must be arranged according to neonate's weight, if the weight of the newborn is < 2.5 kg, the dose of Vitamin K is 0.5 mg and if the weight of the newborn is > 2.5 kg the dose of Vitamin K is 1 mg.
- Some question in the SCBCL lacks Yes and No boxes.
- SCBCL should capture vital sign of the mother and neonate.

After discussion at each orientation session, the participants promised to provide orientation for their respective staffs and to implement the checklist as soon as possible. Generally, a total of 210 health professionals were oriented and the base line assessment was collected from 88 health centers and primary hospitals.

MNH Clinical Mentoring and coaching training. MNH clinical mentoring and coaching is a system of practical training and consultation that fosters ongoing MNH activities to yield sustainable high quality MNH care outcomes. Implementing a well-organized catchment based mentoring and coaching for MNH services in the PHCU would help to ensure quality maternal health service to bringing client satisfaction. The objectives of this training were to:

- Provide the platforms to implement clinical mentoring for MNH services
- Use standardized formats across all MNH clinical mentorship programs
- Provide direction to coaches/mentors on the principles of coaching/mentoring related to MNH services
- Provide the required skills and competencies of coaches/ mentors
- Monitor and evaluate the program systematically

A three days MNH clinical mentoring training was conducted in Amhara and SNNP regions where 42 (56% were females) previously BEmONC trained health workers took part. One mentor is supposed to mentor health workers in 2-3 health centers for a maximum of 6 months. Below are experiences and challenges encountered from SNNPR:

- Changes in partograph utilization in Guba health center in SNNPR:
  The mentor immediately provided orientation to all delivery case team members after the training in Guba health center. The mentor pointed to noticeable improvement in the health center since the mentoring program began. Partograph utilization significantly improved after the training and strengthened referral processes and improved the availability of supplies.
- Challenges related to mentorship**:**
  Despite the positive effects of the mentorship program, some challenges were encountered. The first challenge was the health-worker workload, since the mentorship sessions were designed to happen at health facilities and outside the health facility, the health workers were sometimes overwhelmed with balancing their work and the mentorship demands. However, mentors endeavored to provide support by working alongside the health workers during their work shift and by pre-scheduling visits on less busy days and limiting them to only two to three days per month in each health center.

We recommend such strategy should be in place, especially in the context of heavy workload, which was found to be common in some of health facilities.

MNH job aids printing and distribution. During this quarter, the project distributed different job aids to facilities. The distributed job aids were:

- Counseling job aids to be used during ANC and PNC service provision.
- Danger signs job aids to be used during pregnancy, labor/delivery and postpartum period.
- Birth Preparedness and Complication Readiness (BPCR) job aids.
- Women friendly services job aids.
- Management of breech delivery job aids.
- Assisted vaginal delivery (vacuum extraction) job aids.
- Management of retained placenta job aids.
- Management of third stage of labor job aids
- MNH monitoring charts job aids

Moreover, more job aids were developed and are in the process of printing. The job aids are Mothers prone to deliver preterm baby, Mothers prone to deliver low birth weight baby and Mothers prone to develop postpartum hemorrhage after delivery.

Support on training material adaptation. The project also supported the Oromia RHB in developing a regionally customized training material that will be used for training of health managers on proper mentoring, coaching and supervising on BEmONC. The responsibility of adapting the document from the one which was used by IFHP project and now modified and being used within USAID Transform: Primary Health Care Project was given to the regional MNH TWG. Transform: Primary Health Care Project provided necessary technical, logistics and financial supports while the team was developing the material. The adapted material is a four days training material in the region.

MPDSR. Building trainers' pool on MPDSR of Oromia region was one of the interventions supported by the project in this reporting quarter. The approach of the support was helping the Oromia RHB by organizing TOT on MPDSR. Accordingly, two sessions of three days MPDSR TOTs were organized in collaboration with the ORHB and 62 (8% were females) participants were trained on MPDSR TOT. The major contents of the training package for this TOT were video shows, case scenarios, and exercises on different tools.

3.2.1.4 Newborn Health (NH)

Most of the newborn health services are linked with maternal health services. In most cases quality of maternal health services like ANC, skilled delivery, postnatal care (PNC) and immunization service for the mothers that determine the health outcomes for newborns.

Strengthen existing NICUs at primary hospitals through on job mentoring, material support and maintenance. In this quarter, 3 NICUs at Durbete, Feresbet and Adet primary hospitals of Amhara region were visited and the general findings were as follows:

- All of them have NICU but they have gaps to provide quality services. All have incubators, only Adet PHL has warm radiant, only Durbetie PHL has KMC room, the number of separate rooms were 2 in Feresbet and 3 in other PHLs. There are interruptions of electricity especially at Feresbet PHL and each of them has only 3 beds.
- The number of NICU trained health workers are 4 at Adet and 2 at Durbetie and none at Feresbet PHLs.
- From the data, Adet primary hospital has provided better quality health services because its expected cured rate was > 85% and expected death rate was < 15%.

In Tigray region as part of the follow up and post training review meetings, issues of newborn care were discussed and support was provided accordingly.

3.2.1.5 Child Health and Development (CHD) and immunization

Despite remarkable achievement in reducing mortality in children under the age of five in Ethiopia, many children and newborns are still dying of preventable causes. Various proven packages of life-saving newborn and child health programs and interventions have been introduced and rolled-out at scale. IMNCI, ICCM/CBNC, and EPI programs are among the key interventions to reach children with services at the HC and HP levels.

Challenges were identified through routine program monitoring activities and various assessments and discussed during child health theme team meeting. The major findings include:

- Poor quality of care
- Low level of use of IMNCI/ICCM, CBNC services
- Shortage of essential drugs at HPs
- Poor training database at woreda level
- High EPI defaulter rates, and poor tracing
- Poor cold chain management mechanisms.
- Lack of community based registration that misleads performance (>100% coverage)

The interventions of the Transform Primary Health care project include gap-filling training, pre-deployment ICCM/CBNC training, follow up, coaching, mentoring; review meetings at PHCU level; integration of Immunization in practice (IIP) training with cold chain maintenance; Involving project drivers in cold chain and medical equipment maintenance; and integration of EPI with ICCM training for HEWs. Additionally, activities like defaulter tracing mechanism in health centers and health posts and distribution of child health drugs and commodities through PFSA (Pharmaceuticals Fund and Supply Agency) need to be strengthened.

The interventions under the CHD and EPI thematic area are implemented in collaboration with RHBs, ZHDs, and WorHOs and other partners to avoid duplication. Onsite CE is conducted at HCs without interrupting routine health activities and helps to solve the problem of high turnover of trained staff, since most health workers are trained.

During the reporting period, technical support to the MOH was given at all levels, including introduction of MCV2 (measles-containing vaccine), and HPV2 (human papilloma virus vaccine), and revision of IMNCI, ICCM/CBNC, follow-up, and review meeting guides. Technical and logistic support was provided during polio sub NID (National Immunization Day) in semi-pastoralist areas. During EPI and cold chain maintenance trainings, refrigerators and medical equipment were installed and maintained, which saved a lot of money.

IMNCI training was provided for 156 health workers (46 Oromia, 22 Tigray, 88 SNNP). In SNNP it was provided as Onsite/Whole Site Training Approach. This is a new approach where HWs were trained in their own HCs by trained staffs from the same facility. Theoretical materials were given during weekends, and practical trainings were given during weekdays, especially when there is lesser workload in the afternoons. This helps to solve the problem of trained staff turnover, since maximum number of HWs are trained, it is also conducted without interruption of health services, improves quality of service, and is cost effective. ICCM/CBNC training was provided for 1,298 HEWs (1,190 were pre-deployment): 803 in Amhara, 340 in Oromia, and 155 in SNNP.

Immunization in practice (IIP) training was provided to 82 HWs: 30 in Oromia; 22 in SNNP, and 30 in Tigray regions. Trainings were organized in partnership with RHBs, and other partners based on identified gaps, and facilitators were selected jointly. Transform: primary health care provided both technical support as facilitators and financial support (Perdiem, training materials, refreshment and hall rent). Cold chain maintenance training was provided for 31 health workers in Amhara region. During these trainings, participants and drivers overhauled 93 nonfunctional refrigerators (20 in Amhara, 72 in SNNP, and 1 in Tigray). Project drivers maintained 46 of the refrigerators, two radiant warmers, and installed electric systems.

Integration of EPI with ICCM/CBNC trainings was designed by Transform: Primary Health Care Project. The integrated practical session has given participants the opportunity to learn from HCs and hospitals without using additional time or money. An EPI monitoring chart is being distributed, and fridge tags have been secured from FMOH and are now readied for distribution. Child health drugs were also secured from UNICEF and has been distributed to HPs. Currently these drugs are already integrated to IPLS (Integrated Pharmaceutical Logistic System), to be distributed through the government system. This helps to sustain the supply chain management.

3.2.1.6 Nutrition

The project supports major nutrition specific programs through capacity building, system strengthening and advocacy. The high impact national programs the project supports include management of severe acute malnutrition, Vitamin-A supplementation (VAS) and deworming, growth monitoring and promotion (GMP), maternal nutrition & adolescent nutrition initiatives.

Overall, the project has continued its effort to enhance PHC capacity to deliver effective nutrition screening, monitoring and treatment services and has been working to create an enabling environment by collaborating with partners at all levels.In order to avoid duplication with other nutrition partners and boost collaboration, discussions are continued.. The project hosted a meeting this quarter with USAID/Growth Through Nutrition, and it also visited UNICEF and Alive & Thrive to exchange experiences and materials.

National Nutrition Program (NNP-2) review meeting was held this quarter and the project was among the prime technical supporters. Transform: Primary Health Care Project co-chaired the technical sub team leading the preparation and facilitating some of the sessions in this big national event. The review meeting was held in Addis Ababa, with the presence of delegates from 14 sector ministries and representatives from all regions (including sector heads/delegates). The meeting successfully reviewed performances and status of NNP-2 in regions and sectors. Major implementation challenges were identified and best practices and lessons were shared among participants. It was concluded with clear action points and a consensus on the way forward. The regional project teams are also supporting regional nutrition technical committees to effectively execute agreed action points.

Well learning from the training material effectiveness assessment that was conducted in the previous quarter, the Project has hired a consultant-learning specialist. The CD-based Blended Integrated Nutrition Learning Material (BINLM) now has a stronger quality assurance and certification systems and is compatible with use in flash sticks. BINLM is one of the major trainings entrusted by the health sector to create capacity for improved nutrition service delivery, and the improved material is expected to help and will be jointly tested in the next quarter.

Trainings on some of the high impact nutrition programs as well prescribed by the gap analysis were conducted. Trainers were mostly from the public sector. A total of 28 participants (14 female) were trained on Management of Severe Acute Malnutrition in collaboration with North Showa Zonal Health Department in Amhara Region. Participants were drawn from nine project intervention woredas and they were also selected based on findings of training need assessment done by Zone Health Department and Transform: Primary Health Care Project.

Trainees attending theoretical sessions at Debre Birhan town

One session of Blended Integrated Nutrition Training was given in Oromia Region for participants from 10 intervention districts where there is no other partner supporting the activity. A total of 30 participants (13% were females) took the first orientation session, of which only 26 completed the self-study for the theoretical part and also attended the skill session.

Adolescent nutrition is one of the most neglected areas even though it is a critical stage in the intergenerational cycle of malnutrition. Among the lists of interventions in the national nutrition program, and the project has selected some (in line with its goal and scope). As a learning exercise, the project is working to improve knowledge of adolescents in schools on important aspects of nutrition (including hygiene and sanitation). As students can also serve as change agents in their communities, tailored sessions on IYCF and maternal nutrition are also included.

Adolescent nutrition ToT was given in SNNPR and Amhara regions to a total of 34 participants (6% were females). Participants were selected from different NNP implementing sectors including woreda health offices, education offices, agriculture offices, women and child affairs and water supply offices. Adolescent nutrition roll-out training, on the other hand, was provided to a total of 216 participants (34% were females) in nine different sessions in Amhara and SNNPR regions.

Participants practicing counseling and CF practical demonstration

3.2.1.7 Malaria

Despite progressive reduction in malaria morbidity and mortality, the disease remains to be a serious public health problem in Ethiopia. In March 2017, malaria elimination roadmap framework has been launched to eliminate the disease from Ethiopia by 2030. USAID Transform: Primary Health Care Project works in all woredas with low, moderate and high malaria transmission intensity. To contribute towards reduction of malaria transmission in the country, the Project provides support to woreda health offices and primary health care unit (PHCU) on malaria prevention and case management with special emphasis to malaria in pregnancy and RDT performance and quality improvement. Malaria related technical support is provided during integrated supportive supervision, various trainings (ICCM, IMNCI, and CBNC) and annual review meetings.

Malaria risk populations of the project areas are the primary beneficiaries of malaria related activities of the project. The project activities will give special attention to benefit pregnant women to receive quality malaria case management at ANC clinics. Health professionals working at Woreda and PHCU level, who attend various capacity enhancement trainings and mentoring are also the beneficiaries of the project activities.

Malaria in Pregnancy: Malaria case management training was given to ANC providers to improve the quality of services given to pregnant women who suffer from uncomplicated and severe malaria. Improving the quality of service being provided to malaria cases of pregnant women will avoid preventable deaths of pregnant women and newborns from severe malaria. Integrating malaria case management at regular ANC service also improves access to quality services for febrile pregnant women.

Malaria case management trainings targeting at improving quality of services given to pregnant women were provided in this reporting period. A total of 115 health workers (44 % female) participated in Amhara (58), SNNP (27) and Tigray (30) regions. The project also technically supported and shared costs of capacity enhancement malaria case management training provided for 245 health workers in Oromia Region.

Monitoring malaria in pregnancy: Information on malaria morbidity and mortality in pregnant women is poorly recorded and unavailable in most health facilities. During the previous quarter, the project assessed feasibility of monitoring malaria in pregnancy in 10 health facilities. The result showed that the data and reporting tools from Tigray, Oromia and SNNPR regions do not capture malaria in pregnant women. On the other hand, the Amhara region is using Public Health Emergency Management (PHEM) weekly reporting form to capture pregnant women who tested positive for malaria. Monitoring of malaria in pregnancy will be implemented in all health facilities of Amhara region as of the next quarter.

RDT performance assessment: As per the guideline of the Federal Ministry of Health (FMOH), RDT performance assessment is conducted during supportive supervision using on-site support supervision checklist. RDT performance assessment was undertaken in randomly selected health facilities of Amhara region. Preliminary finding reveals that all health extension workers did not follow the requirement of proper RDT procedures in most health facilities. The on-site supervision conducted in 10 health posts shows that only 30% of the total health posts scored above 80% of the criteria for quality RDT. Performing RDT without gloves, poor waste disposal system, not allowing finger to dry before pricking and failure of incubating the test for the right amount of time were commonly observed errors. The finding shows that six months before the assessment, due to lack of RDT kits, RDT diagnosis service was interrupted at health posts of Gondar and Woldia clusters. After completing the analysis, final report of the random follow up on RDT performance assessment will be presented with other thematic areas.

As of next quarter, RDT performance assessment will be undertaken in 100 health posts selected from the four regions. In addition, continuous mentoring and supervision on RDT quality will be provided to all health posts of the project sites.

Surveillance and Epidemic Monitoring: New malaria surveillance charts designed by FMOH were printed and distributed to 400 health facilities of Oromia Region. The monitoring chart will be used to monitor trends of malaria cases at each catchment area, report cases and responds accordingly. Malaria case management training manuals were also printed and distributed. The manuals will be used in 400 health facilities as reference during malaria case management at health facility level.

Technical support was given at FMOH level during production of malaria elimination manuals. The project staff also participated on facilitation of National and Regional malaria elimination orientation TOT.

3.2.1.8 Obstetric Fistula (OF) and Pelvic Organ Prolapse (POP)

In previous projects, Pathfinder International has been supporting the Ethiopian Federal Ministry of Health's effort to Eliminate Obstetric Fistula (EOF) by 2020 with the US Congressional Earmarked fund for Obstetric Fistula, through the E2A until June 2017.

During year two of the USAID Transform Primary Health Care (TPHC) Project, in alignment with the FMoH's initiative towards the EOF, a renewed focus on OF prevention and treatment is now underway to be implemented in an integrated approach with other thematic areas. The Project supports OF and POP prevention and treatment through support for operationalization of the National Action Plan for EOF Fistula by 2020.

The project will also intensify the scale-up of identification and referral activities for OF and POP involving community mobilization, engaging the media and building Woreda/regional

capacity to organize and conduct clinical training of mid-level health workers in diagnosis skills, as well as support transportation of OF and POP cases.

Moreover, the Transform Primary Health Care Project in collaboration with the Government of Ethiopia (FMoH) and other partners is supporting the completion of the "Woreda Fistula Free Guideline" which will serve as a road map by woredas towards the attainment of the National goal of EOF by 2020. WorHOs have been technically supported to advance the practice of targeting 'hotspot' woredas with more suspected OF cases, including harder-to-reach areas, for OF case identification and referral. By "hot- spot woredas" we refer to woredas with the following characteristics:- Low performing woredas, Geographically remote (in terms of transportation, access to roads, etc.), and woredas with relatively poor access to, and coverage of AYRH, maternal & RH/FP services.

During the reporting quarter, gap identification of trained providers was assessed across the four regions and three sessions of clinical skill based training was undertaken on clinical skill for identification and diagnosis of – OF & POP for midlevel health workers. A total of 54 (53% were females) service providers have been trained in Amhara, Oromia and SNNP regions to improve the practice of "OF + POP" case identification, diagnosis and referrals. The training sessions were organized in collaboration with the Hamlin Fistula Centers of Bahirdar, Mettu and Asella hospitals. Trainees were adequately skilled on how:

- To provide orientation to their colleagues, and the HEWs towards case identification and referral for confirmation.
- To comfortably conduct the digital examination and the dye test, and diagnose OF.
- To diagnose and identify the type of fistula, even in resource limited settings,
- To provide pre-referral care for confirmed cases.
- To be vigilant enough towards prolonged obstructed labor (using the partograph), in preventing OF and arrange timely referral.
- To organize referral from the community to HC, and then to Hamlin Fistula Centers.
- To uphold the value of quality FP, ANC and BEmONC services in the prevention of Obstetric Fistula

As one of the two pronged approaches to the EOF, the Transform: Primary Health Care Project has supported efforts to identify suspected OF and POP cases, referral OD suspected cases for diagnosis, confirm OF cases, and referral for treatment. This is an effort to the contribution of the continuum of care proposed by the FMOH and its partners. Accordingly, during the reporting quarter the project has supported:

- The identification of 236 suspected Obstetric Fistula cases in the four regions,
- The referral of 198 Obstetric Fistula cases, in the four regions,
- The confirmation (diagnosis) of 182 Obstetric Fistula cases, in the four regions,
- The treatment of 99 confirmed Obstetric Fistula cases, in the four regions,
- The identification, diagnosis, referral and treatment of 39 POP cases (only in SNNPR).

Furthermore, other activities were carried out in line with the prevention and treatment of cases of Obstetric Fistula, and Pelvic Organ Prolapse (POP). These include:-

- With the view to integrate and strengthen clinical skills of professionals in OF diagnosis, pre-service integration at regional colleges and universities has been targeted for year two of the project. Concept note is drafted and preceded to subsequent actions.
- With technical support from the SBCC team, developed key messages for OF-POP, and assisted in its translation into Oromiffa and Tigrigna.
- Developed updated list of criteria, for identification of over 160 "OF" hot spot woredas. With the assistance from the MEL team, a map showing the hotspot woredas has been finalized.
- Developed a summarized brief note on the strategies, priorities and major interventions in OF-POP.

3.2.1.9 Adolescent and Youth Health and Development (AYHD)

Transform: Primary Health Care Project has planned and implemented various adolescent and youth related activities to create access to youth friendly health information and services as one of its major focus area of intervention based on the National Adolescent and Youth Health strategy.

Integrating youth friendly services within the public health facilities using different modalities like a separate space approach, mainstreaming in all contact points of the health facility (by making all health facility service points and the health system adolescent and youth responsive) and empowering very young adolescent girls (VYA) through "Her Space" program was very important.

To ensure active and meaningful involvement of young people in all aspects of their own, and their communities' health and development, Transform: Primary Health Care Project made the peer education activities as part of its implementation strategy to improve the health care seeking behavior of adolescent and youth in its target regions. In all youth friendly service facilities 25 peer-educators (girls and boys) per facility were deployed. They are trained, closely mentored and coached to pass tailored messages, counsel on different SRH and other health issues and facilitate referrals to YFS facilities.

Transform: Primary Health Care Project recognizes that adolescent and youth are beyond just a health issue but they involve different sectors. The Project supports the establishment and strengthening of adolescent and youth development (AYD) multi-sector coordination bodies at different levels. The Project will oversight to mainstreaming AYD within the activities of relevant sectors. This will include exploring possible linkages and collaborations with the FMOH's new school health program, which includes; life skills training to promote healthy lifestyles; school-based mass deworming; water, sanitation, and hygiene (WASH); management of common infections, infestations, and disorders; routine and supplemental vaccination programming; SRH; HIV and sexually Transmitted Infection (STI) prevention,

treatment and control services; mental, neurological, substance use/disorder and injury prevention and support. This will be done where they fall within the scope of the project.

Capacity Enhancement to Public Sector Health Service Providers Through YFS/STI training. Transform: Primary Health Care Project continued enhancing the capacity of the regions including universities and health science colleges by providing regional level ToT. The AYHD program provides regional level YFS ToT, thus creating a pool of YFS trainers backed up by university master trainers for use by the public sector. Transform: Primary Health Care Project, has organized rollout training on YFS/STI for health care providers selected from the newly identified YFS facilities in collaboration with the regional health bureaus, zonal health departments and woreda health offices.

46 (46% females) health care providers were trained on YFS/STI rollout training that was organized in Oromia and Tigray regions. This training was for YFS facilities with separate corners in the public sector. Two health care providers from each newly identified and existing YFS facilities were invited during the training. Service providers who were interested in working with young people as well as proactive to facilitate and strengthen YFS; and make it visible as part of the primary health care unit services were selected by facility heads.

The training was designed to equip providers on both YFS and STI. Different participatory strategies such as role plays, demonstrations were also used. These approaches helped the health care providers develop skills on counseling, communicating with young people, establishing, maintaining YFS service functionsand skills transfer to other health care providers in the facility to allow for service continuity even in the absence of the trained provider.

On the job training on YFS/STI for health care providers in YFS mainstreamed facilities. On-the job training is also a national strategic shift from off site to onsite training modalities for health care providers. Transform: Primary Health Care Project has selected 5 facilities from each target regions (20 facilities in all) to start mainstreaming the YFS approach by providing all health care providers basic YFS/STI training while they are on their jobs. The implementation of onsite training approach was the first in its kind for YFS training following the FMOH’s direction to make facilities more responsive to adolescent and the youth.

The Project has provided YFS/STI training to all technical staff in the facilities. The training was given during the weekends and 3:00-6:00 pm on weekdays after they visited their clients at every service point. Before providing the training, an in-depth facility assessment was conducted as baseline using Pathfinder’s Facility Assessment Tool. 124 health care providers (59% were females) from six facilities in SNNP (4 facilities) and Tigray (2 facilities) regions were trained. All health workers attended the training without affecting routine service delivery. The training focuses on youth health related local problems; real experiences based on local socio cultural contexts. Learning methods such as role plays and demonstrations were used which helped the health care providers develop skills on how to

counsel, how to communicate with young people and how to establish and resiliently maintain the YFS service functions.

Capacity Enhancement of Adolescent and Youth on Peer Education and counseling Training: Peer education is a process whereby well trained and motivated young people undertake informal or organized educational activities with their peers. It is also used as an effective approach for empowering adolescents and youth with a view to attaining the objectives of smooth transition from adolescence to adulthood and work towards their future career. The underlined principle behind peer education program is to enable adolescent and youth trust and discuss openly with their peers on sensitive issues such as sexual and reproductive health, HIV and AIDS and others related matters. They are also an important element of the program to create demand among their peer and refer them to the service.

The peer education training was organized and conducted in each YFS facility site, with active engagement of the woreda managers and health facility heads, who have taken peer education TOT. The venues were at each facility, and the training was monitored by the respective health facility heads.

Twenty-five adolescent and youth were selected voluntarily from each site based on pre-set selection criteria, which includes, among others trainees who are, interested to serve their peers voluntarily, known as a role model for others, free from any kind of substance abuse and bad behavior as well as dedicate their time to educate and inform others. During the recruitment, they were encouraged to have equal representation between boys and girls. The recruitment was done from the nearby schools, and out of school clubs here the selection was held in collaboration with the school principals, teachers, kebele administration members and health facility staffs. The peer education and counseling training was designed for five days. The training has covered basic sexual and reproductive health concepts ranging from anatomy and physiology of both sexes up to the physical and emotional changes that occur during adolescence; basic sexual and reproductive health problems such as STI and HIV, unsafe abortion; contraceptive options and basic life skills. The trained peer educators have been assigned to serve and provide different SRH information and to ignite discussion in the YFS waiting rooms while adolescents and youth awaiting their turn for service.

Additionally, they use all opportunities in the community to deliver tailored health and SRH information, informally and counsel their peers when the need arises. They also refer their friends to nearby YFS clinics, thereby bridging the health center and the surrounding community. Basic and refresher peer educators training were also provided to966 (47% were females) peer educators in this quarter.

Quarterly performance review meeting and update for peer educators. As part of the performance monitoring tool, the quarterly performance review meeting was designed to

be used as a platform to evaluate and monitor the plan and performance of both the YFS service and peer-educators' activities in order to improve the quality of YFS services. The meeting was usually facilitated and coached by YFS trained health providers and head of the health centers. Participants were the peer educators, teachers from the schools where they are involved in the peer education program, nearby HEWs if any, and head of the facility. The discussion topics and subjects in the review meetings varied but were generally helpful to the peer educators. They included: - using peer educators as part of the facility staff in realizing the CASH initiative to create clean and green health centers; maximizing the PE work by utilizing the mini media in the school; STI/HIV, family planning, gender based violence and harmful traditional practices status in their respective areas; working with other actors; analyzing achievement with work plan; and conducting community discussions.

The quarter review meetings were conducted for two days, in one of the two days training peer educators participated in CASH Program of their facility by planting trees, and nurturing a vegetable garden in the health center for use as an income generator to use for coffee ceremonies, supporting the communities, and buying seeds. 59 sessions of peer-educators quarterly performance review meetings were conducted in all regions. 1,288 (44% were females) participants have attended these review meetings.

Enhancing Health education through coffee ceremonies: Coffee ceremonies are becoming an important forum for socialization and community mobilization to discuss issues affecting the community. In Transform: Primary Health Care Project, the coffee ceremonies are planned, designed and organized, where priority topics are selected ahead of time and facilitated by YFS trained and/or other health care providers during the coffee ceremonies. The coffee ceremony guides developed from previous projects are being used as a template. Each health center will have the space to contextualize the content to suit their requirements and socio cultural environment. The project has provided each facility with the necessary materials to hold the coffee ceremonies.

These gatherings are also used as a monitoring and evaluation platform where the peer educators review and discuss their plan and performance in the presence of the health center heads, YFS focal persons and other YFS trained health care providers. The usual site for coffee ceremonies is the health center, the community or a nearby school. For school locations, teachers who are trained on peer educators' program were involved in coaching, mentoring and facilitating the ceremonies in their respective schools together with the health center team. Accordingly 192 sessions of coffee ceremonies were conducted and 11,586 (47% were females) participants attended in this reporting quarter.

The following were key points raised and discussed during the coffee ceremony sessions in different regions at different times: Prevention of HIV and AIDS, contraceptives, delaying early initiation of sexual relationship, consequences of unplanned pregnancy and unsafe

abortion, proper use of condoms, consequences of early/child marriage, substance abuse /addiction and its health-related risks.

In addition, on site coaching, mentoring and skill transfer have been to YFS provides as routine activity in project areas**.**

Health managers' orientation on AYH related Policies, strategies: Orientation of health managers on adolescent and youth programs is intended for the project to have a supportive environment to scale up the YFS program. Health managers from RHB, Zones, woredas were invited to attend a two day workshop organized in collaboration with the regional health bureaus. The purpose of the workshop was familiarizing health managers on the new strategies, policies, and standards for working jointly and to scale up the YFS program using the existing facilities as a learning center. In this quarter, 85 (11% were females) managers from Amhara region were oriented, all managers drafted action plans to scale up YFS service in their respective areas. The project staff will follow up the implementation of the action plans.

Equipping and furnishing the newly established YFS facilities: During the first year of the project, 40 health facilities were selected to establish Youth Friendly Services. One of the processes of establishing Youth Friendly Services is to equip and furnish them with a standard list of materials like TV, video deck, cupboards, tables, chairs, computer, printer, benches, consumables and supplies, and SBCC materials. In this regard all the 40 facilities were equipped and furnished with the standard materials.

Providing Health and Development Information, Counseling and Health Services to Adolescent and Youth: Youth friendly health service is scaled up by Transform: Primary Health Care Project and follows the rights based approach, which maintains confidentiality, privacy and respect. Adolescents and youth coming for YFS service should be treated with dignity and free of stigma or injustice. They will be provided with high-quality and comprehensive services and information. They will be given an adequate information to make their choices free and without coercion.

Provision of health information is a step forward to improve health care seeking behavior and increase the uptake of health services. One of the basic services at YFS outlet is creating access to tailored health information and health services to adolescents and the youth.

During this quarter, 366,775 (57% were females) clients provided with health information at the nearby YFS outlets or through the extended reach of peer educators in their communities. As a result 106,149 (62% were females) adolescents and youth received quality health services in a friendly manner in all YFS facilities.

Creating enabling environment: YFS Sensitization workshop: Sensitization workshops were conducted in each of the 12 newly initiated YFS facilities in Amhara and SNNP regions. The

workshop targeted and sensitized local communities, sector offices, young people, auxiliary, and technical staff of selected health facilities, woreda administrators, woreda health office heads, women and children office heads, and youth representatives on the YF services to be provided.

Strengthening the Multi-sectoral Response for Positive Adolescents and youth development: Addressing the health issue of adolescents and youth is beyond the health sector responsibility. Adolescents and youth are everywhere, in schools, universities, factories, in farms, in daily labor etc. They need quality health service, quality education, work/employment, need to form a family, able to discharge their citizenship responsibility. In order to transit from childhood to adulthood they need a holistic response to their growth and development needs. Instead of addressing their needs in fragmented and unsystematic way all the relevant ministries and sector offices should come together to understand adolescents and youth needs, to figure out how each sector should respond to their needs and how they can be supported to successfully pass to adulthood.

Furthermore, investments in health lay the groundwork for future productivity. While fertility decline is necessary for establishing the conditions for a demographic dividend, countries must also make investments in health, education, and gender equality, particularly for young people; and promote job opportunities for young people to accelerate economic growth. These investments are critical first steps in achieving a demographic dividend.

Transform: Primary Health Care Project is highly dedicated to bringing key actors together, to adolescents and youth holistic development, starting from the national level to Kebelle level. The project is in the process of organizing Regional Advisory Committee (RAC), Woreda advisory committee (WAC) and Kebele Advisory Committee (KAC) in all target regions to support the formation of multisectoral response committee at all levels. The first three Woreda level advisory committees were established in SNNP.

Integrating Long Acting Reversible Contraceptives (LARCs) within the YFS: Transform: Primary Health Care promotes an integrated model for strengthening health services and worked with the Federal Ministry of Health to scale up youth-friendly services (YFS) within public facilities where youth can access an integrated service package of FP methods. The Project continued strengthening the integration of LARCs within the YFS to improve access to long acting reversible contraceptives to adolescents and youths, by training youth friendly service providers to offer all contraceptive methods in a one-stop shop approach including LARCs.
To date, among the existing 184 YFS facilities, 52% of the YFS facilities integrated LARCs and provide LARCs service to adolescent and youth seeking the services.

Empowering very young adolescent girls-Her Space Initiative: Her Space Program is an effective way to engage a very young girl and equip her with confidence, support, skills and knowledge she needs not to fall into vulnerability traps as she gets older. The sessions are

led by a mentor who is a young female selected from the community where her spaces are run. The methodology is girl-centered and there is a strong community engagement component that engages parents, families and gatekeepers in not only approving girls attending her spaces, but also participating in activities to create or strengthen support systems at the family and community level. The program empowers very young adolescent girls and is facilitated by mentors who are young females recruited from the community and trained on how to mentor these very young adolescent girls. Girls meet in a **'safe' environment** – e.g. girls freely express themselves without fear of judgement and are not put at risk accessing her space with a very strong community engagement. Parents, siblings, families and gatekeepers will take part to approve girls attending her spaces.
To implement this important initiative, a total of 800 girls from four regions (200 from each) were part of program. Currently, the necessary ground work was finalized: discussion with the RHB, zone and woreda health offices and identification of kebeles in collaboration with woreda health offices were done. Translation of the training manual in local language was done and provided for printing. The training will continue in all regions in the next quarter.

3.2.2 Sub-result 2.2: Improved provider behaviors and communication skills toward a compassionate, respectful, and caring (CRC) health workforce

After each BEmONC training participants will stay at the training center and attend three days additional training on Respectful Maternity Care (RMC). The training will help HWs to deliver respectful maternity service which is the major contributor for improving institutional delivery and better maternal and perinatal outcome. During the reporting period 81 service providers (54% of which are females) training on RMC in addition to BEmONC. At the end of each training, participants prepared action plan with the presence of officials from the public sector/ ZHDs.

3.2.3 Sub-result 2.3: Improved management of health service delivery and oversight of service quality: (QI/QA)

Quality assurance/Quality improvement: Primary Hospital and Health Center quality improvement teams were trained on basic quality improvement training using FMOH HSTQ quality improvement training manual. The training was facilitated at district level. During and after the training the Quality improvement teams were engaged in quality improvement projects for their respective health facilities. The coaching/mentoring session at the health facilities was managed by coaches from ZHD, WorHO and the catchment area mentorship to support the QI team at the health facilities.

Transform Primary Health Care Project implemented the following QA/QI activities in this quarter were.

a. **Preparatory Phase.**

Consensus/will building: There was a consensus/will building session with facility leaders before discussion on initiating QI activities. The purpose of consensus building was to activate leaders, establish readiness for QA/QI processes and to orient them on scope of work for the QI team that will be established.

Establish and strengthen the QI team at health facilities: Support will be provided to facilities to establish Quality Improvement Team/QIT/. Primary hospitals have QI teams but they are not functional and it is an opportunity to strengthen and revitalize the team. The health centers have used their performance monitoring team/PMT/ as QI team with some modification to include major/key functions of the health center.

Baseline assessment: The project conducted self-assessment baseline clinical auditing using comprehensive MNH self-assessment tool composed of set standards and criteria related to MNH service delivery. In the primary hospital, the project supported the QI team using the clinical audit tool developed by FMOH for hospitals. Health centers were assessed using modified self-assessment clinical audit tool that considers major clinical areas, health post linkage and community linkage including CSC and baseline data on KPI. The national MNH self-assessment clinical audit tool aimed at establishing a baseline data of which subsequent progresses will be measured and compared against the baseline data. Data for the last six months on selected MNH service indicators was collected as indicated below for all the facilities to serve as a baseline data to track improvement going forward.

Table: The results of self- assessment clinical audits were:

<table>
<tr><th>Region</th><th>Zone/cluster</th><th>Woreda</th><th>Health facility</th><th>Result (%)</th></tr>
<tr><td rowspan="6">Amhara</td><td rowspan="3">North Gondar</td><td rowspan="3">Tacharmachiho</td><td>Sanja PHL</td><td>22.2</td></tr>
<tr><td>Sanja HC</td><td>20.5</td></tr>
<tr><td>Musiebamb</td><td>7.7</td></tr>
<tr><td rowspan="3">North Wollo</td><td rowspan="3">Wadla</td><td>Wadla PHL</td><td>35.0</td></tr>
<tr><td>Kone HC</td><td>17.9</td></tr>
<tr><td>Hamusit HC</td><td>20.5</td></tr>
<tr><td rowspan="6">Oromia</td><td rowspan="3">Ambo</td><td rowspan="3">Guder</td><td>Guder PHL</td><td>80.4</td></tr>
<tr><td>Guder HC</td><td>24.0</td></tr>
<tr><td>Gorosole</td><td>33.0</td></tr>
<tr><td rowspan="3">Adama</td><td rowspan="3">Boset</td><td>Olenchiti PHL</td><td>70.5</td></tr>
<tr><td>Godedhera HC</td><td>18.0</td></tr>
<tr><td>Olenchite HC</td><td>13.0</td></tr>
<tr><td rowspan="3">Tigray</td><td rowspan="3">Mekele</td><td rowspan="3">HIntalo wajirat</td><td>Adigudem PHL</td><td>85.0</td></tr>
<tr><td>Hewane HC</td><td>44.0</td></tr>
<tr><td>Debub HC</td><td>46.0</td></tr>
</table>

After the clinical audit self-assessment, the project supported the QITs on gap analysis, prioritization of identified problems, and the development of post assessment comprehensive QI action plans.

b. **Implementation Phase.**

Capacity enhancement through training: Transform Primary Health Care Project has conducted a training to all the above mentioned health facilities quality improvement team to enhance quality improvement knowledge including leaders in the health facilities. It was a four day basic QI training and coaching using FMOH-Health System Transformation in Quality, QI training manual.

QI trainers provided tailored support for each QI team using the standard QI training manual developed by FMOH. The trainings were facilitated using different adult learning methodologies such as brainstorming, individual and group exercises, interactive lectures, and small group exercises with plenary discussions to deliver content and information.

The QI tools that were used during this training include Kaizen and model for improvement, problem identification tool, QI tools/process mapping, fishbone, why tree, pare to and, Priority Action Matrix, and PDSA planning and Action Plan Sheet. After exercising these tools, all teams selected their own key problem to be solved and designed their QI project within the bandwidth of the woreda transformation agenda with specific focus on MNH thematic area.

During the reporting period, six sessions of QI trainings were successfully conducted and 140 trainees (21% were females) were selected from five woredas specifically from health facilities, ZHDs and woreda health offices.

20 QI projects were designed in 15 Primary Health Care Facilities. Pre and post test results showed improvement in the scores of training participants.

c. **Follow up Phase**

Coaching/Mentoring: During the reporting period, coaching/mentoring was conducted for Sululta Woreda and its primary health care facilities using the standard coaching checklist. A total of three quality improvement teams in one primary hospital and two HCs were visited and received onsite technical support.

Community engagement for quality improvement: Transform Primary Health Care project has developed a strategy to engage community in quality improvement. Community engagement initiatives have three phases: quality exploration with both community and facility health providers, bridging the gap, and working together. The project has also integrated the community QI piece to be linked with the community mobilization team at the kebele level so that the community team will identify problem, develop, test and implement change ideas to solve the problem related to MNCH services.

Community quality exploration: Community representatives from Kebele (came together to discuss on the quality of MNCH services using a guide for quality exploration and have

identified problems in MNCH service. The community representatives are chairperson, manager, HEW, PHCU director, religious leader, youth association, women association, education office, agriculture office, mother-in-law, husband, recently delivered mother, and traditional birth attendant.

Health provider quality exploration: Health workers from Hiwane and Debub health centers (Tigray region) and Chancho and Duber health centers (Oromia region) has taken part in quality exploration of MNH service conducted at their respective health facility using quality exploration guide and they have identified gaps/problems related with MNH services.

Bridging the gap session: communities from the Kebeles and the health care providers from health centers came together to discuss on the quality gaps they have identified during their respective community and health care providers at quality exploratory phase. On bridging the gap session both community perspectives and healthcare providers' perspectives on quality service delivery were presented by their representatives and this was followed by detailed discussions . Finally, both community and health care providers at the facility agreed on the identified gaps and draw action plan to work together in the future.

Community mobilization workshop: Community engagement in quality improvement session was integrated in 8 HPs during the community mobilization workshop to briefly orient the community team how to work in collaboration with the health facilities in improving the MNCH quality at the community and health post level to avert the maternal, neonatal and child death.

Working with FMOH, HSQD RHB, ZHD, and WorHO: Transform Primary Health Care Project works together with the health system at all levels to establish and strengthen the quality structure at the RHB, ZHD and WorHO level to implement the National Health Care Quality Strategy (NQS). Transform Primary Health Care Project was also involved in the QED network- as a member in the national technical working group/TWG/ for MHN QOC which is working to improve quality of care for mothers, newborns and children. The Project staffs participated in the workshop to operationalize quality improvement in the Network Countries; four learning districts have been selected as learning sites for MNH QOC intervention from transform primary health care project intervention area. Our project is also involved in the QI training manual revision.

In collaboration with Amhara RHB, regional quality improvement steering committee was established to provide advice, guidance and technical support to implement the NQS in the region. Term of Reference (TOR) has been developed for which the regional QI steering committee to be guided. Transform Primary health care project at the regional level has consistently provided technical support and work with the RHB in all QI activities.

In SNNP , the project participated in the supportive supervision to hospitals training, which was conducted in collaboration with regional health bureau health service quality team, at regional level. The hospital supportive supervision coveres 25 hospitals in the region. Seven

of these hospitals (Karat, Gidole, Halaba, Saja, Kebado, Tepi and Shone) were the lead hospitals for our intervention and they were linked with EHAQ collaboration network.

3.2.4 Sub-result 2.4: Innovative service delivery interventions to impact PMCD introduced and scaled up

Back-up LARC family planning support: Back-up LARC family planning support within the PHCU from health center to the health posts provides FP services which are not normally provided at the HP level, including Jadelle and IUCD insertion and removals, and implant removals. The delivery of the back-up LARC-FP service to the HPs was integrated to the existing routine regular visit of providers from the HC to the HPs.

In this quarter, in Tigray region, back-up service was provided by 25 HCs in eight woredas and served a total of 432 clients with different FP services. It includes 155 implanon removals, 18 IUCD insertion, 4 Jadelle insertion and 255 implanon insertion services.

3.3 Result 3: Improved household and community health practices and health-seeking behaviors

3.3.1 Sub-Result 3.1: Increased individual- and household-level care-seeking behavior and uptake of healthy practices

One of the objectives of Transform: Primary Health Care Project is to improve house hold and community health practices and health seeking behavior through the implementation of innovative, evidence-based and result driven behavior change strategies. As part of its overall SBCC intervention, USAID Transform: Primary Health Care has carried out the following activities during the reporting period.

Community mobilization strategy adapted. USAID Transform: Primary Health Care Project adapted the community mobilization approach developed by Save the Children Ethiopia. This approach strengthens community capacity in order to address the underlying barriers for care seeking. The community empowerment process entails four (4) stages which enable community members to organize themselves and address the health problems of their community. Kebele Command Post which brings together various sectors (education, agriculture, health etc.) plays a key role in the community mobilization process. Religious leaders, influential community members, former traditional birth attendants, as well as individuals affected by MNCH issues will also spearhead the community mobilization process along with the members of the kebele command post. The community mobilization team also serves as the nearby support structure for health extension workers.

Community mobilization workshop conducted. USAID Transform: Primary Health Care Project conducted a two day community mobilization workshop in two woredas (8 kebeles) in Oromia and Tigray regions. The workshop was aimed at equipping the participants with the knowledge and skills required to mobilize their communities for health. The workshop

brought together 83 (31% were females) community and government representatives including kebele managers, school directors, agricultural development agents, health center directors, health care providers, health extension workers, religious leaders, former traditional birth attendants as well as women and youth leaders.

Issues related to pregnancy, delivery, newborn care, family planning, nutrition, hygiene and sanitation as well as community mobilization were thoroughly discussed during the workshop. The participants were expected to roll out the community mobilization strategy in their respective kebeles with the support of their catchment health centers. Transform: Primary Health Care staff will also provide direct technical assistance to the eight learning kebeles with the goal of creating models that can share their experiences to the remaining PHCUs and kebeles for potential scale up.

All the participants applauded the workshop and pledged to initiate and intensify community mobilization efforts in their respective localities. The Zonal and Woreda level representatives have also appreciated the workshop and the support rendered by the Project.

Workshop Participants, Sululta town, Oromia region, November24-25, 2017

SBCC materials designed and under print. USAID Transform: Primary Health Care Project has designed three types of posters in Amharic, Affan Oromo, and Tigrigna languages. The posters are aimed at promoting maternal and newborn danger sign recognition as well as prompt care seeking. The posters will be printed and strategically distributed in the upcoming quarter.

The project has also designed two types of brochures that are aimed at creating awareness on issues of appropriate maternal and newborn health behaviors. The brochures will be pretested, printed and distributed in the next quarter.

Table: Summary of SBCC materials designed in Amharic, Tigrigna and Affan Oromo

Description	Quantity	Remark
Poster on pregnancy danger signs	35,100	under print
Poster on newborn danger signs	27,520	under print
Poster on postpartum danger signs	12,400	under print
Brochure on appropriate MNCH behaviors	478,000	ready for pretest
Brochure on issues of obstetric fistula	50,000	ready for pretest

Tiahrt Chart under print: Transform PHC translated the 2017 version of the Tiahrt Chart into Amharic, Affan Oromo and Tigrigna languages. Six thousand charts are now under print in Amharic (2,800), Afan Oromo (2,500) and Tigrigna (700). The chart will be printed and distributed to health posts, health centers and primary hospitals in the upcoming quarter.

IEC materials Distributed. Transform Primary Health Care Project has also distributed 274,007 IEC materials and job-aids in Amhara (59,753), Oromia (213,004) and SNNP (1,250) regions during the reporting quarter. The materials were aimed at creating awareness on AWD and RMNCAH-N related issues. AWD posters, birth certificates, family recognition card, female condom poster, FHG, immunization diploma and post partem counseling posters are some of the materials distributed.

Creating awareness using Family Health Guide: Transform: Primary Health Care Project strategically distributed 158,273 color family health guides in Amhara (58,455), Oromia (98,568) and SNNP (1,250) regions to development team leaders, schools, agricultural development agents, kebele command post members, religious leaders and other influential community members with the goal of heightening community awareness on RMNCAH-N and other priority health issues.

The project has also finalized the printing of 120,000 color FHGs (106,000 in Affan Oromo and 14,000 in Tigrigna languages). The FHGs are being distributed to selected community members.

Mass Awareness Activities Conducted Using Audio Mounted Project Vehicles: Transform: Primary Health Care Project reached an estimated 310,526 individuals in Amhara (94,437), Oromia (144,500), SNNP (59,356) and Tigray (12,233) regions with AWD, FP, malaria, nutrition, WASH, immunization, premature birth and community based health insurance related messages. The messages were transmitted in places where large group of people congregate using audio mounted project vehicles with the goal of heightening community awareness on the health issues.

The project has also oriented its drivers on implementing, estimating and documenting mass awareness activities.

Mass Awareness creation on issues of FP/RH and CBHI, Mister open air market, South Ari Woreda, South Omo Zone, SNNP Region, Dec 19,2017

The project also facilitated the procurement and distribution of 12 amplifiers, 18 microphones, 19 horn speakers, 3 SAX300 speakers, 2 LCD projectors and 3 projector screens. These equipments are fitted on selected project vehicles to strengthen mass awareness activities undertaken by the project. The project has also identified more than forty recorded health messages produced by partner Government Organizations (GO) and NGOs . The messages has been uploaded in 35 flash disks and shared with the cluster offices.

Health Extension Worker- Development Team Leader (HEW-DTL) review and mentoring meeting guide adapted. Transform: Primary Health Care Project adopted the HEW-DTL regular meeting guide which was developed by Save the Children. The guide is aimed at standardizing and ensuring the quality of HEW-DTL regular review and mentoring meetings. The guideline is mainly meant for health extension workers who have the responsibility of equipping health development team leaders with the knowledge and skill required to create awareness among their community. The one pager/guide will be printed and distributed once it gets the buy in of the regional health bureaus.

Strengthen pregnant women conferences. The project reviewed, edited and made few adjustments on the existing pregnant women conference facilitation guide. The Project will print and distribute the guide once it gets the approval of the Federal Ministry of Health. Pregnant women conference is a forum which is aimed at providing a safe space for pregnant women to dialogue, reflect, and take appropriate action on pregnancy, delivery, post-natal and newborn care.

CBHI related activities. In the Health Sector Transformation Plan (HSTP) formulated by the FMOH, and in line with the country's Growth and Transformation Plan-II (GTP II), the GOE has set an ambitious target to expand CBHI coverage to 80% of the eligible households in 80% of the country's woredas by 2020. HCF activities under the project support the

government with this agenda. In this quarter, the project provided CBHI training for HEWs and new CBHI woreda executives, CBHI performance review, and CBHI week campaign activities were accomplished.

SBCC training addressing CBHI: CBHI implementation training was provided to HEWs, supervisors, kebele chairman, managers, school directors, health facility heads and CBHI scheme staff. The training was provided in collaboration with the RHBs, EHIA branches, HSFR/HFG, ZHDs and WorHOs. Topics included: basics of CBHI, premium collection procedures, data management and reporting. In addition, an alternative communication strategy for community mobilization was provided by the respective RHBs, EHIA branch offices and Woreda CBHI schemes. A total of 2,348 (61% were females and 45% HEWs) participants received the orientation in Amhara (384), Oromia (1,668) and SNNP (296) regions.

HEWs attending CBHI implementation training in Yilmana Densa woreda, Amhara region

Orientation training provided for cluster staff on HCF thematic area. Orientation on the project's HCF thematic area was given for staff of two project cluster offices (Finote Selam and Debre Markos) in the Amhara region. The session covered HCF, CBHI and PFM activities. A total of 7 staffs from both clusters attended. The main purpose of the training was to update cluster staff on the thematic objective when conducting mentoring, coaching and supportive supervision at health service delivery points of the PHCU.

CBHI training for new woreda executives. Transform: Primary Health Care project provided CBHI implementation training in seven intervention woredas in Amhara. Participants were also briefed about the Project, the plans that should contribute towards achieving the GoE's transformation agenda, and the contribution of CBHI in ending preventable child and maternal death (PMCD).

Furthermore, CBHI training for new woreda executives was provided in Oromia region. In 2018 (2010 EFY) the Oromia Regional Health Bureau selected 48 woredas to expand the CBHI program. To launch CBHI in these woredas, the RHB, together with EHIA, HSFR/HFG, and Transform: Primary Health Care Project provided a two-day TOT training session for CBHI executive staff in CBHI implementation. The trainees were comprised of representatives from zonal administrations, ZHDs, woreda administrators, WoFEC, the WorHO and three experts from CBHI schemes (a coordinator, accountant and IT manager). The main objective of the training was to provide TOT for Woreda participants to roll out

training for their respective Woreda cabinets and kebele executives. 427 (15% were females) individuals attended in the event.

During the training, zonal administrators directed the participants to launch CBHI in their respective woredas as soon as possible by engaging CBHI community mobilization and awareness creation activities. Participants will provide similar rollout training for woreda cabinet members and kebele executives, and precede with community mobilization and awareness creation activities within a few months.

CBHI week campaign and performance review meetings. The average CBHI enrollment rate in the project intervention woredas in East Wollega Zone at the end of 2009 EFY was about 8.4%. This is very low when compared to other zones in the Oromia region. To make a significant impact on the enrollment rate, the East Wollega Health Department, together with different governmental and non -governmental partners, declared December 11-17, 2017 as “CBHI Week”. Stakeholders that participated in this campaign to encourage enrollment includes the RHB, Zonal Administration Office, Zonal Health Department, EHIA-Nekemte Branch Office, Woreda Administration Offices, Woreda Health Office, Woreda Finance and Cooperation Office, HSFR/HFG, and Transform: Primary Health Care Project. As part of CBHI Week, the Transform: Primary Health Care regional project office facilitated a one-day CBHI orientation training in five woredas on December 12, 2017. HEWs, Kebele chairmen and vice chairmen, Kebele managers, respected elders, religious leaders, women affairs representatives and teachers from each kebele attended the training. In addition, staffs from WorHOs, Woreda cabinet members and HC directors participated. A total of 1,401 (19% were females) participants attended the event.
Within 15 days after the training events, more than 1,482 HHs enrolled and renewed CBHI membership and more than 371, 000 Birr was collected in membership fees.

Sasiga woreda CBHI Week campaign, opening speech by elders

In SNNP, the project conducted an orientation meeting in collaboration with ZHDs and EHIA branch offices on the revised regional CBHI directive and overall CBHI program performance in 4 woredas and 1 zonal administration. The meeting was for zonal health office representatives, WorHO, Kebele leaders, HEWs and CBHI scheme workers. The main objectives were to brief attendees about the newly revised regional CBHI directive, review the overall performance of the CBHI program in the region, and sensitize and mobilize leaders to reinforce program implementation until the regionally pre-declared CBHI enrollment and renewal period ends in January 2018. A total of 593 (21% were females) individuals participated.

Wolaita Zone Chief Administrator giving concluding remarks, SNNPR

The costs of the meetings were shared between the project and EHIA branch offices. At the end of the meeting, woreda and zone administrators highlighted the need to take on increasing CBHI enrollment and renewal and emphasized that all responsible bodies at all levels should improve the leadership and commitment of leaders among kebeles and woredas. Participants agreed to do their best to improve performance gaps over the following months and commence coverage of services provided to CBHI members after fulfilling the 50% enrollment threshold outlined in the regional CBHI directive.

CBHI Community interface meetings. The CBHI interface meeting is conducted between scheme, health facilities and communities. It is an approach used to facilitate good governance through promotion of participation, transparency, accountability and informed decision-making. Its objective is to bring together CBHI members, health service providers, the purchasers and government decision-makers to review their performance, identify challenges, generate appropriate solutions, agreed to take corrective measures and work in partnership to bring changes in the future.

Thirty-three interface meetings were conducted in collaboration with EHIA, ZHDs and WorHOs in the four regions. 1,759 (21% were females) participants attended the meetings in Amhara (118), Oromia (964), SNNP (252) and Tigray (425) regions. Zonal and Woreda health sector leaders, medical service coordinators, HCF and CBHI coordinators, Woreda chief and vice administrators, CBHI executive staff, kebele leaders, school directors, HEWs, HC senior management, kebele and HC supporters/supervisors, and a selected number of CBHI beneficiaries were among the participants. Transform: Primary Health Care Project provided technical support in facilitating the meetings.

During discussions, community participants raised different health sector concerns. Some of the major challenges they mentioned includes: Lack of essential drugs at facility level, shortage of manpower in facilities, low level of cleanness at health facilities, delays in HI ID card provision due to challenges with photographing, delays in service provision, lack of proper respect by some health professionals towards patients, and failure of Woreda CBHI schemes to reimburse health facilities in a timely manner.

Town hall meeting at Sulula Health Center,

At the end of community interface meetings, service beneficiaries (CBHI members) and service providers (facilities and CBHI schemes) jointly prepare detailed action plans from the prioritized issues with set time frames and assigned responsibilities.

3.3.2 Sub-Result 3.2: Strengthened enabling environment for health-seeking behavior, including community engagement in health service oversight

Support the commemoration of World Prematurity Day 2017. Transform: Primary Health Care Project provided technical and financial support to SNNP Regional Health Bureau in commemorating the World Prematurity Day 2017. The day was commemorated in Hawassa town on the 31st of November, 2017 under the motto “Premature Babies can Survive and Become Productive Citizens” and “Quality Care for the Smallest”. Media round tables, media campaigns, panel discussions, IEC material dissemination, mass awareness creation activities (using mobile vans and audio-mounted vehicles), including radio spin-offs conducted as part of WPD 2017 commemoration.

Banner Printed and placed as part of WPD Commemoration in Hawassa town, SNNPR

3.4 Result 4: Enhanced program learning to impact policy and programming related to ending preventable child and maternal deaths (PMCD)

Apart from its role in enhancing program learning to impact policy and programming related to enabling preventable child and maternal deaths (PMCD), Transform: Primary Health Care

Project also serves as learning ground for future policy and program directions, bridging a disconnect between operation research, policy and practice. Conducting and disseminating operation/programmatic research; documenting success stories and best practices and related activities using different venues are some of the key activities. The following are some of the key achievements during the reporting period.

3.4.1 Sub-Result 4.1: Strengthened health system capacity to generate learning and evidence

Partnership: Discussed and established regional operational research system strengthening steering committee to facilitate regional OR capacity strengthening training and regional knowledge hub (RKH) establishment. The committee included five to six members of the regional health bureaus, selected universities, regional research institute and USAID Transform: Primary Health Care Project regional and/or country office staffs. The segments in the committee activities include:

- Setting research priorities for funding among and within the research thematic areas
- Monitoring, evaluating, and supporting research undertakings
- Drawing policy briefs and advising on policy decision making
- Facilitating enhancement of usage of research outputs (evidence-based decision making)
- Use influence and authority to assist the project in achieving its outcomes.
- Review the training package and make the necessary changes and modifications based on the review, end-of-training and other evaluation findings
- Prepare and submit a detail work plan of the training agenda
- Facilitate and conduct the training in a participatory (interactive) manner
- Facilitate to provide soft copies (CD) of reference reading materials to participants
- Facilitate research finding publication
- Coordinate regional research dissemination workshop
- Develop MOU and distribute activity task share to the partner organization (regional health bureau, regional public health research institute, regional university and Transform: primary health care project
- Advise selection of trainees

Advise sustainability of the capacity building activities and also strengthening the RKH

Deciding on research budget allocation, utilization, and disbursement

Dealing with other strategic issues related to research

Performing other related duties

Material development and distribution: During the quarter the project:-

- Developed two operational research training modules in collaboration with regional universities, regional health bureaus and regional public health research institute
- Develop operational research training information bulletin
- Prepared program learning (OR) thematic brief

Operational Research (OR) training: Operational research is key to provide evidence to policy makers and decision makers and enable them to make evidence based decisions. The first cohort first module OR training was conducted for 12 days from December 18-30/2017, in Bahirdar in collaboration with University of Gondar Institute of Health Science, Bahirdar University College of Health Science, Amhara Public Health Research Institute and Regional Health Bureau. The trainees were selected from the regional health bureau, Amhara Public Health Research Institute, regional health science colleges, hospitals and Amhara Transform: Primary Health Care project staff.

After opening remarks emphasizing the importance of OR in the health system, why, what and how to conduct OR, the challenge in OR presented by Dr. Mengistu Asnake, Senior Country Director, Pathfinder International-Ethiopia, COP, USAID Transform: Primary Health Care Project. Dr. Abebaw Gebeyehu, Amhara Region Health Bureau Head, highlighted the regional priority areas, new initiatives and regional gaps towards evidence generation and also the role of OR for evaluating those gaps and new initiatives. Mr. Girma Kassie, Transform: Primary Health care project MEL Director, introduces the training activities, time duration of the training, expected output of the training and their expectation. There were 20 participants from different areas in the region. The first module training was about problem identification and prioritization, problem validation and analysis, proposal development and includes basic Epidemiology and Biostatistics topics. Initially the trainees practiced their OR proposal development, especially on topic selection and justification and specific objective driving. This was followed by assigned teams of trainees to practice their OR protocol development. OR project work would be conducted in groups based on their thematic areas. In consultation with the training facilitators, the trainees identified six thematic OR areas based on the regional priorities. The following are the selected OR topics:

- Referral linkage among under five children in the context of ICCM and its associated factors at primary health care units in North Gondar zone
- ANC drop-out and correlates in the Tach Gayint woreda, South Gondar, Amhara
- Delay and health seeking behaviour of Early Infant Diagnosis among Infant Born to HIV-Infected Women
- Quality of adolescents and youth friendly service provision: Challenges and solution, West Gojjam zone
- Quality of delivery service at selected health facilities: challenges and solutions; North Shoa Zone
- Data quality of health care system: primary health care level

After the training, participants are undertaking OR projects at their respective locations. Mentors were assigned from University of Gondar, Bahirdar University including USAID Transform: Primary Health Care Project staff for each group and are responsible for close follow-up on problem validation, drawing of objectives and project protocol development finalization and ethical clearance processing. The actual operation research starting from data collection to analysis and report writing will continue for the next eight months. For other regions, the OR training will start in the coming quarters. The regional OR steering committee finalized their preparatory work like trainees' selection, trainer identification, OR area prioritization.

3.4.2 Sub-Result 4.2: Evidence of what works in PMCD informed by results from program learning and iterative adaptation

Collaborative work with regional universities already started in Amhara region in the areas of Operations Research. As part of the operations research (OR) training provided for Amhara region, the project assisted the RHB to select OR topics that are relevant for the health sector in the region.

3.4.3 Sub-Result 4.3: Evidence utilized to inform programming and policy with local and global stakeholders

Publication: One research article was published on GHSP, title "Improving Contraceptive Access, Use, and Method Mix by Task Sharing Implanon Insertion to Frontline Health Workers: The Experience of the Integrated Family Health Program in Ethiopia".

Oral and poster conference presentation: Two research abstracts submitted to the 29th EPHA annual conference held in Addis Ababa, on February 2018.

4 Partnership and coordination

Family Planning and Reproductive health: The Project FP/RH team is a member of the FP technical working groups at different levels. During this quarter, the project participated in the updating of the national reproductive health guideline and in a special working group organized by the FMOH to prepare a guide for level-IV HEWs program on comprehensive FP trainings. Similarly, the regional project office FP/RH teams participated in the regional FP TWG, and consultative meetings with partners and regional health offices. Accordingly, in Amhara region discussion were held with Engender Health and Ipas to avoid duplication of efforts, and reached on mutual agreement, that the Transform: Primary Health Care Project will retain 49 woredas while 27 woredas were transferred to Engender Health (20 woredas) and Ipas (7 woredas) as FP/RH interventions woredas.

In this quarter, a significant partnership with MSI-E USAID-SIFPO project was achieved regarding supporting the training on permanent FP skills for the selected eight learning

primary hospitals in the four project regions. As part of the support, MSI will also provide orientation to HEWs and HC providers under the catchment area of the learning primary hospitals (details of quarter activities was discussed under the topic of permanent FP services).

Adolescent and Youth Health and Development (AYHD): The adolescent and Youth thematic area is an active member of the national Adolescent and Youth working group (TWG) that was organized by FMOH. The AYHD team members played an active role in the national and regional level technical working group to improve the quality of the service rendered and scale up of the adolescent and youth services at all level.

In this quarter, the national technical working group organized a national level master ToT training for selected technical working group members on YFS using the newly developed YFS training manual. The training was supported by World Health Organization (WHO) in collaboration with FMOH.

Jan 9 to Feb 7, 2018 was dedicated as a month of Safe Motherhood initiatives and The Day is a celebration event with various activities. This year's Safe Motherhood was launched on Jan 15, 2018 in Hawassa. This year's theme of the Safe Motherhood initiative is **"For Safe**

Motherhood, No Pregnancy During Adolescence": The National technical working group engaged itself in the preparation of this campaign like media training on the theme, preparation of radio and TV spots, orientation of parliamentarians, panel discussions, enter alia.

Transform: Primary Health Care Project is committed to strengthen the national, regional and Woreda level multi-sectoral committee to respond to the needs of adolescents and youth. The Project team has taken the initiative to talk with the State minister of Youth and Sport to revitalize the national technical working group that works on developing the second adolescent and youth status report and strengthen the technical committee functions to constantly inform the ministerial level coalition that was led by the deputy prime minister of Ethiopia. The committee is reestablished and has started working on their assignments.

Obstetric Fistula (OF) and Pelvic Organ Prolapse (POP). The project's is closely working with partners for OF-POP that include:- the FMOH, the Hamlin Fistula Ethiopia, the UNFPA, and the HHoJ. In this regards, during the reporting quarter:

- The Transform Project facilitated a meeting with the Hamlin Fistula Ethiopia senior management, to strengthen partnership and share responsibilities in the national effort to EOF.
- The Tigray, Oromia, Amhara and SNNP regional program offices have delivered technical support to their respective regional health bureaus task force on the EOF, and organized workshops to sensitize staff on OF/POP.

- The project has been actively involved in efforts that required partnership and coordination including the completion of the “Woreda Fistula Free Guidance” by the FMoH,
- The project also attended in the national TWGs meetings that were undertaken twice at the FMoH along with pertinent partners during the reporting quarter.

Health Financing Partnership. The HCF team developed a draft memorandum of understanding (MOU) document to be signed by the USAID Health Sector Financing Reform/Health Finance and Governance (HSFR/HFG) and the USAID Transform Primary Health Care Project. The main objectives of having the MOU are: to establish collaboration between the two projects in relation to technical support provided to the GOE in the implementation of HCF activities in the project operational areas; to augment collaboration of the two projects in leveraging resources in the areas of HCF, PFM, and CBHI; and to avoid duplication of efforts and wastage of resources. The MOU document was prepared by technical working group established by the two parties. The MOU was signed by the Transform: Primary Health Care and HSFR/HFG projects COPs on November 29, 2017.

As per the MOU, activities such as HEW and CBHI executive trainings were conducted together during the reporting quarter. By collaborating in this way, these activities were performed in a consistent and aligned way across the projects, more communities could be covered and the projects could share technical expertise and costs.

The project has also established good partnerships with RHBs and other partners working in HCF. Project staff attended two HCF technical working group (TWG) meetings held in Bahirdar and chaired by the Deputy Head of the Amhara RHB. During TWGs meetings, Project staff has actively participated in the preparation of the region’s CBHI implementation action plan and ensured HCF related project plans were aligned with RHB plans.

Nutrition. As concerted multi-sectoral effort is needed to address the root causes of malnutrition, the project is supporting the implementation of National Nutrition Program- II at all levels. During this quarter, Transform Primary Health Care Project co-chaired the technical preparation of NNP-II review meeting and facilitated some of the sessions. Several monitoring and reporting tools were produced and in the process the health system is strengthened to play its role as a leader of the multi-sectoral efforts. This big event has ended successfully and was attended by more than 400 participants from more than 14 sectors coming from all regions.

Orientation Meeting with Communication for Health Project. Transform: Primary Health Care Project conducted a half day consultative meeting with Communications for Health Project during the reporting period. The meeting was aimed at understanding the overall approach of the two projects. Accordingly, both projects made presentations and discussions on selected programmatic issues. Eighteen experts and senior management

members drawn from the two projects attended the meeting. The meeting was a very good opportunity to understand who is doing what, where, when and how. Transform Primary Health Care Project is still waiting for Communications for Health Project to sign the MoU prepared by the two parties and reviewed over the past few months.

Financially supported Oromia RHB to conduct a televised question and answer competition. Transform Primary Health Care project financially supported Oromia Health Bureau to conduct a televised question and answer (Q and A) competition focusing on family health. The Q and A program was supported by a panel discussion. A total of 40 individuals drawn from model households, Oromia Region Health Bureau, Woreda health offices, and Oromia Communication Office participated in the program. The program was aired on Oromia Broadcasting Network (OBN) TV for about ninety minutes in the month of December, 2018. The program was a very good opportunity to create awareness on issues of family health, particularly on issues of family planning and immunization. The project also supported Oromia Regional Health Bureau in translating the health promotion implementation guideline to Afan Oromo by covering per diem costs for translators.

5 Project management and monitoring, evaluation and learning

5.1 Project management

Project performance review meetings. Transform: Primary Health Care Project uses project performance review meetings (PPRM) as a performance improvement method within the program. PPRM helps to identify the strengths and challenges of the project during the implementation period and address the challenges to improve program implementation for the subsequent quarter or month. During the meeting the implementation status of planned activities were discussed and compared against project plan. PPRM facilitates evidence-based decision making.

Year one quarter IV regional performance review meetings were organized in all regional offices and central office., All regional thematic officers, cluster office staff and representatives from country office have participated in the regional meetings. All cluster offices, regional office also presented their achievements, lessons and challenges and through discussion made. All thematic areas presented their updates. Furthermore, a comprehensive presentation made on random follow-up visit and grant management which were the major new activities in the reporting period.

5.2 Project MEL system implementation

Baseline study: USAID Transform Primary Health Care Project provided technical support to Transform MELA in the design of the baseline data collection tools to ensure that all

relevant indicators from TRANSFORM:PHC were included, as feasible. Project staff also reviewed and provided input into the plans for field implementation. In order to facilitate MELA baseline data collection, the Transform Primary Health Care Project regional offices obtained RHB letters of support for data collection sites.

DHIS2 instance designing: During the quarter, additional progress was made on developing and fine-tuning the DHIS2-based project database. The basic organization units (e.g., facility levels), and data elements (i.e., raw data upon which indicators are calculated) have been programmed. Further, the database now includes the data entry forms to be able to capture training data, and data from follow-up visits. The designing and programming of indicators, dashboards, maps (GIS), and graphs continue to be developed. Furthermore, those data elements that will be populated from the government health sector like HMIS, KPI, and EHCRIG will be developed in the next phase.

Technical support for Federal Ministry of Health on Revised HMIS, CHIS and e-CHIS: USAID Transform Primary Health Care Project provided technical support through MEL team for Federal Ministry of Health in the revision of HMIS, CHIS and e-CHIS. The project is a member of technical working group formed by the MOH. The MEL team attended the regular TWG meetings and workshops.

The FMOH organized a National Health Indicator Revision Workshop at Adama. The objectives of the workshop is to revise the existing indicators based on the HSTP agenda, national and international new initiatives and programs, and focus in emerging and non-communicable disease, and program modification to strengthen one plan, one budget and one reporting system.

The guiding principles of the revision were: HSTP, international and national standards, feasibility, basic principles of HIS, and significance of indicators.

Accordingly, we have done the following activities during this workshop:

- Revised the core indicators list: definition, disaggregation, data source, interpretation, frequency of reporting etc.
- Revised the data capturing tools: registers, ally sheets, reporting formats and patient charts.

These activities were done in small groups and presented to the larger audience and the revision will be approved by the higher level management team.

Furthermore, the project also substantially attended the TWG meetings and consultative workshop on the revision of community health information system (CHIS). The objective of the meeting is to revision of community health information system (CHIS), development of workflow for electronic CHIS and development of HMIS self-learning material.

The project involved intensively in the maternal and child health sub team. This sub team developed drafted maternal and child health CHIS tools.

We have served as a co-chair in the finalization of the maternal child health and nutrition CHIS tools. The team has finalized the Family planning (Including FP removal), ANC, Delivery, PNC and nutrition cards. The team also proposed to have a pregnant mother identification and follow-up register. We have also developed the work-flow for all of these activities.

Finally, we have revised the drafted HMIS self-learning materials developed before based on the revised HMIS. Our MEL team members have revised the TT, Delivery, FP, EPI sections based on the revised registers and reportable data elements and indicators. Furthermore, our staffs have developed new sections for the new registers which are Human Papilloma Virus register, Pregnant and Lactating Women Nutrition Screening (PLW) register, and Comprehensive & Integrated Nutrition Services (CINuS) register.

USAID Transform Primary Health Care Project provided all necessary technical support in our areas of expertise and well acknowledged.

Follow-up visit (FUV): USAID Transform Primary Health Care Project uses follow-up visit checklist as a tool to provide onsite technical support. The tool is designed in consultation with all advisors and used as an entry point to provide onsite technical support at all level. The checklists are updated regularly based on updates and feedbacks. The checklist is developed for WorHO, Primary Hospital (PHL), Health Centre (HC), Health post (HP), Community (Kebele office) and Household (HH).

There are two types of follow-up visits under USAID Transform Primary Health Project and both of them used similar type of checklists: 1) Non-random follow-up visits, also called routine supportive follow-up visits, and 2) random follow-up visits.

In non-random follow-up visits, the visitors (CLOs and RPOs) are responsible for selecting the WorHO, PHLs, HCs, HP, communities and households to be visited. The visitors can use their own logic to select sites to be visited based on their own criteria like giving priority to those facilities that need close follow-up, or sites may be visited by integrating with other activities. The results from the non-random follow-up visits may not be used for generalization; rather it is used for immediate action and as a case study for outcome monitoring and program learning.

However, random follow-up visits are conducted once per year for three months period. The RPO MEL officers, in consultation with the country office MEL team, are responsible for selecting the WorHOs, PHLs, HCs, and Health posts (Communities) to be visited by using a simple random sampling technique. Updated sampling frame was prepared annually for WorHOs, PHLs, HCs and HPs. The visitors are responsible for selecting eligible HHs under each selected HP, using a random walk technique. Random follow-up visit results can be

used for generalization about the level of program outcomes and will help to produce unbiased data for decision making.

The general objective of outcome monitoring using data from the random follow-up visit is to monitor outcomes of health interventions in the target areas.

The specific objectives are:

- ✓To generate representative data that can be used for generalization of the levels of health outcomes in program areas
- ✓To produce periodic data for assessing changes in outcomes
- ✓To assess whether some key health indicators have improved in target areas since the start of the project for which the program is contributing for.
- ✓To produce strategic information for program managers on informed decisions

In this reporting period, USAID Transform Primary Health Care Project conducted the first random follow-up visits in October to December 2017. The random follow-up visits were conducted by regional offices and cluster offices to 164 WorHOs, 78 PHLs, 347 HCs, 694 HPs, 694 communities and 3,470 HHs. All regions completed the data collection successfully and the data entry processes started.

5.3 Success stories and best practice documentation

On site IMNCI training- an opportunity for RDT practical training

Malaria technical support was provided during onsite IMNCI training in Halaba Special Woreda in SNNP. The training utilized a new approach where most of health workers are trained for two consecutive weekends and for five afternoon sessions at their health facility. This model of training delivery helped to fill gaps due to staff turnover, rotation, and attrition, to enhance the quality of care given to under-five children. The standard IMNCI training curriculum only includes theoretical training for malaria RDT; however, with the onsite training, health workers received practical malaria RDT experience.

The onsite IMNCI training was conducted in SNNP at Halaba Special district. A total of 88 health workers participated in the training. All participants had no previous working experience in under-five outpatient department (OPD) or conducting malaria RDTs. Training of health workers on RDT has a dual purpose: conducting emergency RDTs at the health center and for mentoring others at their respective health posts during on-site supportive supervision.

6 Compliance

During the reporting period, several activities were there to ensure Transform: Primary Health Care Project compliance to specific donor and local obligations as part of the overall organizational strategy, objectives, and values. Thus, this section of the report focuses on the programmatic activities of Transform: Primary Health Care Project for the period October to December 2017.

Cognizant of training and capacity building that is importance to compliance, all staff involved in programmatic activities were encouraged to take an online e-learning compliance training on the Protecting Life in Global Health Assistance and Statutory Abortion and US Abortion and Family Planning Requirement. The number of trainees who received a certificate for completing trainings is below.

Office	No of staff taken the e-learning program					
	PLGHA & Statutory Abortion	Total number of staff who took the training	Percentage achieved	US Abortion & FP Req. 2017	Total number of staff required to take the training	Percentage achieved
Country Office - Pathfinder	17	16	94%	17	16	94%
Country Office - JSI	10	11	90%	10	11	90%
Country Office - Encompass	1	1	100%	1	1	100%
Amhara	37	45	82%	35	45	78%
Oromiya	5	40	12.50%	4	40	10%
SNNPR	20	28	71%	20	28	71%
Tigray	18	18	100%	12	18	67%
Total	**108**	**159**	**65%**	**99**	**159**	**59%**

Office	No of staff taken the e-learning program					
	PLGHA & Statutory Abortion	Total number of staff who took the training	Percentage achieved	US Abortion & FP Req. 2017	Total number of staff required to take the training	Percentage achieved
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Oromiya	5	40	12.50%	4	40	10%
SNNPR	20	28	71%	20	28	71%
Tigray	18	18	100%	12	18	67%
Total	**108**	**159**	**65%**	**99**	**159**	**59%**

part of the wider project implementation plan, all Transform Primary Health Care regions plan to train and empower staff in the public sector using different approaches and forums (such as as part of other trainings, during follow up meetings) . Trainings should take place

during scheduled trainings, meetings, and follow-up visits. Accordingly, 1,809 and 1,519 service providers oriented on family planning compliance and environmental compliance, respectively, during the reporting quarter.

The above result shows how respective regional offices and the country office gave attention to impart the importance of compliance in each of the programmatic activities that are being implemented. In all the regional offices' quarterly review meetings, compliance was prioritized. As usual, the training covered pertinent USG legislative and policy requirements applicable to the Transform Primary Health Care Project with special emphasis given on the shifts happened from the past including Protecting Life in Global Health Assistance.

The purpose and objectives of the trainings were to understand the types of programmatic compliance required for USG-funded projects, to review compliance requirements for FP/RH/abortion, Protecting Life in Global Health Assistance, the environment, and to enable trainees to understand their respective roles, responsibilities, and obligations related to compliance. Of all the major topics, FP/RH compliance was given high priority in view of frequent changes happening in the Protecting Life in Global Health Assistance. Thus, communicating changes and ensuring compliance to the new changes associated with the Protecting Life in Global Health Assistance requirement will be an activity which will be monitored in the next quarter.

After laying the foundation to capacitate the staff and the public sector, the next round of activities is to monitor the implementation status of compliance objectives in selected facilities and health posts. To facilitate the compliance monitoring process, state of the art monitoring and reporting applications, which contain complete compliance monitoring checklists have been developed and are being launched. The project acquired 175 Samsung Galaxy Tab S3 tablets for cluster, regional, and country office staff to use during their visits to clinical service delivery units. All the tablets are loaded with the RCS Compliance Monitoring and Reporting Portal app. A 41 page user guide has also been prepared. On the other hand orientation and training on the user guide and the portal at large will be provided in the coming quarter.

At this stage of the project implementation, clear messages have been conveyed to every program staff in all available forums the fact that compliance is responsibility of all staff. Thus, all staffs are taking this responsibility as part of their daily routine. To sustain this mentality, all Transform Primary Health Care Project staff as well as public sectors staff will be continuously involved, informed, and consulted to ensure compliance to USG legislative and policy requirements throughout the project implementation period.

7 Major quarter constraint, challenges & actions, including issues requiring higher level decision

Constraint faces	Actions taken / required
The revised HMIS tools captures age disaggregated data for limited indicators	Continue advocating to age disaggregate for key indicators
Very limited AYHD indicators in the health sector Key Performance Indicators (KPI)	Continue advocating for it
Recording tools at HPs are not conducive to nutrition programs. (e.g. to easily identify children for services like VAS, deworming, and screening)	Evidence based negotiation with FMOH to address the problem
Civil unrest in Oromia	Continue working with care
High trained staff turn-over	On the job trainings at work place
Postponement of several activities mainly trainings and new reforms due to an extended regional ISS in Tigray	Focus was given to non-training activities as a replacement and re-planning of

8 Major tasks for next reporting period

The following are some of the key focus activities for the next quarter (for details, refer quarter two activities in the Year 2 work plan matrix):

- Provide support to the implementation of woreda management standards
- Support the development of Public Finance Management guideline finalization
- Support CBHI implementation
- Provide capacity building to service providers on FP service provision, such as training
- Provide support to MNH activities through training on BEmONC and mentorship
- Support the establishment of newborn corners
- Gap filling training for health workers on child health related services
- Capacity building on EPI such as through training/ mentorship
- Provide gap filling trainings on Nutrition
- Ensure integration of malaria activities with other project activities
- Provide malaria case management and epidemic prevention and control training for ANC service providers
- Fistula and POP screening training for service providers
- Capacity support for YFS sites through training and material support
- Provide basic training on gender and health for PHC health care managers
- Support CRC training to maid wives and MNH service providers
- Provide quality improvement training
- Introduction of safe child birth checklist at PHC level
- Sensitization of HEWs on male involvement
- Need based distribution of Family Health Guide (FHG)

- Provide support on operations research capacity building at regions
- Participate in TWG at national and regional levels
- Conduct compliance training and monitoring using different venues
- Finalizing the development of DHIS2 instance and provide training for project staff.
- Conducting routine follow-up visits and data quality assurance support

Annex 1. Publication printed, TA from home offices and international travel by project staffs using Transform: Primary Health Care project money

a. Publications in print

Title	Author	Year
TOC Booklet	Transform: PHC	2017
FP Register	FMOH	2009
SNP Register	FMOH	2009
HPV Immunization Register	FMOH	2009
LAFP Removal Register	FMOH	2009
Adolescent & Youth Health Training for Health Care Service Providers	FMOH	2017
Syndromic Management of Sexually Transmittable Infections Participant Manual	FMOH	2015
Birth Certificate (Amharic, Oromiffa, Tigrigna)	IFHP	2014
SAM chart booklet	FMOH	2010
OTP quick reference (Oromiffa, Tigrigna, Amharic)	FMOH	2014
Immunization Diploma (Oromiffa	ESHE	2006
OTP card (English, Amharic, Oromiffa)	FMOH	2014
ICCM/CBNC Exercise booklet (Amharic)	FMOH	2013
BEMONC Facilitator Guide	FMOH	2014
BEMONC Participant's manual	FMOH	2014
Malaria case management facilitator guide	FMOH	2015
Family recognition certificate	Transform: Primary Health Care	2017
BEMONC training manual	FMOH	2014
IMNCI Modules 1- 6	FMOH	2015
IMNCI chart booklet	FMOH	2015
IMNCI facilitator guide	FMOH	2015
ICCM/CBNC chartbooklet (Amharic, Oromiffa, Tigrigna)	FMOH	2013
PRRT manual	Transform: Primary Health Care	2017
AMIYCN participant manual	IFHP	2014
SAM participant manual	FMOH	2010
SAM multichart	FMOH	2010
Adolescent nutrition participant manual	Transform	2017
SAM facilitator guide	FMOH	2010
Safe child birth checklist	FMOH	2015

b. Short-term technical assistance during the reporting period

Name	Organization	Date	Purpose of the TA
Candace Lew	Pathfinder International	October 22 – November 1, 2017	STTA to the Transform program: Contraception
Heather Jue Wong	JSI	November 6-18, 2017	To provide financial and operations support to the project
Andrea Dickson	JSI	October 11-20, 2017	To provide change narration training for Transform: Primary Health Care staff
Kristin Eifler	JSI	October 10-19, 2017	To attend Transform: Primary Health Care launch

c. International travel during the reporting period

Name	Date	Country and host organization	Purpose of travel
Dr. Kidest Lulu	October 25 – 30, 2017	New delhi, India	Participate and present in the World Congress on Adolescent Health taking place in New Delhi, India
Almaz Bekele	October 25 – 30, 2017	New delhi, India	Participate and present in the World Congress on Adolescent Health taking place in New Delhi, India
Habtamu Zerihun	November 4 – 13, 2017	Boston, Pathfinder International	To work to align Transform Primary Health Care DHIS2 instance with HQ DHIS2 instance and to attend global leadership summit
Dr. Mengistu Asnake	November 4 – 12, 2017	Boston, Pathfinder International	To attend senior leadership meeting
Dr. Kidest Lulu	Nov.25 – Dec.6, 2017	Washington DC, Pathfinder International	To attend different technical meetings
Aynalem H/Michael	Dec.10 – Dec. 15, 2017	Tanzania, WHO	To attend a workshop to operationalize quality improvement in the network countries
Dr. Hailemariam Segni	October 24-26, 2017	Malawi, Save the Children	To attend Global KMC Acceleration Partnership C0ommnity of Practice Workshop
Dr. Araya Abraha, Mekelle University	October 24-26, 2017	Malawi, Save the Children	To attend Global KMC Acceleration Partnership Community of Practice Workshop
Zuriash Halefom, FMOH	October 24-26, 2017	Malawi, Save the Children	To attend Global KMC Acceleration Partnership Community of Practice Workshop
Zergu Tafese	November 14-16, 2017	Morocco, JSI	To attend the JSI Strategic information workshop
Ismael Ali	November 14-16, 2017	Morocco, JSI	To attend the JSI Strategic information workshop

Annex 2: Performance as measured by quarterly reportable PMP indicators

Code	Result/ Indicator/ regions	Quarter 1 (Oct-Dec 2017)			Annual (Oct 2017 - Sept 2018)		
		Planed	Achieved	% Achieved	Planed	Achieved to date	% Achieved to date
I	Result 1: Improved management and performance of health systems						
1.3	# persons trained on management approaches and guidelines by type	840	1,463	174.2%	4800	1,463	30.5%
	Amhara	270	649	240.4%	1020	649	63.6%
	Oromia	300	534	178.0%	2340	534	22.8%
	SNNP	180	215	119.4%	960	215	22.4%
	Tigray	90	65	72.2%	480	65	13.5%
	Female		685			685	
1.13	Number of integrated follow up visit made to WorHOs for onsite technical assistance by project staff using the integrated project follow up visit checklist	300	163	54.3%	902	163	18.1%
	Amhara	76	39	51.3%	228	39	17.1%
	Oromia	135	69	51.1%	406	69	17.0%
	SNNP	70	36	51.4%	210	36	17.1%
	Tigray	19	19	100.0%	58	19	32.8%
II	Result 2: Increased sustainable quality of service delivery across the PHCU's continuum of care						
2.24b	Number of visits made by adolescents and youth for health care at YFS sites	125,000	106,149	84.9%	500,000	106,149	21.2%
	Amhara	32,468	41,034	126.4%	129,870	41,034	31.6%
	Oromia	29,762	8,240	27.7%	119,048	8,240	6.9%
	SNNP	35,173	16,950	48.2%	140,693	16,950	12.0%
	Tigray	27,597	39,925	144.7%	110,390	39,925	36.2%
2.24c	Number of person trained on AYHD related issues	1555	1,136	73.1%	4,864	1,136	23.4%
	Amhara	375	344	91.7%	1474	344	23.3%
	Oromia	355	234	65.9%	2054	234	11.4%
	SNNP	525	498	94.9%	1024	498	48.6%
	Tigray	300	60	20.0%	312	60	19.2%
	Female		553			553	
2.31	Number of persons trained on nutrition related issues	175	334	190.9%	980	334	34.1%
	Amhara	30	112	373.3%	150	112	74.7%
	Oromia	85	56	65.9%	410	56	13.7%
	SNNP	30	166	553.3%	240	166	69.2%
	Tigray	30	0	0.0%	180	0	0.0%

Code	Result/ Indicator/ regions	Quarter 1 (Oct-Dec 2017)			Annual (Oct 2017 - Sept 2018)		
		Planed	Achieved	% Achieved	Planed	Achieved to date	% Achieved to date
	Female		98			98	
2.33e	Number of health workers trained on malaria case management.	375	1,569	418.4%	1660	1,569	94.5%
	Amhara	55	861	1565.5%	370	861	232.7%
	Oromia	110	386	350.9%	655	386	58.9%
	SNNP	55	270	490.9%	395	270	68.4%
	Tigray	155	52	33.5%	240	52	21.7%
	Female		1387			1,387	
2.34	Number of person trained on FP/RH service provision	591	925	156.5%	3568	925	25.9%
	Amhara	105	203	193.3%	1285	203	15.8%
	Oromia	234	310	132.5%	1152	310	26.9%
	SNNP	130	334	256.9%	760	334	43.9%
	Tigray	122	78	63.9%	371	78	21.0%
	Female		620			620	
2.35	Number of persons trained on Child Health	642	1,567	244.1%	2157	1,567	72.6%
	Amhara	47	834	1774.5%	272	834	306.6%
	Oromia	275	416	151.3%	1125	416	37.0%
	SNNP	135	265	196.3%	550	265	48.2%
	Tigray	185	52	28.1%	210	52	24.8%
	Female		1372			1,372	
2.36	Number of person trained on Maternal and Newborn Health	204	366	179.4%	781	366	46.9%
	Amhara	41	128	312.2%	238	128	53.8%
	Oromia	92	179	194.6%	304	179	58.9%
	SNNP	55	42	76.4%	213	42	19.7%
	Tigray	16	17	106.3%	26	17	65.4%
	Female		109			109	
2.43	Number of integrated follow up visit made to health facilities (PHLs, HCs or HPs) for onsite technical assistance by project staff using the integrated project follow up visit checklists	1,875	1,089	58.1%	5,625	1,089	19.4%
	Amhara	475	254	53.5%	1,425	254	17.8%
	Oromia	831	424	51.0%	2,493	424	17.0%
	SNNP	440	235	53.4%	1,320	235	17.8%
	Tigray	129	176	136.4%	387	176	45.5%

Code	Result/ Indicator/ regions	Quarter 1 (Oct-Dec 2017)			Annual (Oct 2017 - Sept 2018)		
		Planed	Achieved	% Achieved	Planed	Achieved to date	% Achieved to date
III	**Result 3: Improved household and community health practices and health-seeking behaviors**						
3.4	Number of person trained on SBCC	300	914	304.7%	826	914	110.7%
	Amhara	90	384	426.7%	210	384	182.9%
	Oromia	120	530	441.7%	390	530	135.9%
	SNNP	30	0	0.0%	150	0	0.0%
	Tigray	60	0	0.0%	76	0	0.0%
	Female		522			522	
3.8a	Number of contacts made to adolescents and youth to provide health information at YFS sites	425,000	366,775	86.3%	425,000	366,775	86.3%
	Amhara	110,390	128,808	116.7%	441,558	128,808	29.2%
	Oromia	101,190	25,584	25.3%	404,762	25,584	6.3%
	SNNP	119,589	23,788	19.9%	478,355	23,788	5.0%
	Tigray	93,831	188,595	201.0%	375,325	188,595	50.2%
3.17	Number of integrated follow up visit made to households for onsite education/ counseling by project staff using the integrated project follow up visit checklist	8,700	3,430	39.4%	12,180	3,430	28.2%
	Amhara	1,520	780	51.3%	2,128	780	36.7%
	Oromia	5,400	1,360	25.2%	7,560	1,360	18.0%
	SNNP	1,400	720	51.4%	1,960	720	36.7%
	Tigray	380	570	150.0%	532	570	107.1%
5	**Compliance to USG policies and regulation**						
5.1	Number of person trained on family planning compliance to USG legislative and policy restrictions	2,808	3,543	126.2%	5,368	3,543	66.0%
	Amhara	1146	712	62.1%	2,684	712	26.5%
	Oromia	896	1,154	128.8%	896	1,154	128.8%
	SNNP	390	1,117	286.4%	390	1,117	286.4%
	Tigray	376	560	148.9%	1,398	560	40.1%
	Female		2087			2,087	
5.3	Number of person trained on environmental compliance to USG rules and regulations	3,085	3,364	109.0%	5,922	3,364	56.8%
	Amhara	1146	638	55.7%	2,961	638	21.5%
	Oromia	1,173	994	84.7%	1,173	994	84.7%
	SNNP	390	1,191	305.4%	390	1,191	305.4%

Code	Result/ Indicator/ regions	Quarter 1 (Oct-Dec 2017)			Annual (Oct 2017 - Sept 2018)		
		Planed	Achieved	% Achieved	Planed	Achieved to date	% Achieved to date
	Tigray	376	541	143.9%	1,398	541	38.7%
	Female		1973			1,973	

Annex 3. Additional information on number of person trained by key training topics

Sr.No	Training topic	Regions				Total
		Amhara	Oromia	SNNP	Tigray	
	Health Systems					
1	PFM TOT training for RHBs, Bureau of Finance and Economic Development (BOFED), ZHDs and finance and economic departments	-	-	-	34	34
2	UDDM Rollout training at PHCU level	60	59	35	-	154
3	Roll out training on revised HMIS	28	-	-	-	28
4	LMG Rollout training at PHC level	103	81	180	-	364
5	LMG _Senior Alignment Meeting(SAM)	74	54	-	-	128
6	Orientation sessions on the implementation and utilization of CSC	-	273	-	-	273
8	Training of HEWs on CBHI promotion, enrollment and contribution payment facilitation (to be integrated into HEW IRT), using CBHI Module	384	530	-	-	914
9	Training on CBHI for Newly selected CBHI woredas Executive organs	-	67	-	-	67
10	Training on decentralized planning and budgeting to ZHD PPD and WorHO	-	-	-	31	31
	Family planning					
11	Implanon TOT for health care providers	76	-	21	-	97
12	Implanon rollout training for HEWs	48	125	25	-	198
13	Implanon NEXT Roll out orientation for HEWs	-	125	123	-	248
14	Implanon NEXT Training of Trainees (TOT) orientation for health care providers	-	19	20	-	39
15	Roll-out training on comprehensive IUCD for health center providers	59	-	20	-	79
16	Comprehensive LARCs	-	-	-	18	18
	Maternal & Newborn Health					
17	Training on BEmONC	34	30	-	17	81
18	MPDSR training for managers and providers	-	62	-	-	62
19	Clinical mentoring training for HWs	22	-	20	-	42
20	Provide clinical mentoring orientation on BEmONC for Woreda health managers	-	87	22	-	109

Sr.No	Training topic	Regions				Total
		Amhara	Oromia	SNNP	Tigray	
21	Respectful Maternity Care	34	-	-	-	34
22	Managers orientation on MEmONC	38	-	-	-	38
	Child Health					
23	Training on IMNCI for HWs	-	20	88	-	108
24	ICCM/CBNC pre service competency enhancement training for HEWs	779	311	100	-	1,190
25	Gap filling training on ICCM/CBNC for HEWs	24	29	55	-	108
26	Gap filling cold chain and medical equipment maintenance training for HWs, biomedical technicians and project drivers	31	-	22	-	53
27	Gap filling training on Immunization in practice and cold chain users training for HWs	-	30	-	30	60
28	IMNCI TOT for H/S/C Tutors	-	26	-	-	26
29	IMNCI & CBNC for health workers Training	-	-	-	22	22
	Nutrition					
30	Blended Nutrition Rollout training (Knowledge part)	-	30	-	-	30
31	Adolescent Nutrition TOT training	18	-	16	-	34
32	Adolescent Nutrition Rollout training to HEWs, school teachers and agricultural development agents	66	-	150	-	216
33	SAM Rollout training for health service providers	28	-	-	-	28
34	Blended Nutrition Rollout training (Skill part)	-	26	-	-	26
	Malaria					
35	Malaria case management and epidemic prevention and control training for ANC service providers	58	-	27	30	115
	Obstetric Fistula (OF) and Pelvic Organ Prolapse (POP)					
36	Fistula and POP screening training for service providers	20	16	18	-	54
	Adolescent and Youth Health and Development (AYHD)					
37	YFS/STI rollout training for service providers	-	25	85	-	110
38	Basic peer education and counseling training for peer educators	50	100	188	-	338
39	Refresher training for peer educators and counselors	294	109	225	-	628
40	YFS training for HWs	-	-	-	21	21
41	YFS mainstreaming training	-	-	-	39	39
	Gender					
42	Basic training on gender and health for PHC health care managers	-	-	22	-	22
	QI/QA					
43	Quality improvement training for healthcare providers at facility level (QI Team)	55	57	-	28	140

Sr.No	Training topic	Regions				Total
		Amhara	Oromia	SNNP	Tigray	
44	Community Exploration Session on Quality	-	30	-	-	30
45	HWs Exploration Session on Quality	-	16	-	-	16
46	QI Bridging the gap session	-	14	-	-	14
47	Training for Kebele command post and HEWs on Community mobilization strategy	-	38	-	-	38
	Program learning					
48	Operations Research	20	-	-	-	20
	USG Policy Compliance					
49	FP compliance training to all project staff in regional and cluster offices	-	-	32	-	32
50	Environmental compliance training to all project staff in regional and cluster offices	-	-	32	-	32

Annex 3. Additional information on non-training achievements

Sr.No	Activity	Regions				Total
		Amhara	Oromia	SNNP	Tigray	
1	Number of follow up visits to WorHOs	39	69	36	19	163
2	Number of follow up visits to Primary Hospitals	20	16	19	14	69
3	Number of follow up visits to HCs	78	136	72	48	334
4	Number of follow up visits to HPs	156	272	144	114	686
5	Number of follow up visits to Kebles/ communities	156	272	144	114	686
6	Number of follow up visits to Households	780	1,360	720	570	3,430
7	Number of Primary Hospitals (PHLs) started QI/QA (Old+New)	2	3	-	1	6
8	Number of HC/ PHCU started QI/QA (Old+New)	4	6	-	2	12
9	Number of HP/Community engaged in QI (Old+New)	-	4	-	4	8
10	Number of Identified suspected fistula cases	58	115	44	19	236
11	Number of suspected cases referred for diagnosis	30	105	44	19	198
12	Number of confirmed fistula cases referred for treatment	23	101	44	14	182
13	Number of fistula case treated	19	34	35	11	99
14	Number of fistula case re-integrated after treatment	-	-	-	12	12
15	Number of Early marriages canceled	54	8	-	151	213
16	Number of refrigerators maintained by project support	-	-	60	2	62
17	Number of medical equipment's assembled by project support	-	-	10	-	10
18	# of HCs started YFS to date (Old+ New) with project support	47	41	54	41	183
19	# of session of coffee ceremonies conducted at YFS sites	47	11	24	110	192

Sr.No	Activity	Regions				Total
		Amhara	Oromia	SNNP	Tigray	
20	# of Health facilities started FP/HIV integrated services (Old+New)	38	57	9	18	122

SBCC materials distributed based on need

Sr.No	Type of SBCC materials	Region				Total
		Amhara	Oromia	SNNP	Tigray	
1	AWD posters	-	4,000	-	-	4,000
2	Birth Certificate	1,000	17,999	-	-	18,999
3	Family Recognition card	100	6,727	-	-	6,827
4	Female condom poster	-	53	-	-	53
5	Heath Communication material Development	58,453	15,308	1,250	-	75,011
6	Immunization Diploma	200	-	-	-	200
7	Post partem counseling poster	-	168,716	-	-	168,716

Contraceptive distributed based on request from public sector

Sr.No	Contraceptive logistics type	Levels					Total
		Amhara	Oromia	SNNP	Tigray	National	
1	Condom (Pieces)	2,100	6,075	-	-	6,000,000	6,008,175
2	Injectable (Vials)	-	-	1,200	402	-	1,602
3	Pill (Cycles)	-	183,600	-	-	-	183,600
4	Implanon (Set)	58	8,780	1,450	1,485	-	11,773
5	Jadelle (Set)	13	-	-	590	-	603
6	IUCD	5	-	-	-	-	5
7	ECP distributed to new YFS sites	-	293	-	-	-	293
8	Placebo for Implanon NXT training	-	130	-	-	-	130