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USAID Transform: Primary Health Care Activity

Health System Strengthening by Investing in Packages of Activities Across Woreda Family Planning/Reproductive Health Systems: An Evaluation Report

By

Yewondwossen Tilahun (MD, MPH)

Senior Technical Advisor

Addis Ababa, Ethiopia

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Acronyms

ART	Antiretroviral therapy
CBHI	Community based health insurance
COP	Chief of party
EPCMD	Ending preventable child and maternal deaths
FP/RH	Family planning and reproductive health
F&O	Finance and operations
GO	Government of Ethiopia
HC	Health center
HEP	Health extension program
HEW	Health extension worker
HMIS	Health management information system
HP	Health post
HSS	Health system strengthening
HSTP	Health Sector Transformation Plan
IUCD	Intrauterine contraceptive device
IPLS	Integrated pharmaceutical logistic system
IPFP	Immediate postpartum family planning
KII	Key informant interview
LARC	Long-acting reversible contraceptive
M&E	Monitoring and evaluation
MEL	Monitoring, evaluation, and learning
MNCHC	Maternal, neonatal, and child health
MOH	Ministry of Health
PAC	Postabortion care
PHC	Primary health care
PHCU	Primary health care unit
PHL	Primary hospital
RHB	Regional Health Bureau
SNNPR	Southern Nation Nationalities and People Region
SWOT	Strength, weakness, opportunity, and threats
TA	Technical assistance
TOT	Training of trainers
UHC	Universal health coverage
USAID	United State Agency for International Development
WorHO	Woreda Health Office
WHO	World Health Organization
YFS	Youth-friendly services

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Executive Summary

Background

USAID Transform: Primary Health Care, is a five-year and nine-month Activity (January 2017-September 2022) led by Pathfinder International in partnership with the Government of Ethiopia to prevent child and maternal deaths by strengthening the country's primary health care system at all levels. The Activity's diverse group of implementation partners includes JSI Research & Training Institute, Inc., Abt Associates, EnCompass LLC, and the Ethiopian Midwives Association. The Activity operates in five major regions of the country: Amhara; Oromia; Southern Nations, Nationalities, and Peoples' Region; Sidama; and Tigray. The Activity aimed to strengthen the health system to ensure sustainable, quality, and equitable family planning and reproductive health service provision across the continuum of primary health care by investing in a package of activities at the woreda level of the health system. To that end, the Activity has implemented several packages of activities in the intervention regions since 2017.

Purpose

The purposes of this evaluation were to assess whether the objectives and goals of the FP/RH interventions were achieved at all health-system pillars and levels, and to document lessons that can inform the future design of family planning and reproductive health support to the public sector. This small-scale evaluation will assist the Activity in reaching decisions related to: (1) addressing gaps in the service delivery system; (2) the effectiveness of the implementation strategy to strengthen family planning and reproductive health care at the lower level of the health system; (3) integration and ownership of the activities, and self-reliance of the public sector; (4) implementation design and strategy lessons for future programming; and (5) informing partners' approaches to supporting provision of family planning and reproductive health services.

Methods

The assessment design used an effect evaluation approach, based on the following sources of quantitative and qualitative data: (1) review of intervention facility performance reports between 2017 and 2019; (2) a facility-based survey of 16 primary health care units; and (3) in-depth interviews with 77 key informants. The Activity evaluated the implementation process by triangulating information obtained from reports and key informant interviews. The Activity assessed health and health-system outcomes by contrasting baseline data with post-intervention survey data and conducting key informant interviews. The Activity assessed the overarching system-wide effect of the packages of interventions implemented using performance reports, a quantitative survey, and qualitative data from key informant interviews. The 16 primary health care units were selected purposively for quantitative data collection, and the 77 key informants were randomly selected from health facilities and woreda health offices situated in the 16 primary health care units. To familiarize data collectors with the quantitative and qualitative data collection tools, the Activity held a one-day orientation session.

Findings

A package of activities, consisting of a family planning and reproductive health planning exercise and ownership orientation workshop, were implemented across a woreda family planning and reproductive health care system covering 282 primary health care units, 25 primary hospitals, and 52 woreda health offices. The Activity organized onsite Implanon insertion training for health extension workers by health center staff. All assessed primary health care units trained health extension workers onsite. On average, each health center trained five health extension workers on Implanon insertion. The Activity introduced integrated backup long-acting reversible contraceptive service support from health centers to communities/health posts to the system. Availability of expected family planning and reproductive health services at the health center level increased from 18.7% at baseline to 93.8% post-intervention. Availability of expected family planning services at the health post level increased from 44% at baseline to 68.5% at the endline. Backup service support from health centers to health posts (communities) increased from 0% to 100% at health posts where the survey was conducted. Family planning service utilization at the health center level increased for short-acting and long-acting contraceptive insertion and removal services by 269%; the number of long-acting reversible contraceptive users increased by 285%. Family planning service utilization and service mix at the health post level increased by an average of 6%. Additionally, the Activity observed a shift from short- to long-acting methods, from 91% of clients using short-acting methods at baseline to 64% at endline. The proportion of clients using long-acting methods increased from 9% at baseline to 36% at endline.

Conclusion

Despite the small number of primary health care units included in the quantitative evaluation, the experience of the Activity demonstrated that investing in package of activities across the woreda family planning and reproductive health care system proved to be an implementation strategy that can address all six health system pillars. The strategy ensured sustainable, quality, and equitable access to all expected family planning and reproductive health services to communities and promoted public-sector ownership and efficiency in planning and family planning and reproductive health service management. We recommend expanding investment in packages of activities across a woreda family planning and reproductive health care system to other non-intervention areas with close follow-up and technical support of the initial startup.

Introduction

USAID: Transform Primary Health Care Activity

USAID Transform: Primary Health Care is a five-year and nine-month Activity (January 2017-September 2022) led by Pathfinder International in partnership with the Government of Ethiopia to prevent child and maternal deaths by strengthening the country's primary health care (PHC) system at all levels. The Activity's diverse group of implementation partners includes JSI Research & Training Institute, Inc., Abt Associates, EnCompass LLC, and the Ethiopian Midwives Association. The Activity operates in five major regions of the country: Amhara; Oromia; Southern Nations, Nationalities, and Peoples' Region (SNNPR); Sidama; and Tigray. The Activity supports the attainment of the Health Sector Transformational Plan I & II (HSTP I & II) agendas. USAID: Transform PHC is led by the chief of party (COP). The deputy COP/health system strengthening (HSS) director; monitoring, evaluation, and learning (MEL) director; two technical team leaders; and the finance and operations (F&O) director form the national senior management team. In the implementation regions, the Activity has regional managers; technical coordinators; monitoring and evaluation (M&E), finance, and operations officers; and staff with technical expertise who support the Regional Health Bureau (RHB) and zonal staff and provide oversight and technical assistance to the woredas. At the zonal level, 30 cluster offices with expertise in the Activity's major thematic areas implement Activity interventions.

Purpose of the Evaluation

The USAID: Transform Primary Health Activity evaluated a new strategy of investing in a package of activities across woreda family planning and reproductive health (FP/RH) care systems. The evaluation will guide Activity decisions related to measuring the effectiveness of the implementation strategy in strengthening FP/RH care at the lower level of the health system; understanding how to apply design and implementation lessons to future programming; and sharing our experience with the public sector to guide partners' approaches to supporting FP/RH services.¹

The World Health Organization (WHO) defines HSS as improving the six health-system building blocks—service delivery, health workforce, health information systems, access to essential medicines, financing, and leadership and governance—and managing their interactions to achieve more equitable, sustained improvements across health services and outcomes.² Some health policy challenges are primarily of concern to low-income countries under pressure to ensure quality, effective, safe services.³

¹ Frumkin, Micah, Emily Kearney, and Molly Hageboeck. "Evaluation Statements of Work." Washington, DC, USA: USAID, 2011.

² World Health Organization (WHO), ed. *Monitoring the Building Blocks of Health Systems: A Handbook of Indicators and Their Measurement Strategies*. Geneva: WHO, 2010.

³ WHO. "Everybody's Business - Strengthening Health Systems to Improve Health Outcomes: WHO's Framework for Action," 2007, 44.

USAID's vision for HSS aligns with the six building blocks and focuses on improving processes that directly affect health-system functions.⁴ As HSS interventions often influence multiple functions, multiple indicators are necessary to track and evaluate performance.⁵ According to the Alliance for Health Policy and Systems Research, inadequate technical guidance, program management, and supervision constrain scale-up of health services at the service delivery, policy, and strategic management levels. Weak centralized systems for planning and management, including reliance on donor funding, reduce flexibility and ownership.⁶ WHO's HSS framework also cites limited financial access, gaps in provider knowledge and skills, and weak leadership and management as challenges.⁷

Systems thinking provides a deliberate, comprehensive suite of tools and approaches to map, measure, and understand these dynamics to design safe, robust interventions and evaluations. There is strong global consensus on the need to strengthen health systems; however, there is no established framework or formula for doing so in low-income countries, and no standard package of interventions.⁸ Different partners have implemented different HSS interventions, such as USAID's community-based health insurance (CBHI) program for informal sector workers in Ethiopia.⁹

Ethiopian Context

In Ethiopia, fertility rates and unmet need for FP have historically been very high. However, data from the past two decades indicate a simultaneous increase in the use of modern contraceptive methods and a drop in unmet need for FP. Modern contraceptive use by currently married Ethiopian women increased from 6% in 2000 to 35% in 2016, while unmet need remains high at 25% in 2011 and 22% in 2016.¹⁰ The pregnancy-related maternal mortality ratio remains high, though it declined from 678 maternal deaths per 100,000 live births in 2011 to 412 in 2016.¹¹ According to the Fragile States Index, Ethiopia is one of the 15 countries in the "very high alert" or "high alert" category for maternal deaths.¹²

⁴ "USAID Vision for Health System Strengthening 2030." Washington, DC, USA: USAID, 2021. <https://www.usaid.gov/global-health/health-systems-innovation/health-systems/Vision-HSS-2030>.

⁵ "USAID Vision"

⁶ Alliance for Health Policy and Systems Research. *Strengthening Health Systems: The Role and Promise of Policy and Systems Research*. Geneva: Alliance for Health Policy and Systems Research, 2004.

⁷ WHO, "Everybody's Business"

⁸ de Savigny, Donald, Taghreed Adam, eds. "Systems Thinking for Health Systems Strengthening." Geneva, Switzerland: Alliance for Health Policy and Systems Research and WHO, 2009, 107.

⁹ "USAID Vision"

¹⁰ "Ethiopia Demographic and Health Survey (DHS) 2016." Addis Ababa, Ethiopia, and Rockville, MD, USA: Central Statistical Agency [Ethiopia] and ICF, 2016. <https://dhsprogram.com/publications/publication-FR328-DHS-Final-Reports.cfm>.

¹¹ "Ethiopia DHS 2016"

¹² WHO. Trends in Maternal Mortality 2000 to 2017: Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. Geneva: WHO, 2019. <https://apps.who.int/iris/handle/10665/327595>.

Health services in Ethiopia are provided by a network of health facilities arranged in a three-tier health care delivery model: 1) primary health care units (PHCUs) and primary hospitals (PHLs); 2) general hospitals; and 3) tertiary hospitals. PHCUs are the main source of primary care services, especially for rural communities. The Ethiopian HSTP-II states that the growing investment in expanding health services, infrastructure, and health workforce resulted in increased access to primary health coverage from 51% in 2000 to more than 90% in 2019; however, the universal health coverage (UHC) index remains at lower (43%).¹³ Despite improvement in service delivery, numerous continuing challenges persist both at PHCU- and hospital-based services: high turnover of health extension workers (HEWs), challenges sustaining replacement and training of HEWs, limited resources, inadequate health extension program (HEP) service delivery modalities and points, inefficient facility management, and weak accountability, among others.¹⁴

The HSTP-II recognizes the existing low level of service utilization, particularly among rural dwellers. Several factors are at play, including misperceptions, diverse sociocultural beliefs and practices, facility-related factors like stockouts of medical supplies and equipment, and poor geographical accessibility.¹⁵ Client satisfaction with service delivery,¹⁶ high transportation cost to reach health facilities, and distance to the nearest health center (HC) or hospital¹⁷ contribute to low service utilization.

¹³ "Health Sector Transformation Plan II (HSTP-II) 2020/21-2024/25 (2013 EFY-2017 EFY)." Ministry of Health (MOH) - Ethiopia, February 2021. <https://fp2030.org/sites/default/files/HSTP-II.pdf>.

¹⁴ HSTP-II.

Bekele, Abebe, Mengistu Kefale, and Mekonnen Tadesse. "Preliminary Assessment of the Implementation of the Health Services Extension Program: The Case of Southern Ethiopia." *The Ethiopian Journal of Health Development* 22, no. 3 (2008). <https://www.ejhd.org/index.php/ejhd/article/view/514>.

Workie, Netsanet W, and Gandham NV Ramana. "The Health Extension Program in Ethiopia." UNICO Studies Series. Washington, DC, USA: World Bank, 2013. <https://openknowledge.worldbank.org/handle/10986/13280>.

¹⁵ HSTP-II

¹⁶ Atnafu, Asmamaw, Adane Kebede, Bisrat Misganaw, Destaw Fetene Teshome, Gashaw Andargie Bikis, Getu Debalkie Demissie, Haileab Fekadu Wolde, et al. "Determinants of the Continuum of Maternal Healthcare Services in Northwest Ethiopia: Findings from the Primary Health Care Project." *Journal of Pregnancy* 2020 (August 26, 2020): 1–8. <https://doi.org/10.1155/2020/4318197>.

¹⁷ Girma, Fitsum, Challi Jira, and Belaineh Girma. "Health Services Utilization and Associated Factors in Jimma Zone, South West Ethiopia." *Ethiopian Journal of Health Sciences* 21, no. Suppl 1 (August 2011): 85–94.

In the past two decades, to strengthen PHC facilities to provide quality, equitable health services, the Ethiopian Ministry of Health (MOH) has initiated multiple HSS interventions.¹⁸ These include the HEP,¹⁹ CBHI,²⁰ the woreda-based HSTP,²¹ task sharing for Implanon insertion and removal,²² and woreda health management standards.²³ Despite increased capacity for health planning reported by HSTP-II, many other studies conducted in Ethiopia indicated low overall routine health information use for evidence-based decision making in woreda health offices (WorHOs) and lower-level health facilities.²⁴ Use of routine health management information systems (HMIS) for decision making is affected by multiple factors, including awareness gaps, lack of technical capacity of health professionals, low levels of data management knowledge, and lack of availability of HMIS guidelines.²⁵ Investment in HSS is crucial to promote country ownership and sustainability of services, scale-up of new initiatives, and more efficient implementation within the health system.²⁶

Background on HSS Interventions

Characteristics of HSS interventions

In 2017 the Activity designed an implementation strategy for investing in a package of activities across the woreda FP/RH care system to strengthen the health system and ensure sustained, quality, equitable FP/RH services in the intervention regions: Amhara, Oromia, Tigray, SNNPR, and Sidama. This strategy considered the roles of PHCUs, PHLs, and WorHOs in systematically addressing FP/RH challenges (**Table 1**). Before implementing the package, managers of WorHOs, HCs, PHLs, and logistic personnel from these offices and health facilities attended a consensus- and skill-building workshop. **Figure 1** highlights topics covered during the workshop.

¹⁸ HSTP-II

¹⁹ "Health Extension Program Implementation Guide." MOH of Ethiopia, 2012.

²⁰ Feleke, Solomon, Worki Mitiku, Hailu Zelelew, and Tesfaye D. Ashagari. "Ethiopia's Community-Based Health Insurance: A Step on the Road to Universal Health Coverage." Washington, DC, USA: USAID, January 2015. <https://www.hfgproject.org/ethiopia-community-based-health-insurance-step-road-universal-health-coverage/>.

²¹ "Woreda-Based Health Sector Annual Core Plan: Health Sector Transformation Plan EFY 2012." MOH of Ethiopia, October 2019.

²² "Training Strategy: Scaling up Availability and Access to Implanon Service Through Provision by Health Extension Level." MOH of Ethiopia, 2009.

²³ "Woreda Management Standard in Ethiopia." MOH of Ethiopia, n.d.

²⁴ Chanyalew, Moges Asressie, Mezgebu Yitayal, Asmamaw Atnafu, and Binyam Tilahun. "Routine Health Information System Utilization for Evidence-Based Decision Making in Amhara National Regional State, Northwest Ethiopia: A Multi-Level Analysis." *BMC Medical Informatics and Decision Making* 21, no. 1 (December 2021): 28. <https://doi.org/10.1186/s12911-021-01400-5>. Tilahun, Binyam, Alemayehu Teklu, Arielle Mancuso, Kassahun Gashu, Ashenafi Tazebew, Berhanu Endehabtu, and Zeleke Mekonnen. "How Can the Use of Data at Each Level of the Health System Be Increased to Improve Data Quality, Service Delivery, and Shared Accountability?" 20TH ANNUAL REVIEW MEETING. 20th Annual Review Meeting, December 2018. Endriyas, Misganu, Abraham Alano, Emebet Mekonnen, Aknaw Kawza, and Fisha Lemango. "Decentralizing Evidence-Based Decision-Making in Resource Limited Setting: A Case of SNNP Region, Ethiopia." Edited by Itamar Ashkenazi. *PLOS ONE* 15, no. 7 (July 30, 2020): e0236637. <https://doi.org/10.1371/journal.pone.0236637>. Asemahagn, Mulusew Andualem. "Determinants of Routine Health Information Utilization at Primary Healthcare Facilities in Western Amhara, Ethiopia." Edited by Albert Lee. *Cogent Medicine* 4, no. 1 (January 1, 2017): 1387971. <https://doi.org/10.1080/2331205X.2017.1387971>.

²⁵ Tilahun, "How Can the Use of Data." Asemahagn "Determinants of Routine Health Information Utilization"

²⁶ "USAID Vision"

Figure 1. Framework for Investing in Packages of FP/RH Activities Across Woreda Primary Care System

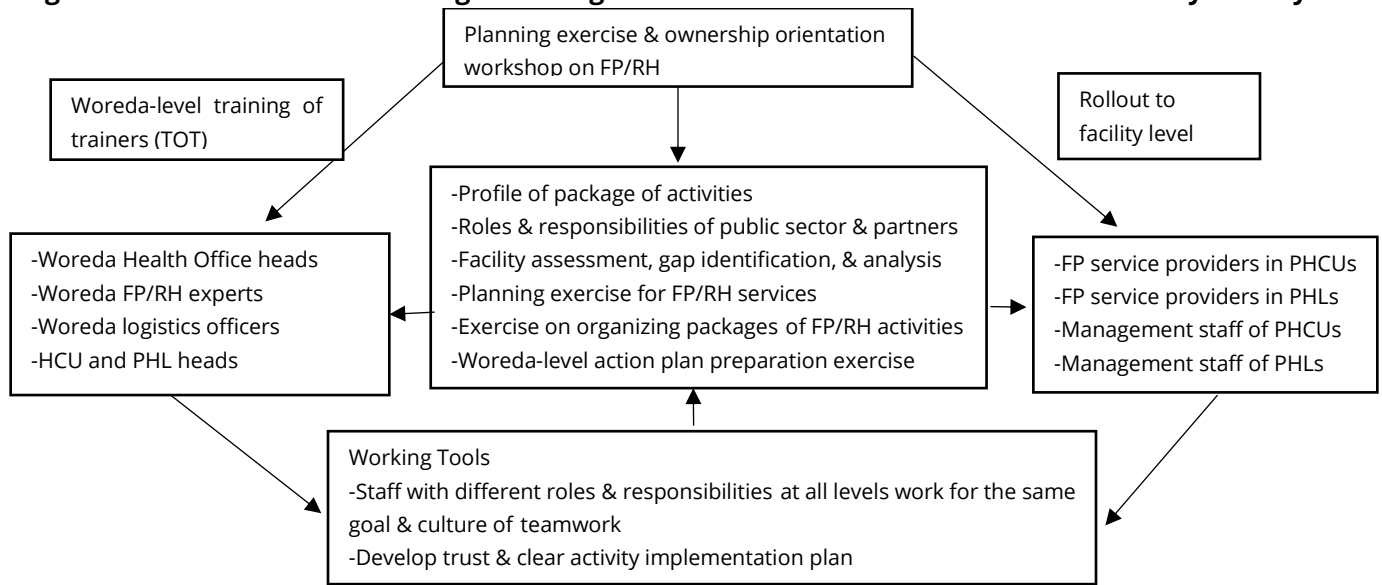


Table 1. HSS Intervention Characteristics by Health System Pillar

Service delivery area	Type of FP/RH intervention activity package	Audience (Providers, facilities, institutions)	Detailed description of interventions		
			Strategic objectives	Materials for planning exercise	Expectation after the intervention
HMIS	FP/RH service planning exercise 1. TOT at woreda level	<ul style="list-style-type: none"> • WHO/heads • Woreda FP experts • Woreda, HC, PHL logistic officers 	<ul style="list-style-type: none"> • Improve planning of FP/RH services using service data for decision making • Improve data generation skills • Improve quality of performance report and analysis • Develop a culture of teamwork among personnel who have different roles and responsibilities but are engaged in the same activity 	<ul style="list-style-type: none"> • Annual service registration books from FP unit, delivery room, FP service integration units, and health posts (HPs) • PowerPoint presentations on introduction of planning exercise on FP/RH (Annex B) • Planning exercise tools 1 & 2 (Annex B1) 	<ul style="list-style-type: none"> • Properly tally service data of all FP/RH services by month (tool 1) • Compile tallied service data numerically by month (tool 2) • Plot table, graphs by FP/RH service type and by month • Interpret performance and trend of FP/RH service by type and by month • Properly fill information in service registration books
	2. Rollout at facility level	<ul style="list-style-type: none"> • PHCU and PHL management • Service providers from FP unit, delivery, postabortion care (PAC), antiretroviral therapy (ART), youth-friendly services (YFS), immunization 			
Procurement and supply chain system	Planning exercise on FP/RH services 1.TOT at woreda level	<ul style="list-style-type: none"> • WorHO/heads • Woreda FP experts and HC and PHL logistics officers 	Strengthen supply chain by: <ul style="list-style-type: none"> • Estimating the amount and type of supplies and commodities required for a single client for each FP/RH service • Estimating annual demand for supplies and commodities 	Planning exercise tools 3, 4, 5, & 6 (Annex B1)	<ul style="list-style-type: none"> • Quantify recommended amount and type of supplies and commodities to serve a single client for each FP/RH service (tool 3) • Prepare annual estimate of supplies and commodities for all FP/RH services for a facility (tool 2 & 4)

Service delivery area	Type of FP/RH intervention activity package	Audience (Providers, facilities, institutions)	Detailed description of interventions		
			Strategic objectives	Materials for planning exercise	Expectation after the intervention
	2.Rollout at facility level	<ul style="list-style-type: none"> • PHCU and PHL management • FP service providers from FP unit, delivery, PAC, ART, YFS, immunization 	<p>for each FP/RH service in a facility</p> <ul style="list-style-type: none"> • Compiling annual estimates at woreda level • Preparing demand-based supply distribution plan for each service unit in a facility 		<ul style="list-style-type: none"> • Prepare a supply and commodity distribution plan for each FP service unit at a facility level (tool 5) and interpret the distribution plan • Compile supplies and FP commodities of all facilities in a woreda (tool 5) and prepare distribution plan at the woreda level (tool 6) • Interpret supply and commodity distribution plan for FP/RH services at woreda level
Health financing	Planning exercise on FP/RH services 1.TOT at woreda level	<ul style="list-style-type: none"> • WorHO/heads • Woreda FP experts • Woreda, HC, PHL logistics officers 	<ul style="list-style-type: none"> • Improve the skills of providers, logistics officers, and health managers on budget formulation process • Strengthen ability of all health facilities to prepare data-based budget for FP/RH services • Use the actual data-based budget to advocate to decision makers to allocate budget for FP/RH services 	Planning exercise tools 7 and 8 (Annex B1)	<ul style="list-style-type: none"> • Estimate cost of supplies and prepare procurement plan for a facility (tool 7) using data from tool 4 • Compile the procurement plan of each facility (PHCUs, PHLs) and prepare procurement plan at woreda level (tool 8) • Interpret budget allocated for each FP/RH service by facilities
	2.Rollout at facility level	<ul style="list-style-type: none"> • PHCU and PHL management • FP service providers from FP unit, delivery, PAC, ART, YFS, immunization 			

Service delivery area	Type of FP/RH intervention activity package	Audience (Providers, facilities, institutions)	Detailed description of interventions		
			Strategic objectives	Materials for planning exercise	Expectation after the intervention
Facility management and organization	<ol style="list-style-type: none"> 1. Exercise how to assess health facilities, identify gaps, and prepare an action plan to address the gaps at woreda level 2. Support PHCUs to conduct workplace Implanon training 3. Support PHCUs to conduct backup long-acting reversible contraceptives (LARCs) support to communities 4. Exercise how to organize package of activities in a facility 5. Support WorHOs to conduct FP/RH trainings 	<ul style="list-style-type: none"> • WorHO/heads • Woreda FP experts • Woreda, HC, PHL logistics officers • Facility management and FP service providers 	<ul style="list-style-type: none"> • Develop skills for assessing the status of FP/RH services in health facilities (identify skill gaps, service availability, supply, follow-up, and monitoring) • Prepare plan to address the gaps (at woreda, facility, and partner level) • Develop self-reliance and ownership among facilities • Develop culture of assessing, planning, and finding solutions as a team • Integrate LARC-Implanon training at workplace level so each HC can train HEWs • Integrate backup services at the PHCU level and expand FP service and method mix to the community • Offer all expected FP/RH services at facility level, including the new initiatives • WorHOs organize and conduct their own FP/RH trainings 	<ul style="list-style-type: none"> • Tool for health facility assessment (FP/RH activities) (Annex C, pp 1-2) • Tool to analyze gaps identified (Annex C1, pp 1-2) • Tool to summarize gaps analyzed in each facility and prepare an action plan for all facilities at woreda level (Annex C2, pp 1-3) • Guide to develop an action plan (Annex C3) • Sample action plan form (Annex C4) • Exercise tools for organizing a package of FP/RH activities at facility level (Annex E) • Guide to support HCs to provide workplace Implanon training (Annex I) • Guide to support HCs to provide backup LARC support to communities (Annex H) • Guide to support WorHOs to provide FP/RH trainings (Annex I1) 	<ul style="list-style-type: none"> • Able to assess FP/RH activities on their own • Able to summarize and analyze assessment data of all facilities in the woreda and prepare an integrated action plan as a team • Know what, how, and who to involve to organize package of activities • Understand what workplace training is, integration of the training in the system, and partners' roles • Understand what backup LARC service means, integration of the service in the system, and partners' roles • Understand the guide and how to form a pool of trainers, organize pre-/during-/post-training activities and maintain support from partners

Service delivery area	Type of FP/RH intervention activity package	Audience (Providers, facilities, institutions)	Detailed description of interventions					
			Strategic objectives	Materials for planning exercise	Expectation after the intervention			
Service delivery	1. Consensus-building pre-workshop session with WorHO team	<ul style="list-style-type: none"> • WorHO team • WorHO heads • Woreda FP experts, woreda, HC, PHL logistics officers • Facility management and FP service providers 	<ul style="list-style-type: none"> • WorHO leads and is responsible for all project activities implemented • Know roles and responsibilities across all levels in the system and translate into practice 	<ul style="list-style-type: none"> • Outline of pre-workshop brainstorming session topics with WorHO (Annex A) • Presentations on roles and responsibilities of public sector and partners (Annex D) 	<ul style="list-style-type: none"> • Woreda health office owns and leads the package of FP/RH activities to be implemented at woreda level • Facilities to implement and own the package of FP/RH activities 			
	2. Presentation on roles and responsibilities of public sector and partners							
	3. Learn how to organize package of FP/RH activities at a facility level					<ul style="list-style-type: none"> • Offer all expected FP services and activities in all health facilities in a woreda (HCs, HPs, and PHLs) 	<ul style="list-style-type: none"> • Exercise tool for organizing expected FP services/activities at the facility level (Annex E) 	<ul style="list-style-type: none"> • Each facility able to practice and initiate package of FP/RH activities implemented during the project
Service delivery	4. Presentations on profile of package of FP/RH activities to be Implemented	<ul style="list-style-type: none"> • WHO heads • Woreda FP experts, woreda, HC, PHL logistics officers • Facility management and FP service providers 	<ul style="list-style-type: none"> • All participants at all levels in the health system know the type of activities to be implemented • Activities are integrated into the existing system • Public sector develops self-reliance and ownership 	<ul style="list-style-type: none"> • Presentations on package of FP/RH activities to be implemented (Annex F) 	<ul style="list-style-type: none"> • All training participants from government sector know: <ul style="list-style-type: none"> ○ Number of activities in the package ○ Services to scale or initiate ○ How to integrate use of guide 			
	5. Integrate FP services into other health service outlets (delivery, PAC, ART, immunization, and YFS)					<ul style="list-style-type: none"> • Address missed opportunities for client access to FP services and information 	<ul style="list-style-type: none"> • Guide to integrate FP services into other health service outlets (Annex G) 	<ul style="list-style-type: none"> • Training participants from the government sector understand the guide: which FP method in which unit and why
	6. Initiate backup LARC services from HC to communities					<ul style="list-style-type: none"> • Improve rural access to FP services and method mix not routinely provided at HPs • Integrate outreach FP services • Improve client satisfaction 	<ul style="list-style-type: none"> • Guide to initiate integrated backup LARC services from HC to communities (Annex H) 	<ul style="list-style-type: none"> • Training participants from government sector understand <ul style="list-style-type: none"> ○ New initiatives ○ HC is primarily responsible ○ Integration, organization, implementation, and follow-up is the responsibility of the PHCU team

Service delivery area	Type of FP/RH intervention activity package	Audience (Providers, facilities, institutions)	Detailed description of interventions		
			Strategic objectives	Materials for planning exercise	Expectation after the intervention
Human resources for health	<ol style="list-style-type: none"> 1. Support PHCUs to conduct onsite HEW Implanon insertion training on their own 2. Strengthen capacity of WorHOs to conduct FP/RH trainings 	<ul style="list-style-type: none"> • Heads of WorHOs • Woreda FP experts, • Woreda, HC, PHL logistics officers • Facility management and FP service providers 	<ul style="list-style-type: none"> • Ensure sustained public-sector LARC-Implanon training program • Adapt effective models for transformative education and maintenance of skills and competence: alternative model to offsite training • Address high HEWs turnover • Develop skills of WorHO staff to organize pre-/during-, and post-training activities • Support WorHOs to manage all trainings in the woreda 	<ul style="list-style-type: none"> • Guide to support PHCU to conduct onsite HEW Implanon insertion training (Annex I) • Guide to organize, conduct, and follow Implanon insertion training of HEWs at workplace (Annex I1) • Guide to support WorHOs to conduct FP/RH trainings on their own (Annex J) • Sample format to document profile of pool of FP/RH trainers (Annex J1) 	<ul style="list-style-type: none"> • All facilities and training participants from government sector know: <ul style="list-style-type: none"> ○ The strategic objective of the FP/RH package of activities ○ How to support the PHCU to conduct the training ○ The implementation guides ○ Integrate, organize, conduct, and follow up on the training (by the PHCU team as part of their responsibilities)
	3. Conduct peer-to-peer education on LARC skills at facility level (delivery room) followed by a fulfillment training (activity not included in the report)		<ul style="list-style-type: none"> • Transformative education and maintenance of skills & competence for immediate postpartum family planning (IPPPF) training where low client numbers pose a challenge for practice • Address the shortage of delivering women for trainee clinical IPPFP practice 	<ul style="list-style-type: none"> • Peer education on LARC-IPPPF skills at facility level (Annex K) • Learning schedule for peer-to-peer education on IPPFP skills (Annex K1) • Follow-up and monitoring format for peer-to-peer education on IPPFP skill (Annex K2) 	<ul style="list-style-type: none"> • All facilities and participants understand and implement peer-to-peer education on IPPFP at delivery, including fulfillment of IPPFP training at woreda level

HSS intervention pathway in the Activity's intervention areas

The HSS intervention pathway was adapted from USAID's Framework and Guideline for the Assessment and Evaluation of Health System Strengthening Programs.²⁷ The pathway shows the implementation strategy designed to support the different levels in the health system to reach WorHO heads, FP experts and logistics personnel, as well as facility heads, logistics officers, FP service providers, and management staff from PHCUs and PHLs. The intervention strategy is linked to and explains the packages of activities, including a planning exercise, an ownership orientation workshop on FP/RH, and a consensus- and skill-building workshop conducted before implementation. The Activity conducted a woreda-level TOT workshop and rolled it out to the health facilities. Workshop topics included:

- Activities to be implemented, including provider capacity strengthening; scale-up, HEW training, and post-training supply provision for IPPFP and Implanon; integration of FP into other health services; development of FP/RH teaching aids; HC capacity strengthening to provide community-level backup LARC support; and preparation of WorHOs to provide FP/RH trainings;
- Roles and responsibilities of partners and public sector;
- Exercises on facility assessment, gap identification, and analysis;
- Exercise on organizing a package of FP/RH services in a facility;
- Skills-building exercise on facility-level FP/RH planning, including logistics management and budget formulation, using routine service data; and
- Preparation of woreda- and facility-level action plans to address issues discussed in the workshop.

The pathway also shows the linkage between the package of intervention activities and management of their interactions to achieve more equitable, sustained improvements across health services and outcomes, including the overarching system-wide effects (**Figure 2**).

Operational Definitions

FP/RH service planning exercise: FP/RH service planning exercise by health facility heads, logistics officers, WorHO managers, and FP service providers using routine service data, practical tools, and technical support provided by the Activity

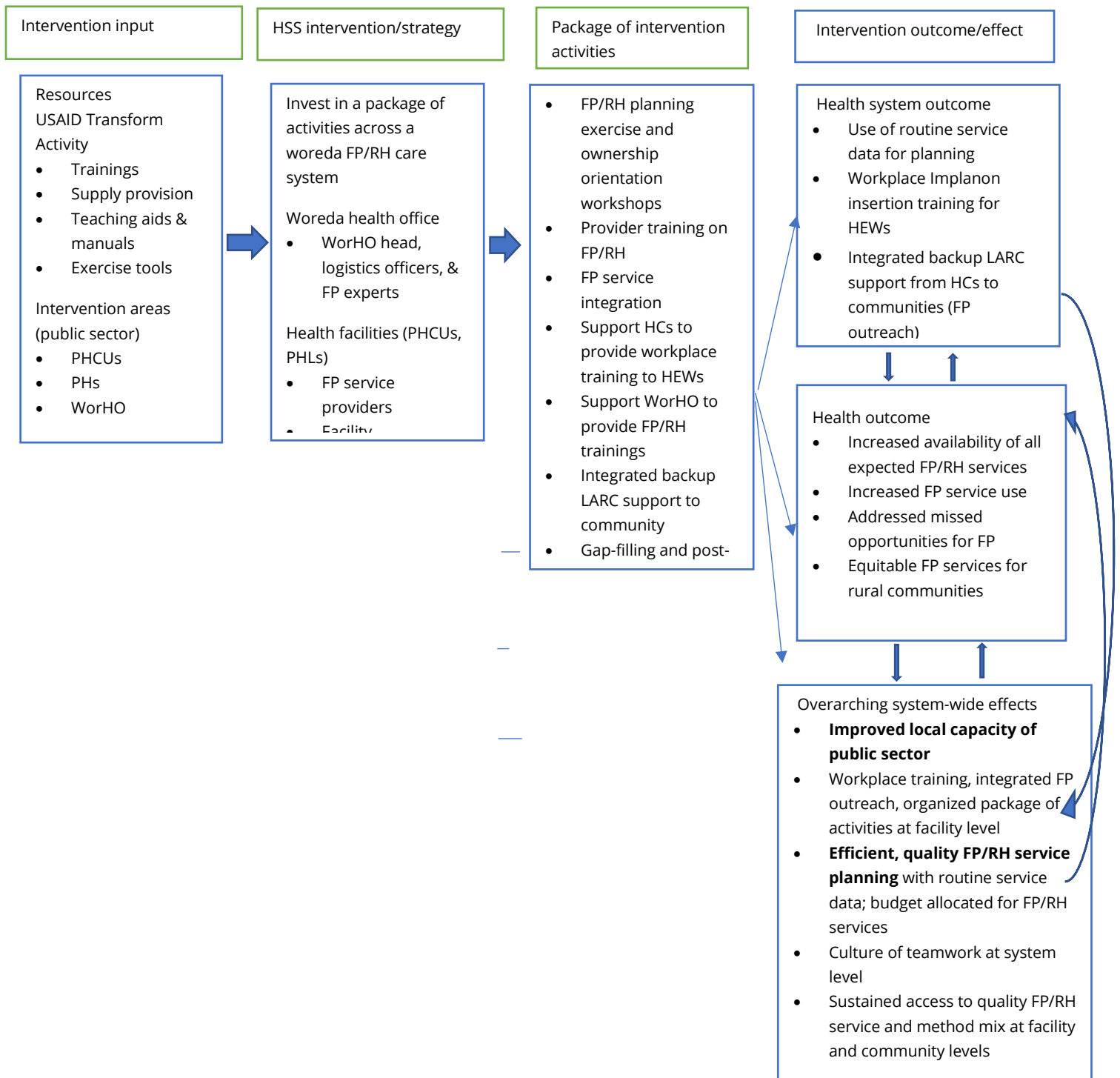
Ownership orientation on FP/RH services: Orientation workshop for participants from the PHC system (WorHOs, PHLs, HCs) that covered roles and responsibilities of the public sector and partners

Package of training materials: Presentation materials for the Implanon training for HEWs, including a tabletop flip chart, training monitoring tools and checklists, and arm models for practicum

Onsite training: Need-based Implanon insertion training for HEWs at the HC level by an established trained team of health workers who organize, conduct, and follow up the training using the package of training materials

²⁷ Katz, Itamar, Grace Chee, Alexandra Hulme, and Sayaka Koseki. "Framework and Guideline for the Assessment and Evaluation of Health Systems Strengthening Programs." Bethesda, MD, USA: Health Systems 20/20, Abt Associates Inc., September 2012. <https://www.hfgproject.org/framework-guideline-assessment-evaluation-health-systems-strengthening-programs/>.

Figure 2. Pathway and Linkages Between Activity Inputs, HSS Intervention, Outcome, and Effect (Adapted from USAID Framework)



Materials and Methods

Evaluation Setting and Design

The Activity conducted the evaluation in the regions (Amhara, Oromia, Tigray, SNNP, and Sidama) where it implemented packages of FP/RH activities between 2017 and 2019. At the start of Activity implementation, 42 PHCUs under 10 WorHOs were selected as pilot intervention areas, and 16 PHCUs were purposively selected for data collection.

The evaluation employed a mixed-method qualitative approach. A questionnaire with open-ended questions elicited data from 77 key informants—FP service providers from different units (FP, delivery, and PAC), heads of PHCUs, and staff members of WorHOs who participated in the implementation of FP/RH activities in the 16 PHCUs. In addition, trained data collectors used a structured quantitative questionnaire to collect baseline and post-intervention information from the 16 PHCUs' service registries and reports and other documents. The Activity also conducted a desk review of progress reports on the packages of FP/RH activities implemented in 282 PHCUs in 52 woredas between 2017 and 2019.

Data Collection and Analysis

The questionnaires were adapted from USAID's framework for assessing and evaluating HSS programs and further customized based on the experiences of Activity staff scaling up the Implanon and intrauterine contraceptive device (IUCD) insertion and removal program, implementing LARC trainings, and communicating with the MEL unit.²⁸ The baseline and post-intervention data for each FP/RH activity was collected within one year before and after implementation.²⁹ The Activity oriented quantitative and qualitative data collectors on the data collection tools and questionnaires. Assessment coordinators supervised and monitored data collectors throughout the data collection period to ensure data quality.

The quantitative data were first entered into the epidemiological-data software (EPIDATA version 3.31). After the data was cleaned, it was exported into SPSS (version 20) for further cleaning and analysis. Step-by-step analysis of the qualitative interview data from the 77 participants was done through organizing data, coding, categorizing ideas and concepts, building overarching themes, ensuring reliability and validity, and finding possible and plausible explanations for the findings. Variables were defined, categorized, and recoded for analysis.³⁰ Descriptive statistics were used to report averages and frequency distributions generated for various baseline and post-intervention assessment variables.

²⁸ Katz, "Framework and Guideline." Tilahun, Yewondwossen, Candace Lew, Bekele Belayihun, Kidest Lulu Hagos, and Mengistu Asnake. "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." *Global Health: Science and Practice* 5, no. 4 (December 28, 2017): 592–602. <https://doi.org/10.9745/GHSP-D-17-00215>. Asnake, Mengistu, Elizabeth G. Henry, Yewondwossen Tilahun, and Elizabeth Oliveras. "Addressing Unmet Need for Long-Acting Family Planning in Ethiopia: Uptake of Single-Rod Progestogen Contraceptive Implants (Implanon) and Characteristics of Users." *International Journal of Gynecology & Obstetrics* 123 (November 2013): e29–32. <https://doi.org/10.1016/j.ijgo.2013.07.003>. Tilahun, Yewondwossen, Sarah Mehta, Habtamu Zerihun, Candace Lew, Mohamad I Brooks, Tariku Nigatu, Kidest Lulu Hagos, et al. "Expanding Access to the Intrauterine Device in Public Health Facilities in Ethiopia: A Mixed-Methods Study." *Global Health: Science and Practice* 4, no. 1 (March 21, 2016): 16–28. <https://doi.org/10.9745/GHSP-D-15-00365>.

²⁹ Katz, "Framework and Guideline."

³⁰ Connor, Helene O, and Nancy Gibson. "A Step-by-Step Guide to Qualitative Data Analysis." *Pimatzwin: A Journal of Aboriginal and Indigenous Community Health* 1, no. 1 (2003). <http://www.pimatzwin.com/uploads/1289566991.pdf>.

The Activity assessed the process and system-wide effect of the HSS interventions by triangulating information from performance reports between 2017 and 2019 and results of key-informant interviews (KIIs). Similarly, the Activity assessed health-system and health-outcome indicators through a qualitative review of progress reports, KII results, and site visits, followed by a percentage calculation and change in performance observed between baseline and post-implementation.³¹

Findings

Process Evaluation

Financial management, M&E, and collaborative process for packages of FP/RH activities

The Activity's fund has been managed according to the contract and agreement between USAID and Pathfinder using a costed implementation plan to track spending on activities and outputs over time to ensure cost-effectiveness. The F&O director prepared a monthly trend analysis to review financial performance. With the costed implementation plan, the F&O director monitored efficiency, ensured effective and compliant management of the Activity's resources, discussed any significant or unusual variances with staff, and took immediate corrective action when needed.³² The Activity monitored and evaluated activities using health-service and outcome indicators disaggregated by sex, and, where possible, age, and baseline, midterm, and endline surveys. Activity staff also made 286 FP/RH supportive supervision and mentorship visits to 444 facilities from 2017 to 2019.³³

The Activity coordinated and collaborated with stakeholders to maximize impact on preventing maternal and child deaths. From 2017 to 2019, key technical staff at the central level participated in 38 national and regional technical working group meetings and shared timely information about Activity interventions and policy and regulation changes, building linkages with other investments including USAID Activities and Bill and Melinda Gates Foundation-funded initiatives such as the Institute for Healthcare Improvement-led Quality Improvement Project, Last10 Kilometers (L10K), and Universal Immunization Through Improving Family Health Services Project.³⁴

FP/RH thematic activity performance

Before implementing the package of activities, the Activity conducted woreda-level planning, consensus, and skill building workshops and TOTs and rolled them out to the facility level (**Table 2**). There were 935 participants in the TOT workshops (WorHO heads, FP experts, and logistic officers from 52 WorHOs, and heads and logistics officers from 307 PHCUs and PHLs). When the workshops were rolled out to the health facilities, 1,867 FP service providers and facility management staff from 282 HCs and 25 PHLs participated. The Activity triangulated performance reports and the results of the 77 KIIs to understand the impact of each package of activities implemented from 2017 to 2019 on the six health system pillars.

³¹ Katz, "Framework and Guideline."

³² "USAID-Transform: Primary Health Care Project Program Description." USAID-Transform Primary Health Care Project, 2017.

³³ "Trend of Random Follow-up Visit (RFUV): USAID-Transform Primary Health Project-April 2020." Addis Ababa, Ethiopia: USAID TRANSFORM: Primary Health Care Project, April 2020.

³⁴ "USAID-Transform"

Health information system: The TOT and training participants gained skills for tallying and compiling routine FP/RH service data from service registration books. Training participants prepared annual service data (disaggregated by month) and used the information to report performance and service coverage using infographics, and to analyze the data and use the findings for technical and administrative decision making. Of the key informants interviewed, 90% (68) reported using the routine service data for FP/RH service planning and said that they had practiced good planning with consistent and efficient use of resources. As a result, they avoided stockouts and minimized waste.

Logistics management: During the planning exercises, participants identified and quantified the supplies and FP commodities required for a single client for each FP/RH service and estimated annual need for all FP/RH services, including a supply distribution plan for each FP service unit in a health facility. Of the key informants, 95% (73) reported reviewing the service data to plan and complete requisition and procurement of supplies. The Ethiopian Pharmaceutical and Supply Agency's (EPSA) responses to their supply requests improved. The required annual quantity of supplies and FP commodities at woreda level was compiled from each PHCU and PHL in the woreda, which helped the WorHOs to know the FP/RH service status in each facility, and to allocate and reallocate available resources, including identifying FP/RH services that required additional support from the WoHOs or other parties.

Health financing: All individuals who participated in the woreda- and facility-level trainings estimated the cost of supplies and prepared service data based on the annual budget for FP/RH activities, which included the facility-level procurement plan. The annual budget requirement for supplies at the woreda level was compiled from each PHCU and PHL in the woreda. When key informants were asked if the planning exercise on FP/RH promoted more efficient spending of public resources at the facility level, 90% (70) said yes, because the supply requests were demand-based and minimized the waste of resources. Of the key informants, 68% (53) reported that the quality of budget formulation improved after the planning exercises. Those who reported no improvement said that the routine service data-based budget planning was not fully implemented because of high turnover of trained staff. Additionally, 72% (56) reported that the government allocated budget for FP/RH after the planning exercise; woreda decision makers allocated budget for FP/RH services in 20 PHCUs in 6 woredas. Compared with other budget planning and request methods, planning based on the actual service data is more effective at encouraging budget allocation for the WorHOs, PHCUs, and PHLs.

Facility management and organization: In addition to learning to plan with routine service data, TOT and training participants gained the following technical skills and knowledge:

- Facility assessment, gap identification, and analysis. Each facility team assessed the actual status of FP/RH service uptake against the planned packages of FP/RH activities implemented by the Activity. Each health facility team identified gaps, and these were compiled and analyzed at the woreda level.
- Skill for organizing facility-level packages of FP/RH activities.
- How to initiate new interventions by integrating them into the existing health care system and how to ensure sustainability of FP service integration. HEWs participated in onsite training on Implanon insertion and integrated backup LARC support from HCs to communities (HPs).
- Roles and responsibilities of the public sector and partners in FP/RH activities
- How to prepare an action plan that addresses gaps and issues identified in the workshop

Of the key informants, 96% (74) said that the FP/RH planning exercise and ownership orientation was instrumental in promoting public-sector ownership and ensuring sustainability. They planned, implemented, supported, followed, and monitored the activities themselves.

Training: The Activity supported 52 WorHOs to organize and conduct FP/RH trainings by forming a pool of 130 trainers across the intervention area and providing training packages. The Activity filled skill gaps in LARC insertion and removal, Implanon insertion, and PAC by training 6,653 providers from 4,572 HCs, HPs, and PHLs. IPPFP services were scaled up to 434 facilities by training 562 delivery-room providers. Comprehensive FP services were scaled to 331 communities (HPs) by training 352 level IV HEWs.

Onsite Implanon insertion training for HEWs: Of 282 HCs, 77 formed teams of trainers, received a package of training materials, and organized and conducted trainings that enabled the HCs to organize onsite Implanon insertion training for HEWs. Training data from 50 PHCUs shows that 234 HEWs from 210 HPs were trained. Of key informants interviewed, 92% reported that onsite training of HEWs improved health services at the community level, was cost-effective, promoted ownership and sustainability by strengthening local capacity, increased service uptake, and minimized service interruption at the HP, level unlike traditional offsite Implanon training. All key informants reported that onsite Implanon insertion training of HEWs improved availability of skilled HEWs, ensured Implanon service continuity at the HP level, was cost-effective, and minimized HEW absence from duty stations.

Post-training and gap-filling supplies and provision of kits: The Activity supported 3,068 facilities to initiate services immediately after trainings, and 3,565 facilities received gap-filling supplies and FP kits during supportive supervision visits to ensure service continuity. Of the key informants interviewed, 95% (74) reported improved service access and use and increased FP users and service mix after implementation of the activities, including LARC, IPPFP, and PAC trainings and FP service integration.

FP integration into other health service outlets, including integrated backup LARC service support from HCs to communities: Access to FP services increased through integration in delivery rooms, PAC, ART, immunization, and YFS service units in 282 HCs and 25 PHLs in 52 woredas. In total, 282 PHCUs initiated backup LARC service support, providing more than 114,000 clients with their methods of choice (about 18% received removal services). When asked if integrated backup LARC support could be an alternative to traditional mobile FP outreach programs, 97% of key informants said yes.

Challenges encountered during implementation of packages of FP/RH activities

The Activity identified several implementation challenges, including gaps in follow-up and support for the new interventions. Furthermore, “business as usual” thinking hindered investment in packages of activities across the woreda FP/RH care system. The full packages of activities were not implemented in all intervention areas. The public sector also identified challenges. Facility management and service providers exerted less effort to integrate the new interventions including, integrated back-up LARC support, FP service integration into other health service outlets, workplace training for HEWs, and the planning exercise for FP/RH services. They were also less dedication to owning, following, and monitoring implemented activities. The view of implementation of the Activity as “partners’ business” posed a barrier to investment in packages of activities across the woreda FP/RH care system. Despite these gaps, Activity structure and capacity was strong enough to manage all FP/RH activities at all levels. Organized, experienced M&E and F&O systems efficiently supported achievement of the technical objectives.

Table 2. Process Evaluation & Performance Summary of Package of FP/RH Activities Implemented from 2017 to 2019

Health system building blocks	Activities implemented	# Activities performed	Audience	# Trained, oriented	#Facilities, WorHOs covered
<ul style="list-style-type: none"> Health information system Procurement and supply chain system Health financing 	TOT: Planning FP/RH services using routine service data	52	PHCU heads, logistics staff	637	282 PHCUs
			PHL heads, logistics staff	122	25 PHs
			Woreda health managers, FP experts, logistics officers	176	52 WorHOs
	Rollout: Planning FP/RH services using routine service data	307	PHCU FP providers, management staff	1,692	282 PHCUs
			PHL FP providers, management staff	175	25 PHLs
Facility management and organization	TOT: Presentation of package of FP/RH activities	52	PHCU heads, logistics staff	637	282 PHCUs
	TOT: Orientation on roles and responsibilities of public sector and partners				
	TOT: Facility assessment, gap identification and analysis, and action plan preparation exercise				
	TOT: Exercise on organizing a facility-level package of FP/RH activities				
	Rollout: Presentation of package of FP/RH activities	307	PHCU FP providers, management staff	1692	282 PHCUs
	Rollout: Orientation on roles and responsibilities of public sector and partners				
	Rollout: Facility assessment, gap identification and analysis, and action plan preparation exercise				
Rollout: Exercise on organizing a facility-level package of FP/RH activities					

Health system building blocks	Activities implemented	# Activities performed	Audience	# Trained, oriented	#Facilities, WorHOs covered
Service delivery	Training on comprehensive LARC, Implanon; orientation on Implanon NXT generation, IPPFP	268	HEWs	3,880	2,569 HPs
			Clinical care providers, WorHO staff	1,521	1,258 HCs, PHs
	Scale-up training on IPPFP	35	Clinical care providers from delivery room	562	434 HCs, PHs
	Scale up comprehensive FP training for level IV HEWs	19	Level IV HEWs	352	331 HPs
	FP integration into delivery, PAC, ART, immunization, and YFS units	307	HCs and PHLs		282 HCs, 25 PHLs
	Post-training supply provision after FP/RH trainings	629	HCs, HPs, and PHLs		3,408 HPs, HCs, PHLs
	Gap-filling supply provision for FP/RH services including backup and implant removals		HCs, HPs, and PHLs		3,068 HPs, HCs, PHLs
	Provision of FP/RH job aids		HCs, HPs, and PHLs		3,565 facilities
	Support to initiate integrated backup LARC support to communities	282	PHCUs		282 PHCUs
	Supportive supervision and mentorship	268	PHCUs, PHLs, HPs		444
	Participate in national and regional FP technical working group meetings	38	MOH, RHB, FP/RH partners		MOH, 4 RHBs
Human resources for health	Support HCs to provide onsite HEW Implanon insertion training	307			
	Form team of Implanon trainers				158
	Provision of training materials				148
	Conduct onsite training			234	77
	Support initiation of peer-to-peer education on LARCs and IPPFP		HCs		6
	Support woreda health offices to: <ul style="list-style-type: none"> Form pool of trainers Provide training materials Conduct FP/RH trainings 	52	WorHOs		Pool of 130 trainers

Effect of FP/RH Activities on Health Outcomes at HC Level

The Activity analyzed the effect of the packages of FP/RH activities on health outcomes at the HC level using the quantitative baseline and post-intervention performance data collected from 16 PHCUs in the implementation area and 77 KIs from these PHCUs. The packages implemented to strengthen the system and improve health outcomes include:

- Training of health care providers on comprehensive provision of LARCs and PAC;
- Scale-up of IPPFP services and level IV HEW programs;
- Provision of gap-filling and post-training supplies and FP kits, including FP/RH teaching aids;
- Integration of FP services in ART, PAC, immunization, and YFS units within a health facility; and
- Introduction and implementation of the integrated backup LARC service support from HCs to communities (HPs).

The health outcome indicators were designed to measure increases in expected FP/RH services at the facility level and community access to and use of FP/RH services.

Expected access to FP/RH services at HC level

A national FP/RH goal of the MOH of Ethiopia is to ensure that trained providers and contraceptive methods are available and accessible in health facilities so that individuals can choose from a range of contraceptive methods and have access to implant and IUCD follow-up and removal services.³⁵ According to the FP service availability and readiness assessment report of the Ethiopian Public Health Association (2016), 94% of all health facilities offered family services; however, the percentage of facilities providing the expected full range of FP services, including IPPFP, was very low.³⁶ The MOH annual performance report for 2019-2020 emphasized ensuring the availability and provision of a full method mix in all HCs³⁷ (**Table 3**).

Among HCs surveyed at baseline, 18.7% offered all expected FP services, while 81.3% had no or less functional services. IPPFP services were not available in any of the 16 HCs, and less functional PAC services were available in only 3 HCs. After the intervention, 93.8% of HCs offered all expected FP/RH services. Integration of FP services into other health units improved access to FP/RH services; before the intervention, in almost all HCs, no FP services were available or integrated into PAC, ART, immunization, or YFS units. After the intervention, more than 75% of HCs integrated FP services into other health units. Of key informants interviewed, 95% observed an increase in expected FP/RH services after HCs implemented activities like gap-filling FP/RH trainings, scale-up of the IPPFP program, FP service integration, and provision of FP-related supplies and kits.

³⁵ "National Guideline for Family Planning Services in Ethiopia." Federal Democratic Republic of Ethiopia MOH, October 2011.

<https://scorecard.prb.org/wp-content/uploads/2018/05/National-Guideline-for-Family-Planning-Services-in-Ethiopia-2011.pdf>.

³⁶ "Ethiopia Service Availability and Readiness Assessment: 2016 Summary Report." Addis Ababa, Ethiopia: Ethiopian Public Health Institute (EPHI), January 2017. <http://www.eph.gov.et>.

³⁷ "Annual Performance Report 2012 EFY (2019/2020)." Addis Ababa, Ethiopia: MOH Ethiopia, 2012.

Table 3. Expected FP/RH Services at HCs at Baseline (2017) and Post-intervention (2019)

Expected FP/RH services in a HC	Baseline			Post-intervention		
	FP/RH service availability (n=16)			FP/RH service availability (n=16)		
	Not available	Less functional	Functional	Not available	Less functional	Functional
Short-acting FP services	0	3	13	0	0	16
Implanon insertion services	0	10	6	0	0	16
Implanon removal services	0	13	3	0	0	16
Jadelle insertion services	3	10	3	0	0	16
Jadelle removal services	4	9	3	0	0	16
IUCD insertion services	7	9	0	0	3	13
IUCD removal services	6	10	0	0	1	15
IPFP in the delivery (all recommended methods)	16	0	0	0	1	15
PAC services	13	3	0	1	3	12
HC in %	13 (81.3%)		3 (18.7%)	1 (6.2%)		15 (93.8%)
FP integration into other health service units	Baseline			Post-intervention		
	Not available	Less functional	Functional	Not available	Less functional	Functional
PAC-FP (all methods) (15 HCs)	12	3	0	2	1	12 (80%)
ART (short-acting methods and implants) (4 HCs)	4	0	0	0	0	4 (100%)
YFS (implant and IUCD) (9 HCs)	9	0	0	0	0	9 (100%)
Immunization (short-acting methods) (16 HCs)	13	2	1	2	1	13 (81.25%)

FP/RH service utilization at HC level

In addition to ensuring availability of and access to all expected FP/RH services, integration of FP into other health service units contributed to increased use of FP services. Post-intervention performance data showed a 280% increase in short-acting and LARC insertion and removal service use in the assessed HCs (baseline 15,994 clients) and a 285% increase in the number of LARC users increased (baseline 4,760 clients). After FP services were integrated into delivery rooms, PAC, ART, and immunization units, a significant number of clients received Implanon, Jadelle, and IUCD insertion services in health facilities where no LARC services were available at baseline (**Table 4**). Packages of activities implemented at the HC level to improve health outcomes during the Activity intervention period are presented in **Tables 5 and 6**.

Table 4: FP Service Utilization in 16 HCs

FP/RH service units in HCs	Short-acting methods			LARC insertions			LARC removals		
	Baseline	Post-intervention		Baseline	Post-intervention		Baseline	Post-intervention	
	# Clients served	# Clients served	Change	# Clients	# Clients served	Change	# Clients served	# Clients served	Change
Health centers									
FP unit (16 HCs)	11,234	29,490	2.6	4,144	8,990	2.2	616	1,786	2.9
IPFP in delivery room (16 HCs)	0	145	145	0	2,005	2,005	NA	NA	NA
PAC-FP (15 HCs)	0	38	38	0	230	230	NA	NA	NA
FP in ART (4 HCs)	0	566	566	0	37	37	NA	NA	NA
FP in YFS (9 HCs)	NA	NA	NA	0	256	256	NA	NA	NA
FP in Immunization (16 HCs)	0	961	961	0	254	254	NA	NA	NA
Total	11,234	31,200		4,144	11,772		616	1,786	

Table 5. Availability of Skilled FP/RH Providers

FP/RH trainings	Baseline					Post-intervention				
	#HCs	# Trained, skilled providers available	# HCs with skilled providers available			#HCs	# Trained, skilled providers available	# HCs with skilled providers available		
			None	One	More than one (%)			None	One	More than one (%)
Comprehensive LARC training for clinical care providers	16	18	0	14	2 (12.5%)	16	50	0	2	14 (87.5%)
Providers trained on IPFP	16	0	16	0	0 (0%)	16	32	0	3	13 (81.25%)
PAC training for clinical care providers	16	3	13	3	0 (0%)	16	20	1	9	6 (37.5%)

Table 6. Availability of FP Kits in HCs

Type of supply	#HCs	Baseline			Post-intervention			
		# HCs with FP kits and teaching aids available			#HCs	# HCs with FP kits and teaching aids available		
		None	One	More than one (%)		None	One	More than one (%)
FP/RH teaching aids (four types)	16	16	0	0 (0%)	16	1	15	
IUCD kits	16	6	7	3 (18.8%)	16	0	1	15 (93.8%)
Implant removal kits	16	2	9	5 (31.25%)	16	0	0	16 (100%)
IPPPF-IUCD kits	16	16	0	0 (0%)	16	0	0	16 (100%)

Effect on Health Outcomes of Investing in FP/RH Activities at HP Level

The Activity team analyzed the baseline and post-intervention data collected from 89 HPs (10 HPs with trained Level IV HEWs). Qualitative data collected from the 77 KIIs complemented the quantitative analysis. Implementation of the package of HSS interventions was measured using the following indicators to track increases in community-level access to and use of FP services:

- Number of HEWs trained on basic Implanon insertion;
- Number of orientation sessions conducted on the new Implanon Next Generation (NXT) (previous training focused on classic Implanon) for HEWs;
- Number of comprehensive FP trainings conducted at HP level for level IV HEWs;
- Packages of post-training supplies and FP kits provided to HPs;
- Packages of supplies and FP kits provided to fill gaps;
- Number of integrated backup LARC-support services introduced into the PHC system;
- Number of FP/RH-related teaching aids provided to HPs; and
- Number of exercises conducted on supply request and reporting.

Expected HP-level access to and actual use of FP services

Of the 89 HPs assessed at baseline, only 68.5% (61) offered short-acting methods, 44% (39) offered Implanon insertion, and none offered back-up LARC-support services from HCs to the community. At post-intervention, short-acting, long-acting, and backup services were available in all 89 HPs. At baseline none of the HPs assessed offered comprehensive FP services. Of the 10 HPs that trained level IV HEWs, 90% (9) initiated comprehensive FP services—56% (5) functional and 44% (4) less functional. Though this assessment was done with a small number of HPs with trained level IV HEWs, the findings shed light, supported by other studies, on the role of IUCD insertion and removal skill gaps in their previous inability to initiate comprehensive FP services at the HP level (**Table 7**).³⁸

³⁸ Teklu, Alula M., Hamid Yimam, Girmay Medhin, and Teklemichael Gebru Tesfay. "Competency of Level-4 Health Extension Workers to Provide Long Acting Reversible Contraceptives: A Task Shifting Initiative in Ethiopia." Preprint. In Review, November 5, 2019.

Table 7. Expected FP Services Available in HPs

Expected FP services at HP level (89 HPs)	Baseline			Post-intervention		
	Not available	Less functional	Functional (%)	Not available	Less functional	Functional (%)
Health posts with HEWs trained on Implanon insertion (89)						
Short-acting FP services	0	28	61 (68.5%)	0	0	89 (100%)
Implanon insertion	0	50	39 (44%)	0	0	89 (100%)
Backup services	87	2	0	0	2	87 (98%)
HPs with level IV HEWs (10)						
Implanon removal services	10	0	0	1	4	5 (50%)
Jadelle insertion services	10	0	0	1	4	5 (50%)
Jadelle removal services	10	0	0	1	5	4 (44%)
IUCD insertion services	10	0	0	2	4	4 (44%)
IUCD removal services	10	0	0	2	4	4 (44%)

At HPs where packages of FP/RH activities were implemented, FP service use increased by 6%. The post-intervention findings showed a shift among FP clients from short-acting methods to LARCs; 91% (26,547) used short-acting methods at baseline; post-intervention, this decreased to 64% (19,135). The number of LARC users increased from 9% (2,633) to 36% (11,061) (**Table 8**).

Table 8. FP Service Utilization at HPs

FP services (89 HPs)	Short-acting methods			LARC insertions			LARC removals		
	Baseline	Post-intervention	Change	Baseline	Post-intervention	Change	Baseline	Post-intervention	Change
	# Clients served	# Clients served		# Clients served	# Clients served		# Clients served	# Clients served	
Routine FP services	26,547	19,135	-7,412	2,633	5,067	+2,434	NA	59	+59
Backup LARC support	0	813	+813	0	5187	+5,187	0	748	+748
Total	26,547	19,948		2,633	10,254		0	807	

<https://doi.org/10.21203/rs.2.16852/v1>. Katz, Karen R, Bethelhem Fekade, Kayla Stankevitz, Mario Chen, Alula M. Teklu, and Tadele Kebede. "Quality of Long-Acting Reversible Contraception Provision by Level 4 Health Extension Workers." Durham, NC, USA: FHI 360, 2019. https://pdf.usaid.gov/pdf_docs/PA00WJJZ.pdf.

Inputs implemented to improve health outcomes at the HP level are presented in **Tables 9 and 10**.

Table 9. Availability of Skilled HEWs on Implanon and Comprehensive FP Services

Trainings	Baseline		Post-intervention	
	# HPs under the 16 HCs	Total skilled HEWs available	# HPs under the 16 HCs	Total skilled HEWs available
HEWs trained by HCs on Implanon onsite at the PHCU level	89	0	89	84
HEWs oriented on Implanon NXT Generation who were previously trained on classic Implanon	89	8	89	25
HEWs trained on Implanon offsite through central level rollout	89	52	89	0
Levels IV HEWs trained on comprehensive FP services	10	0	10	11

Table 10. Availability of FP Kits in HPs

Supplies and FP kits	Baseline				Post-intervention			
	# HPs	# HPs with FP kits and teaching aids available			# HPs	# HPs with FP kits and teaching aids available		
		None	One	More than one (%)		None	One	More than one (%)
FP/RH teaching aids	89	89	0		89	0	89	
IUCD insertion kits	10	10	0	0	10	1	0	9 (90%)
Implant removal kits	10	10	0	0	10	1	0	9 (90%)

Health System Outcomes

Planning exercise on FP/RH services

As part of the HSS interventions, the Activity facilitated an exercise for planning FP/RH services for managers of WorHOs; heads of PHCUs and PHLs; woreda-level logistics officers; FP service providers in delivery, ART, PAC, YFS, and immunization units; and management staff of HCs and PHLs. The exercise improved participants' skills and abilities to plan FP/RH services using routine service data. This promoted a culture of collaboration among FP service providers, logistics officers, and health managers at different levels. Using actual service data to prepare budget and supply requests influenced decision makers to allocate resources for FP/RH services.

At baseline, no skilled staff were available in the 5 WorHOs and 16 HCs assessed; at post-intervention, all had skilled personnel (**Table 11**). Following the skill-building exercise, in 13 (81.5%) of the HCs, data collectors observed planning documents; quantified supplies required for each FP service unit; and data-based budget, procurement, and supply-distribution plans. Nearly 90% (69) of key informants interviewed said that the exercise helped with demand-based planning, efficient use of resources, and reduced stockouts and wastage. Immediately after the exercise, decision makers in three woredas allocated budget for FP/RH services in 12 PHCUs (12 HCs and 65 HPs) (**Table 12**).

Table 11. Skilled Health Workers and Managers in FP/RH Planning Using Routine Service Data from HCs and WorHOs

Capacity strengthening	Baseline		Post-intervention	
	# HCs/WorHOs	Skilled personnel	# HCs/WorHOs	Skilled personnel
PHCU heads/CEOs, logistics officers, pharmacy staff	16 HCs	0	16 HCs	48
WorHO managers, logistics officers, pharmacy staff	5 WorHOs	0	5 WorHOs	18
Planning exercise: Rolled out at HCs	#HCs	Skilled personnel	#HCs	Skilled personnel
PHCU heads/CEOs	16	0	16	17
Logistics officers, pharmacy staff from PHCUs	16	0	16	17
Providers from FP unit	16	0	16	20
Providers from delivery	16	0	16	21
Providers from PAC	3	0	16	17
Providers from ART	4	0	4	4
Providers from YFS	9	0	9	9
Providers from immunization	16	0	16	16

Table 12. Budget Allocated for FP/RH Services by PHCU

Woreda	Name of PHCU	# HPs under PHCU	Budget allocated in Birr
Dara	Banko Markos	5	20,000
	Dama Banko	4	20,000
	Kebado PH	9	20,000
	Odolla	7	20,000
Dara Otlich	Abera Doko	4	15,000
	Teferi Kela	5	15,000
	Tulla Hirecha	4	15,000
	Andide	8	25,000
	Chichu	6	25,000
	Sisota	3	25,000
	Tumticha	7	25,000

	Udo	3	25,000
South Ari (SNNPR)	Berka	6	55,000
	Gazer PH	9	55,000
	Meytser	6	55,000
	Shangama	3	55,000
	Tembel	2	55,000
	Tolta	4	55,000
	Wub Hamer	8	55,000
	Bitemal	4	55,000
	Senigal	4	55,000
Abegele (Amara)	Newraq	6	50,000
	Tsana	3	40,000
	Serya	4	40,000
	Embadago	2	30,000
	Debi	2	35,000
Ziquala (Amara)	Tsitsika	5	50,000
	Kidamit	3	40,000
	Arshewa	3	40,000
	Telaje	2	30,000
	Mishera	2	35,000
Weeraa Dijjo	Ajo Huluko	4	35,000
	Besheno PH	11	35,000
	Konicha	7	35,000
	Wejago Yato	6	35,000
Bena Tsemay	Alduba	5	40,000
	Birale	3	40,000
	Gisma	2	40,000
	Kako	5	40,000
	Qey Afer	7	40,000
	Shalla	8	40,000

Yeki	Bechi	5	25,000
	Fide	4	25,000
	Kubito	4	25,000
	Shay	3	25,000
	Zinky	6	25,000
Segen Zuria	Hailota	7	10,000

Organizing the onsite Implanon insertion training for HEWs by HCs

The Activity enhanced the capacity of HC staff to organize onsite Implanon insertion training for HEWs to lower the cost and duration of training without compromising quality. This was an important strategy to overcome the skilled workforce shortage due to high turnover. Almost all key informants reported that onsite training promoted ownership, sustainability, and capacity, and that it was cost-effective and minimized the number of days spent in the training compared to traditional offsite training for HEWs, which interrupt services at HPs for extended periods.

The effect of this intervention on health system was demonstrated by the findings of operational research the Activity conducted in 2020 comparing the onsite training with the offsite approach. The onsite training was found to be cost-effective. The public sector was able to organize, conduct, and follow up on the trainings on their own with minimal resources. The approach allowed the public sector to conduct trainings on demand and immediately replace HEWs who left and train new ones. The 2020 operational study suggested that onsite training is a promising strategy to address the high turnover of HEWs at the community level (HPs) level in Ethiopia.³⁹ The study also indicated that the onsite training model reduced the number of days spent in training from eight to three, avoiding service interruption at HP level. In addition, onsite training created an opportunity for HEWs to perform more procedures (five or more Implanon insertions) during training compared with the traditional offsite approach. Onsite training strengthened linkages and working relationships between HC staff and HEWs at HPs, while ensuring a continuum of FP services and strong relationships between clients and service providers at the community level.

Integrated backup LARC-service support from HCs to communities (HPs)

Nationally, HEWs are tasked with providing short-acting methods and Implanon insertion services at the HP level; however, there is a shortage of trained HEWs who can provide Implanon insertion.⁴⁰ To address this gap, the Activity introduced and implemented integrated backup LARC-service support from HCs to communities (HPs) to increase FP access and use, specifically of FP services not routinely provided by HEWs at the community (HP) level, including Implanon, Jadelle, and IUCD insertion and removal services (**Table 8**).

³⁹ "Training Strategy"

⁴⁰ "Health Extension Program"

This intervention was aimed at HCs in the Activity areas. At baseline, none of the HCs were providing backup LARC service support to HPs; however, after the intervention, all PHCUs integrated and conducted backup services from HCs to communities (HPs). The technical and administrative activities of the backup services were entirely organized and run by the HCs, except provision of technical assistance and FP kits by the Activity. Before the intervention, the FP services in the 89 HPs under the assessed HCs were limited to short-acting methods and Implanon; after the backup support intervention, all expected FP services were available, including implant removal. The programmatic relevance of the backup intervention is not limited to providing FP services not normally offered at the HP level; it also addresses the high demand for FP services, including LARC-Implanon insertion and short-acting services, that must be routinely available at the HP level. The backup support service activities were verified during quantitative data collection by observing the service registration books at the HP level. In addition, almost all (75) of the key informants reported that the backup program was cost-effective and could be carried out locally and integrated into the system to help ensure sustainable service access for the community.

Operational research conducted by the Activity on the effect of integrated backup LARC service support from HCs to communities (HPs), showed a significant increase in FP service coverage and mix compared to communities without backup support. The study also found that clients served through backup support spent less time and money to reach the service of their choice.

Overarching System-wide Effects

This section of the report discusses and summarizes the effects of the interventions on HSS and shares recommendations for each relevant system domain based on the USAID framework.⁴¹

Improved Local Capacity of Public Sector

Ethiopia has been experiencing high turnover of health providers for a long time.⁴² Traditionally, Implanon insertion and removal training in Ethiopia was conducted offsite. This was cost-intensive and reliant on local and international NGOs.⁴³ The Activity demonstrated that HCs can conduct Implanon insertion training, support, and follow-up the HPs under their respective catchment areas on their own by integrating it into the woreda system. HCs can organize Implanon insertion trainings for HEWs immediately on demand to replace HEWs who leave the HPs and to ensure continuity of services at the community level. Almost all HCs in the Activity intervention areas were able to organize and provide integrated backup LARC services to the rural community on their own using their own staff and resources. This increased access to FP service and broadened the FP method mix in underserved rural communities. In addition, PHCU staff improved their skills to identify gaps and organize packages of expected FP/RH services at the facility level.

Efficient, Quality FP/RH Service Planning

Data use for decision making at the lower health system level has been uncommon in Ethiopia.⁴⁴ A systematic review in Ethiopia in 2020 identified weak selection, quantification, procurement, and stock control and management; delays in the purchasing procedure; and unpredictable service demand or patient flow as the prevailing logistics challenges.⁴⁵ To address this gap in the FP/RH service delivery system, the Activity enhanced the capacity of personnel involved in FP/RH service delivery. The planning exercise increased the availability of reliable facility-level performance data to produce quality reports and prepare efficient logistics and financial plans for FP/RH services. The exercise addressed supply chain challenges in the intervention areas of the Activity in all regions.

⁴¹ Katz, "Framework and Guideline." Banteyerga, Hailom, Akililu Kidanu, Sara Bennett, and Kate Stillman. "The System-Wide Effects of the Global Fund in Ethiopia: Baseline Study." Washington, DC, USA: USAID, October 2005.

⁴² Alem Getie, Girma. "Assessment of Factors Affecting Turnover Intention Among Nurses Working at Governmental Health Care Institutions in East Gojjam, Amhara Region, Ethiopia, 2013." *American Journal of Nursing Science* 4, no. 3 (2015): 107. <https://doi.org/10.11648/j.ajns.20150403.19>. Assefa, Yibeltal, Yalemzewod Assefa Gelaw, Peter S. Hill, Belaynew Wassie Taye, and Wim Van Damme. "Community Health Extension Program of Ethiopia, 2003–2018: Successes and Challenges toward Universal Coverage for Primary Healthcare Services." *Globalization and Health* 15, no. 1 (December 2019): 24. <https://doi.org/10.1186/s12992-019-0470-1>. Gesesew, Hailay Abrha, Bosena Tebeje, Fessahaye Alemseged, and Waju Beyene. "Health Workforce Acquisition, Retention and Turnover in Southwest Ethiopian Health Institutions." *Ethiopian Journal of Health Sciences* 26, no. 4 (July 14, 2016): 331. <https://doi.org/10.4314/ejhs.v26i4.5>.

⁴³ Asnake, "Addressing Unmet Need." "Implanon Insertion Training Evaluation Report." Addis Ababa, Ethiopia: Federal MOH of Ethiopia, 2012. Kebede, Fikreab, Keneni Gutema, Abyot Asres, Tana Wuliji, and Emily Lanford. "Rapid Assessment of the Health Worker In-Service Training Situation in Ethiopia: Survey of Training Program Provider Practices and Key Informant Interviews." Bethesda, MD, USA: University Research Co., LLC (URC), 2014.

⁴⁴ Chanyalew, "Routine Health Information System." Tilahun, "How Can the Use of Data."

⁴⁵ Mohammed, Solomon Ahmed, Haile Yirga Mengesha, Abel Demerew Hailu, and Yohannes Shumet Yimer. "Integrated Pharmaceutical Logistic System in Ethiopia: Systematic Review of Challenges and Prospects." *Journal of Biology and Medicine* 1, no. 2 (November 7, 2020): 113.

According to the costed implementation plan, Ethiopia’s limited financial commitments are not commensurate with need.⁴⁶ The planning exercise improved the basic planning skills of health-system managers, yielding the following changes in health financing and management:

- Managers owned the planning process, building trust and confidence within the health system;
- The exercise fostered understanding of the importance of teamwork among individuals with different roles and responsibilities involved in the same activities but working separately;
- Facility- and woreda-level managers made data-based estimates for FP/RH budget needs;
- Facility- and woreda-level managers knew the estimates of supplies and FP commodities; and
- Decision makers preferred budgets prepared with service data over those based on estimates.

Table 13. System-wide Effect of Planning Exercise and Ownership Orientation Workshop

Interventions	Strengths	Challenges	Recommendations
Package of FP/RH activities: <ul style="list-style-type: none"> • Ownership orientation • Facility assessment, gap identification & analysis • Training on organizing a package of FP/RH activities • Facility-led trainings • Provision of integrated backup LARC services to communities • FP-service integration 	<ul style="list-style-type: none"> • Availability of all expected FP/RH services • Increased service access • HCs ownership & sustainability of services 	None	Implement package of FP/RH activities across woreda FP/RH care system as a strategy to ensure locally-owned, sustainable, quality, & equitable FP/RH services at the PHC level.
Exercise for planning FP/RH services using routine service data	<ul style="list-style-type: none"> • Data-based information • Reliable service performance data • Quality reporting • Use of data for logistic & financial planning of FP/RH services 	Not all components of the exercise were practiced in facilities (service coverage, supply quantification, procurement & distribution plan, woreda-level supply estimation & budget)	<ul style="list-style-type: none"> • Advocate/recommend this intervention to MOH for HSS. • The tools and guidelines used in the planning exercise might need revision, expert review, and integration with similar planning programs by MOH.
Use of routine service data for planning and logistics management	Efficient resource use & reduced supply & commodity shortage & wastage	FP commodity distribution is dependent on the entire supply system	Provide FP commodities annually or biannually according the estimated demand of a facility.
Use of routine service data for cost estimation for quantified items & preparation of budget & procurement plan for FP/RH services	Improved budget formulation & promoted budget allocation for FP/RH services	None	
Workplace (onsite) Implanon insertion training of HEWs	<ul style="list-style-type: none"> • Ensured availability of skilled HEWs • Community-level FP service continuity • Sustainable program 	None	<ul style="list-style-type: none"> • Alternative to offsite training • Could be expanded to all PHCUs for FP and other health services provided at HPs
Integrated backup LARC service support from HCs to communities	<ul style="list-style-type: none"> • Community access to all expected FP services • Public-sector ownership 	None	Initiate the intervention in all PHCHs as part of strategy for FP service expansion to rural communities

⁴⁶ “Costed Implementation Plan for Family Planning in Ethiopia, 2015/16-2020.” MOH of Ethiopia, 2016.

Table 14. Key Informants' Response to Questions on HSS Interventions

	Questions for key informants, organized by health system building blocks	Responses (n=77)			Summary of reasons for 'yes' responses
		Yes	Somewhat	No	
	HIS				
Q1	Are FP/RH service data used for budget planning and supply quantification?	69	8	0	Good planning, consistency, efficient use of resources
	SERVICE DELIVERY				
Q2	Did service access improve after planning exercise and ownership orientation on FP/RH?	73	4	0	Clients shifted from short- to long-acting methods, service mix increased
	PROCUREMENT AND SUPPLY CHAIN MANAGEMENT				
Q3	Did procurement and distribution of supplies for FP/RH services improve after planning exercise?	73	4	0	PHCU reviewed service data to plan for needs, make timely procurement requests, and report supply and follow-up. EPSA response to supply requests improved, wastage minimized
	HEALTH WORKFORCE				
Q4	Did onsite training improve availability of HEWs and ensure service continuity at the HP level?	77	0	0	Cost-effective, responsive, minimized disruption of HP services, enhanced local capacity and self-confidence, increased responsibility, improved service accessibility and continuity
	HEALTH FINANCING				
Q5	Did the government allocate budget for FP/RH after planning exercise and ownership orientation on FP/RH?	56	10	11	Budget shortage remained a challenge, no specific budget allocated
Q6	Did quality of budget formulation improve after the planning exercise?	53	14	9	Not fully implemented because of high staff turnover
Q7	Did the planning exercise on FP/RH promote more efficient spending of public resources?	70	7	0	Requests were demand-based. We planned what we needed, quantified use of supplies, and eliminated wastage.
	Management and organization				
Q8	Did planning exercise and ownership orientation on FP/RH promote public-sector ownership and service sustainability?	74	3	0	It became the core part of the government's program and increased confidence of the public-sector staff. The backup visit schedule and the follow-up activities are being integrated into the existing health care system.
Q9	Was onsite training of HEWs by HC a good approach that the public sector should consider including in the national training system?	71	6	0	Cost-effective, promoted ownership and sustainability by improving local capacity, increased service uptake, minimum interruption of services at the PHCUs, unlike offsite training
Q10	Should integrated backup LARC support to HPs from the HCs be considered by policy makers for inclusion in the national FP service expansion approach?	75	2	0	Cost-effective, locally led, integrated into the system, ensures sustainable service access and availability at the community level

Table 15. Observations During Quantitative Data Collection at the 16 PHCUs

Observations	Response	
	Yes	No
Service data-based planning		
Quantified list of supplies for each FP/RH service in the HC prepared using service data	13	3
Procurement plan and budget for FP/RH services in the HC prepared using service data	13	3
Supplies and FP commodity distribution plan for FP/RH services in the HC prepared using service data	13	3
HCs able to provide onsite LARC-Implanon insertion training for HEWs		
HC received training materials for Implanon training (tabletop PowerPoint presentations, arm models, training monitoring tools)	15	1
Established team of Implanon insertion trainers from the HCs	15	1
HC organized and provided the Implanon insertion training to HEWs under the PHCU using the training materials and trainer team	15	1
Integrated backup LARC (FP outreach) service support from HCs to communities		
Established a backup LARC support visit to the community from the HC	16	0
Regular visit schedule and registered clients served through integrated backup LARC support	16	0

Conclusions, Recommendations, and the Way Forward

The implementation experiences of USAID: Transform Primary Health Care Activity demonstrated that investing in packages of activities across a woreda FP/RH care system tackles prevailing challenges holistically rather than focusing on a single activity to resolve a specific challenge. This approach to support the public sector ensured system-level ownership, sustainability, and access to equitable, quality FP/RH services at all health facilities in all woredas where the Activity was implemented. It allowed personnel at all levels to acquire basic skills to identify gaps, use routine service data for planning, and manage new initiatives through integration into the existing system. In general, when partners design FP/RH programs to support the public sector, investment across the woreda care system is recommended over focusing on a single activity. The Activity is planning to organize a workshop to disseminate the findings of this evaluation to MOH, RHB, ZHDs, and WorHOs, including health facility managers.

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