



USAID
FROM THE AMERICAN PEOPLE

ETHIOPIA

TRANSFORM MONITORING, EVALUATION, LEARNING AND ADAPTING (TRANSFORM MELA) ACTIVITY

FINAL PERFORMANCE EVALUATION TRANSFORM: PRIMARY HEALTH CARE (PHC) ACTIVITY

Submission Date: August 19, 2022
Revised Version: September 9, 2022
Final Version: November 1, 2022

USAID/Ethiopia
Submitted to:
Gebeyehu Abelti, COR

Submitted by:
The Mitchell Group, Inc. (TMG)
Contract Number: OAA-I-15-00028 Task Order No.: AID-663-TO-17-00001
Transform MELA Activity, Addis Ababa, Ethiopia

Michael Midling, PhD, Chief of Party/Principal Investigator
Email: mmidling@ethiopiadmela.com
Phone: +251-986356914

Principal Contacts:
Abi Fasosin, Senior Advisor
Email: abif@the-mitchellgroup.com
Phone: +001-202-557-9412 (Direct)

This document was produced for review by the United States Agency for International Development Ethiopia (USAID/Ethiopia). It was prepared by The Mitchell Group, Inc. (TMG) for USAID/Ethiopia for the "Transform Monitoring, Evaluation, Learning, and Adapting (Transform MELA) Activity."

ACTIVITY INFORMATION

Activity Title	TRANSFORM MONITORING, EVALUATION, LEARNING AND ADAPTING (TRANSFORM MELA): ACTIVITY
Contract/Task Order Numbers	Contract No.: OAA-I-15-00028 Task Order No.: AID-663-TO-17-00001
Name of Prime Implementing Partner	The Mitchell Group, Inc. (TMG) 1816 11th Street, NW, Washington, DC 20001 Tel: 202-745-1919
Activity Start Date	March 7, 2017
Activity End Date	August 31, 2022
Period of Planning and Conducting the Evaluations	September 1, 2021 – August 31, 2022

TABLE OF CONTENTS

ACRONYMS AND ABBREVIATIONS	i
ABSTRACT	1
1) EXECUTIVE SUMMARY	1
2) BACKGROUND AND CONTEXT	5
Activity Background	5
3) EVALUATION PURPOSE AND EVALUATION QUESTIONS	6
Evaluation Purpose	6
Evaluation Questions	7
Audience and Intended Uses	7
4) EVALUATION METHODS, ETHICAL CONSIDERATIONS AND LIMITATIONS	7
4.1. Sampling of Woredas	7
4.2. Sampling of Households	8
4.3 Sampling For the Health Facility survey	8
4.4 Selection of Key Informants	9
4.5. Data Collection Methods	9
4.6 Data Analysis	10
4.6 Ethical considerations	11
4.7 Limitations	12
5) FINDINGS	12
5.1 How effective were Transform approaches in contributing to improving MNCH/FP outcomes?	13
5.1.1 Were Transform activities implemented as planned? If not, why not?.....	14
5.1.2 To what extent did the activity improve MNCH/PH outcomes and reduce inequities in different groups and intervention areas?	14
Family planning performance	15
Maternal health performance	17
Newborn health performance	19
Child health performance	20
5.1.3 What interventions are replicable or can be scaled up in different settings? ..	29
5.1.4 What is the effect of context (conflict, COVID-19 pandemic, internal displacement) on the Transform interventions and achievements?	30
5.2 How and to what extent did transform program activities facilitate local ownership, sustainability and coherence?	32

5.2.1	What mechanisms are in place to ensure government ownership of Transform health system interventions?	32
5.2.2	To what extent did the government staff perceive that the approaches established by the project will be sustained by the government and continue to sustain improvements?	34
5.2.3	To what extent did the project improve community involvement and its role in accountability, transparency in decision-making, and advocacy for community health needs?	35
5.2.4	To what extent did the project improve community engagement for advocacy and health service oversight? What capacity for community engagement did Transform build?	35
5.2.5	How does TPHC coordinate with other development partners and their activities?	36
5.3	How did the activity consider gender dynamics in implementation?	37
5.3.1.	To what extent did the government staff/people perceive that the project established processes are functional to track and address gender and inequitable health outcomes?	39
5.3.2.	What gender equity results did Transform Program Activities' interventions achieve?	40
5.3.3.	What gaps exist in the current USAID/ Transform intervention design/programming in terms of addressing the key gender issues in the targeted regions of Ethiopia?	40
5.4	Indicator Trends at Baseline, Midline, and Endline	41
5.5	How and to what extent has the Transform IP been able to adapt their interventions about learnings and new evidence?	41
5.5.2.	How did respondents perceive that these adaptations contributed to MNCH/FP outcomes?	44
5.5.3.	What lessons were learned for project future design, management, and monitoring?	44
6)	CONCLUSIONS	45
7)	RECOMMENDATIONS	46
	ANNEXES	50
	ANNEX 1. EVALUATION QUESTIONS AND DATA SOURCES	50
	ANNEX 2. DETAILED EVALUATION METHODS	52
	ANNEX 3. DATA ANALYSIS	56
	ANNEX 4. PHC TRANSFORM ACTIVITY RESULTS FRAMEWORK	57
	ANNEX 5. GLOSSARY OF TERMS	58

List of Table and Figures

List of Tables

Table 1: Coverage of Transform PHC Activity by Region.....	6
Table 4: Summary of Activity Performance by Key Performance Indicators.....	13
Table 5: Family planning program performance at baseline and endline by region.	15
Table 6: Maternal health program performance outcomes at baseline and endline.....	18
Table 7: Newborn health performance at baseline and endline by region.....	19
Table 8: Baseline and endline comparison of child health indicators by region.....	21
Table 9: Percentage of sampled health facilities that reported performing each BEmONC Signal function on the day of the survey.....	23
Table 10: Percentage of key adolescent and youth health interventions reported to be provided in sampled facilities.....	24
Table 11: Sub-grants by health facility and year in Kembata and Halaba Zone (in Ethiopian Birr – ETB).	28
Table 12: Baseline and endline comparison of gender indicators by region.....	38

List of Figures

Figure 1: Family planning program performance at baseline and endline, and LOA target (Top) and performance trend (bottom) in Transform PHC intervention areas.....	15
Figure 2: Reported stockouts of FP commodities in transform PHC intervention and non-transform intervention three months prior to the survey.....	16
Figure 3: Baseline and endline comparison of FP services by intervention and non-intervention areas.	16
Figure 4: Maternal health outcomes at baseline and endline with LOA targets (Top) and performance trend (Bottom) in Transform PHC intervention areas.	17
Figure 6: SBA, early PNC, and ITN outcomes at baseline and endline by Transform intervention and non-Transform intervention areas.	18
Figure 7: Newborn health outcomes at baseline and endline with LOA targets (Top) and performance trend (bottom) in Transform PHC intervention areas.....	19
Figure 8: Newborn health performance outcomes at baseline and endline by transform intervention and non-transform intervention areas.....	20
Figure 9: Skill lab in SNNP.....	20
Figure 10: Expanded Program on Immunization and Vitamin A supplementation at baseline and endline with LOA targets (top) and full immunization performance trend (bottom) in Transform PHC intervention areas.....	20
Figure 11: Baseline, endline and LOA comparison of access to preventive and curative childhood illness treatment (top) and performance trend (bottom) in Transform intervention areas.	21
Figure 12: Child immunization performance outcomes at baseline and endline by intervention and non-intervention areas.	22
Figure 13: Child health performance outcomes at baseline and endline by intervention and non-intervention areas.....	22
Figure 14: Comparison of available adolescent and youth health services in intervention and non-intervention areas.....	24
Figure 15: Number of health workers who received training provided by the transform program by thematic area (Source: TPHC training report).....	25
Figure 16: CBHI enrollment at baseline and endline by region.	28
Figure 17: Health facility performance in Transform PHC intervention areas.....	29
Figure 18: Baseline and endline comparison of selected gender-related indicators.....	37
Figure 19: Percent of Transform PHC intervention and non-transform intervention health facilities providing specific GBV services at the time of the survey.	39
Figure 20: Indicator trends at baseline, midline, and endline	41

ACRONYMS AND ABBREVIATIONS

ANC	Antenatal Care
ARI	Acute Respiratory Infection
BEmONC	Basic Emergency Obstetric and Newborn Care
CBHI	Community-Based Health Insurance
CBNC	Community Based Newborn Care
COR	Contracting Officer's Representatives
CPR	Contraceptive Prevalence Rate
CRC	Compassionate and Respectful Care
CSC	Community Score Card
DHSI2	District Health
EHCRIg	Ethiopian Health Center Reform Implementation Guidelines
EHSIG	Ethiopian Hospital Services Transformation Guidelines
EPCMD	Ending Preventable Child and Maternal Deaths
EPHI	Ethiopian Public Health Institute
EQs	Evaluation Questions
FP	Family Planning
GBV	Gender Based Violence
GIA	Greatest Impact Analysis
GIS	Geographic Information Systems
GOE	Government of Ethiopia
HC	Health Center
HDR	Health in Developing Regions
HF	Health Facility
HH	Household
HMIS	Health Management Information System
HP	Health Post
HSTP	Health Sector Transformation Plan
iCCM	Integrated Community Case Management
ICMNCI	Integrated Community management of Newborn and Childhood Illnesses
IFS	iron-folic acid supplementation
IMNCI	Integrated management of Newborn and Childhood Illnesses
IP	Implementing Partner
IRB	Internal Review Board
ISS	Integrated supportive supervision
KI	Key Informant
KII	Key Informant Interview
KPI	Key Performance Indicators
LAFP	Long-Acting Family Planning
LMG	Leadership, management, and governance
LOA	Life of Activity
MELA	Monitoring, Evaluation, Learning, and Adapting
M&E	Monitoring and Evaluation
L6Ms	Last 6 Months
L2Ws	Last 2 Weeks
MCPR	Modern Contraceptive Prevalence Rate
MCV	Measles coverage
MNCH/FP	Maternal, Newborn, Child Health, and Family Planning
MOH	Ministry of Health
NGO	Non-Governmental Organization
NICU	Newborn intensive care unit

OR	Operational Research
ORS	Oral Rehydration Salts
PCMD	Preventing Child and Maternal Deaths
PHC	Primary Health Care
PHCU	Primary Health Care Unit
PPFP	Post-Partum Family Planning
PMP	Performance Management Plan
RH	Reproductive Health
RHB	Regional Health Bureau
RMNCH	Reproductive, Maternal, Newborn, and Child Health
SBA	Skilled Birth Attendant
SDG	Sustainable Development Goal
SNNPR	Southern Nations, Nationalities, and People's Region
TMG	The Mitchell Group, Inc.
TPHC	Transform Primary Health Care
USAID	United States Agency for International Development
USG	United States Government
WHO	World Health Organization
WorHO	Woreda (district) Health Office
WMS	Woreda Management Standards
ZHD	Zonal Health Department

ABSTRACT

The final performance evaluation of the Transform Primary Health Care (TPHC) activity was conducted to assess achievement of results and inform the design of future activities. The evaluation was designed to answer questions of effectiveness and quality of the continuum of care, ownership, sustainability and coherence, gender dynamics and learning and adaptive management. The results showed that the activity implemented effective interventions such as woreda twinning, FP program planning, skills labs and V-Scans, leadership management training, sub-granting, coaching and mentoring, “Her Space” program, community-based health insurance (CBHI) enrollment, etc. Most health outcomes have declined after the mid-term and marked regional difference persist, and the activity did not meet most of its end of activity targets, largely due to contextual factors, especially conflict and Covid, and systemic weaknesses beyond the scope of the activity (stockouts of commodities, high staff turnover, etc.). However, declines were worse in non-Transform intervention areas, indicating that the Transform program likely prevented greater deterioration as measured by key performance indicators.” The findings also indicate the need for concerted and continued health systems strengthening interventions that support the Ministry of Health (MOH) to improve human resource management and retention, reinforce coordination of all development partners and revitalize and restore community-based health programs and “last mile” logistics. Gains were achieved in supporting twinned woredas, but further work is necessary to implement improvements and conduct operational research to sort out bottlenecks in service delivery and ensure the continuum of care. USAID/Ethiopia was recommended to continue supporting community-based behavior change interventions and to revisit facility-based target setting to increase the number of woredas that demonstrate to sustainably deliver quality MNCH/FP services through an efficient network of hospitals, health centers and restored health posts in alignment with health system goals.

1) EXECUTIVE SUMMARY

Background

The final performance evaluation of the Transform Primary Health Care (TPHC) activity was conducted from May to August 2022. The purpose of the evaluation was to measure achievements of Transform PHC in terms of its Activity-level results framework, to explore underlying reasons for achievement, assess inhibiting factors that caused non-achievement of anticipated results, as well as to review intervention approaches used by the implementing partner (IP). The performance evaluation contributed to evaluate the impact of the entire Transform program, which included two other PHC activities and the Transform Monitoring, Evaluation, Learning and Adaptation (MELA) that conducted the evaluations, and inform USAID/Ethiopia’s decisions related to future investment in supporting MNCH/FP interventions.

TPHC was designed to improve PHC outcomes in almost all zones and 434 intervention woredas in four regions: Amhara, Oromia, Southern Nations, Nationalities and People’s Region (SNNPR) and Tigray. Due to recent unrest in Tigray, the performance evaluation did not include this region. TPHC was to achieve four intermediate results:

- 1) Improved management and performance of health systems.
- 2) Increased sustainable quality of service delivery across the primary health care unit’s continuum of care.
- 3) Improved household and community health practices and health-seeking behavior.
- 4) Enhanced program learning, and impact policy and programming related to preventing child and maternal deaths (PCMD).

Evaluation Methodology

The evaluation used a pre-post cross-sectional design that compared endline performance to baseline and midline, regional and intervention and non-intervention areas performance to answer four questions:

1. How effective were the Transform PHC Activity approaches in contributing to improving maternal, newborn, child health, and family planning (MNCH/FP) outcomes? What were the drivers of the observed changes? What constraints affected the achievements?
2. How and to what extent did Transform PHC Activity facilitate local ownership, sustainability, and coherence?
3. How did Transform PHC consider gender dynamics in activity design and implementation?
4. How and to what extent has the Transform IP been able to adapt their interventions in response to learnings and new evidence?

Quantitative and qualitative mixed data collection methods used in the evaluation included: a household survey of 2,703 randomly selected households in 80 intervention woredas and 692 households in 23 non-intervention woredas; a health facility survey of 181 health facilities in intervention areas and 49 facilities in non-intervention areas; review of activity documents developed in the life of the activity; and key informant interviews with selected stakeholders at USAID/Ethiopia, Ministry of Health (MOH), Regional Health Bureaus (RHBs), Zonal Health Departments (ZHD) and Woreda Health Offices (WorHO).

Performance was measured in terms of the activity's results in the following technical areas: family planning, maternal health, newborn health, child health and immunization, and adolescent and youth health. Activity interventions were evaluated for their effectiveness to improve outcomes as well: communication of MNCH/FP messages, behavior change and treatment seeking practices, women's participation in decision-making, community-based health insurance, woreda twinning and quality improvement, leadership, management and governance training and coaching, and use of information and lessons to adapt and improve.

Findings

Overall performance declined after midterm for most performance outcomes and few life of activity (LOA) targets were met. Several factors explained the decline, most notably conflict and Covid-19. Performance is presented below by technical area.

- **Family Planning.** Long-acting FP was the only outcome that increased slightly from baseline (from 11.8 to 12.7%) and whose LOA target was met. After having increased at midline, modern contraceptive prevalence rate (MCPR) and postpartum family planning (PPFP) indicators declined in both intervention and non-intervention areas, though no difference was statistically significant. There were differences by region but no significant differences between intervention and non-intervention woredas. Interviewed women reported being turned away from facilities due to lack of FP commodities or of trained providers. They also reported wanting to have more children, religious restrictions, fear of side effects and partner refusal as reasons for non-use.
- **Maternal Health.** Except for early antenatal care (ANC) and skilled birth attendance (SBA), the performance of all the other maternal health indicators declined, and no LOA target was met. ANC4+ has declined from baseline and even more after midline indicating the difficulties in ensuring continuity of care in the intervention woredas. There were differences by region, with Oromia and SNNP showing improvement in the implementation of essential components of ANC. Early ANC improved in both intervention and non-intervention areas. SBA increased in intervention areas and declined in non-intervention. All other indicators declined in both. No difference was statistically significant. KIs reported the following reasons for the decline: conflict, COVID, weak community health program, high leadership turnover, long distance to facilities, lack of counseling, and mothers' beliefs they do not need to go to a health facility if they feel well.
- **Newborn Health.** All the four performance indicators (essential newborn care, early PNC for newborns, exclusive breast feeding and early breastfeeding) improved from baseline, but when compared to midline, only exclusive breastfeeding improved from midline, while other indicators declined. No LOA targets were met, though. Regional differences showed Amhara had the lowest performance. Newborn health outcomes have increased in both intervention and non-

intervention areas, except exclusive breastfeeding that declined in non-Transform intervention areas. This difference was statistically significant ($p = 0.01$).

- **BEmONC.** More health facilities in intervention areas provide all Basic Emergency Obstetric and Newborn Care (BEmONC) signal functions than health facilities in non-intervention areas. Except for parenteral oxytocin and antibiotics administration, other BEmONC signal functions are provided in more health facilities in intervention than non-intervention areas
- **Child Health.** Measles coverage and Vitamin A supplementation increased significantly ($p < 0.001$) in both intervention and non-intervention areas. However, full vaccination has significantly declined ($p < 0.001$) to 26.8% in intervention areas, even more after midterm. No LOA targets were met except for Vitamin A supplementation in all regions except for Penta 3 that increased in Oromia and SNNP and markedly decreased more than 20 percentage points in Amhara.
- Deworming and ARI treatment with antibiotics have increased significantly ($p < 0.001$) in both intervention and non-intervention areas. Fever treatment within 24 hours of onset declined significantly ($p < 0.001$). Diarrhea treatment decreased in SNNP which is a concern because its incidence increased from baseline. Only the deworming LOA target was met, which had a marked increase after midterm.
- **Gender.** Overall, higher percentage of health facilities in Transform PHC intervention areas provide different types of gender-based violence (GBV) services than non-Transform intervention areas. The proportion of women accompanied by their spouses during delivery increased slightly, while being accompanied for ANC declined. Women participation in health care decision making and women accompanied by their spouses during ANC showed a statistically significant decline ($p < 0.001$) from baseline and more when compared to the midterm. No LOA targets were met. There were no statistically significant differences between intervention and non-intervention areas.
- **Adolescent and Youth Health.** Overall, a higher proportion of health facilities intervention areas provide adolescent and youth friendly services than non-intervention areas. About one out of four surveyed facilities in intervention areas provide all adolescent and youth friendly service components, while only one in ten did in non-intervention areas.
- **Community-based health insurance (CBHI).** Households' enrollment in CBHI significantly increased ($P < 0.001$) and the LOA target was surpassed at endline. Enrollment increased in both intervention and non-intervention areas and there was no statistically significant difference.
- **Quality improvement.** At the endline, 59.2% of the sampled facilities had a performance score of greater than 80% as per the Ethiopian Hospital Services Transformation Guidelines/Ethiopian Health Center Reform Implementation Guidelines (EHSTG/EHCRIG) and implementation of quality improvement plan of health facilities was 74.8%, which exceeded the respective LOA targets.
- **Ownership, Sustainability and Coherence.** TPHC was reported to have improved ownership through several interventions, namely leadership, management and governance (LMG) training, quality improvement interventions; improved planning and budgeting, especially for family planning; and woreda twinning and sub-granting.
- **Learning and Use of Evidence.** TPHC implemented the midterm evaluation recommendations and conducted research to inform policies and intervention design and implementation. "For example, the activity conducted research to integrate post-partum FP services in maternity waiting homes and explored ways to improve quality of care."

Conclusions

Contextual factors, particularly conflict and Covid-19 affected the capacity of the activity to achieve its LOA targets, as evidenced by the decline in achievements since the midterm. Despite these challenges, the final evaluation demonstrated that TPHC has improved early ANC and skilled birth attendance, long-acting FP, measles vaccination and vitamin A supplementation. It also established innovative processes, such as twinning woredas and FP program planning; helped to improve the functioning of regional public health systems and programs; and strengthened the leadership, management, and governance skills of staff in selected woredas and facilities. TPHC also

demonstrated an iterative learning program that, among other results, helped expand CBHI and inform policy and programming.

The Activity achieved these results through a combination of technical support interventions to the public health system. The interventions included: establishing skill labs; provision of on-the-job training, mentoring, and coaching; post training follow-up visits and supervision; provision of equipment and supplies; and sub-grants. TPHC's technical support was reported to have improved quality and thereby increased coverage of high impact health interventions. However, despite a wide range of such interventions, lack of optimum quality is still a roadblock to the consistent delivery of MNCH/FP services. As described below, and likely due to contextual headwinds, household and community health practices and health-seeking behaviors declined, and continuity of MNCH/FP services remains a challenge.

Gender outcomes were generally positive but require further efforts. As a positive outcome, the availability of post GBV interventions increased at health facilities supported by intervention when compared to non-intervention areas. The activity was also able to increase the availability and range of adolescent and youth health services. However, the utilization rate and impact of such services on gender inequalities, such as early marriage and early pregnancy, requires further study.

Recommendations

Recommendations for the Ministry of Health

- Reinforce coordination of development partners to effectively implement woreda transformation.
- Revitalize community health programs.
- Assess woreda and health facility twinning partnership bottlenecks and make path correction measures before scale-up.
- Integrate FP counseling across all contacts in the continuum of care.
- Commission supplemental operational research to explore the underlying factors contributing to the decline in performance of selected key performance indicators, such as ANC4+, which has been declining since baseline.
- Add and retain additional health facility personnel to ensure consistent provision of services, especially in difficult-to-reach areas.

Recommendations for USAID

- Continue support for innovative approaches on social and behavior communication change to bring sustained behavioral change within MNCH/FP practices.
- Revisit target setting methodology and assumptions and ensure performance is monitored continuously by a third party for course correction and target adjustments.
- Reinforce leadership capacity building.
- Develop a dual health system strengthening strategy that continues support for the Health Sector Transformation Plan and implements a recovery strategy to build resilience in conflict zones.
- Strengthen support for health posts and health centers with additional supplies and equipment.
- Improve ownership, sustainability, and coherence by providing specific metrics to progressively demonstrate ownership by woredas and facilities.
- Continue support for participatory learning and adapting to address ongoing challenges within the health system.

Recommendations for the current TPHC activity

Given that this is the final evaluation of the TPHC activity, the recommendation to the IP is to ensure the effective transfer and handover of its research reports, tools and training manuals to all its GOE counterparts.

2) BACKGROUND AND CONTEXT

This is the report of the final performance evaluation of the Primary Health Care Transform Activity (Transform PHC). In 2017, USAID/Ethiopia launched the Transform Program, a five-year (2017–2021) integrated reproductive, maternal, newborn, and child health (RMNCH) and water, sanitation and hygiene (WASH) program to reduce maternal and child morbidity and mortality in Ethiopia. The Transform Program operated across ten regions in Ethiopia and comprised three Activities: Transform PHC, Transform Health in Developing Regions (HDR), and Transform Water, Sanitation, and Hygiene (WASH).¹

In 2017, USAID/Ethiopia also awarded a contract to The Mitchell Group, Inc. (TMG) to implement the Transform Monitoring, Evaluation, Learning, and Adapting (MELA) Activity. The role of Transform MELA was to provide and synthesize high-quality Monitoring and Evaluation (M&E) data for the activities, USAID/Ethiopia, and the Ministry of Health (MOH) of Ethiopia and to guide them in learning and adaptive health system management. As part of its contract, Transform MELA also conducted the baseline, midline and now the final performance evaluation of the Transform PHC and Transform HDR Activities, the Transform Program Impact Evaluation, and the development of selected case studies to document important lessons learned that highlight the contribution of the Transform program. The evaluations took place from May to August 2022. The WASH activity was not included in the final evaluations. Annex 5 presents a glossary of the definitions used in all the Transform evaluations. This report outlines the objectives and methods to conduct the final performance evaluation of the Transform PHC activity, and it presents the findings, conclusions, and recommendations for sustaining current performance and for the future improvement of Primary Health Care (PHC) programs in Ethiopia.

ACTIVITY BACKGROUND

The Transform PHC (TPHC) Activity was implemented by Pathfinder International (prime), John Snow International, Encompass, Abt. Associate, Ethiopian Midwife Association, and Malaria Consortium. TPHC aimed to contribute to preventing child and maternal deaths (PCMD) through supporting the implementation of the Health Sector Transformation Plan (HSTP)-Government of Ethiopia (GOE) at different levels of the health system. Annex 4 presents the results framework for this activity and reflects the theory of change that the Activity was designed to implement. By supporting the GOE's strategic initiatives, TPHC aimed to achieve four high-level intermediate results (IRs):

- 1) Improved management and performance of health systems.
- 2) Increased sustainable quality of service delivery across the primary health care unit's (PHCU) continuum of care.
- 3) Improved household (HH) and community health practices and health-seeking behavior.
- 4) Enhanced program learning, and impact policy and programming related to PCMD.

Maternal newborn, child health and family planning (MNCH/FP), reproductive health (RH), and malaria represented the primary intervention areas of Transform PHC. The activity operated in five major regions in the country– Amhara, Oromia, Southern Nations, Nationalities, and People (SNNP),

¹ Beginning from September 2021, the Transform program is being implemented in ten regions. This evaluation however will not include a separate analysis for the newly formed South-West Ethiopia region.

Sidama, and Tigray – and targeted a total of 434 woredas over the five-year lifespan of the program.² Woredas in Tigray were not included in the evaluation due to security reasons. Table I presents the coverage of the Transform PHC activity in the evaluated regions, representing a total sampling frame of 381 woredas:

Table I: Coverage of Transform PHC Activity by Region

Regions	Intervention Woredas		Total Woredas in Each Region	Percent of woredas covered by Transform
	Start	End		
Amhara	76	94	143	66
Oromia	133	162	325	50
SNNP	98	111	186	60
Sidama	13	14	37	38
Tigray	17	53	88	60
Total	337	434	691	63

Throughout the life of the activity, TPHC implemented several interventions to assist and support the MOH and its regional health bureaus—RHBs to improve MNCH/FP outcomes. TPHC was designed to support the institutionalization of health care quality; to implement performance standards at different levels of the health system, and for various health service performance improvement initiatives, to strengthen public financial management and health management information systems (HMIS); to build the capacity of the health workforce; and to provide medical equipment and supplies.

3) EVALUATION PURPOSE AND EVALUATION QUESTIONS

EVALUATION PURPOSE

The final performance evaluation of the Transform PHC Activity was intended to inform USAID/Ethiopia’s decisions related to future investment in supporting MNCH/FP interventions. The purpose of the evaluation was to measure achievements of Transform PHC in terms of its Activity-level results framework (see results framework in Annex 4) and explore associated underlying reasons for achievement or non-achievement of anticipated results, as well as to review intervention approaches used by the implementing partner (IP).

The evaluation assessed the degree to which the IP proactively adapted to contextual changes during the intervention period. In addition, the evaluation report documents lessons learned and best practices—incorporating illustrative vignettes on selected case studies based on field visits—to inform the future programming of similar program activities by USAID/Ethiopia. The evaluation also assessed factors that contributed to the observed results and those which may have inhibited achievement, focusing on the following key areas:

- **Effectiveness**, which is defined as the extent to which the interventions achieved their objectives and activity results.
- **Gender equity**, which is defined as fairness of treatment for women and men, according to their respective needs.
- **Adaptive management**, which is defined as an intentional approach to making decisions and adjustments in response to new information and changes in context.

² The number of target woredas increased from 360 in the second year to 434 (including Tigray =53 woredas) in the final year due to administrative re-structuring.

- **Sustainability**, which is defined as the extent to which interventions and their benefits will continue beyond the life of the program.

EVALUATION QUESTIONS

The performance evaluation answered the following questions related to Activity performance:

1. How effective were the Transform PHC Activity approaches in contributing to improving MNCH/FP outcomes? What were the drivers of the observed changes? What constraints affected the achievements?
2. How and to what extent did Transform PHC Activity facilitate local ownership, sustainability, and coherence?
3. How did Transform PHC consider gender dynamics in activity design and implementation?
4. How and to what extent has the Transform IP been able to adapt their interventions in response to learnings and new evidence?

Specific sub-questions were identified under each key EQs as presented in Annex I. The Impact Evaluation of the Transform program ascertained the extent to which the Activity improved MNCH/FP outcomes in Transform intervention woredas compared to non-Transform intervention woredas (see the Impact Evaluation Report 2022). The impact of the overall Transform Program is addressed in a separate impact report.

AUDIENCE AND INTENDED USES

The audiences of this final evaluation report are USAID/Ethiopia, specifically the Health Office, MOH authorities, RHBs and other country-level partners, and healthcare providers. For these audiences, the report also provides documented evidence of the lessons learned and best practices that can inform new policies and MNCH/FP programs.

4) EVALUATION METHODS, ETHICAL CONSIDERATIONS AND LIMITATIONS

4.1. SAMPLING OF WOREDAS

All regions were included, except Tigray, and a purposive sample of zones and woredas was developed to gather qualitative data. Quantitative data were also collected in all visited zones. In order to measure the effectiveness of the TPHC interventions, woredas were selected based on their performance classification as high, moderate, or low³ performing, using the results of the Greatest Impact Assessment (GIA) which used MNCH/FP performance indicators from HMIS 2016 and that has been used for high level monitoring.⁴ The reason for using the GIA was to categorize woredas based on their recent RMNCH performance data and prioritize woredas where the results of the PHC interventions could be evaluated.

Simple random sampling was used to select woredas in the TPHC targeted regions with other development partner intervention data in the five selected MNCH/FP thematic areas; that is, maternal

³ Coverage greater or equal to 80% is high; coverage 60% to 79% is moderate; and coverage < 60 % is low.

⁴ Source: USAID GIA analysis summary (2016). Transform MELA used the woreda performance categorization in the GIA analysis to ensure that there will not be sample selection bias for the endline evaluation between Transform program intervention and non-Transform intervention woredas. GIA criteria used were: Early institutional neonatal mortality rate; Proportion of surviving infants vaccinated with Penta-3; Proportion of people of all ages tested positive for malaria; Proportion of children under 5 years who tested positive for malaria; Proportion of children with moderate malnutrition; Proportion of children with severe malnutrition; Institutional maternal mortality rate; Proportion of pregnant women that received at last ANC4; Proportion of births attended by skilled health worker; Early postnatal care coverage; Proportion of pregnant women tested for HIV; and Contraceptive acceptance rate.

health, child health, neonatal, family planning, and immunization, and woredas that have GIA performance categorization information. A total of 80 intervention woredas and 23 non-intervention woredas were selected for the performance evaluation.

All intervention woredas that received three or more interventions from other development partners were excluded. All woredas with no GIA woreda performance categorization information and woredas in Sidama Region, which does not have data on development partners, were also excluded from the sampling frame. Conflict-affected woredas were excluded due to security reasons. Table 2 (below) shows the sampled woredas by GIA performance.

Table 2: Distribution of sampled intervention woredas by GIA performance.

Region	Low performance	Moderate performance	High Performance	Total
Amhara	8	12	4	24
Oromia	12	18	5	35
SNNP ⁵	7	11	3	21
Total	27	41	12	80

4.2. SAMPLING OF HOUSEHOLDS

A household (HH) survey employed a three-stage cluster sampling technique. At the first stage, the evaluation team drew a random selection of kebeles (the lowest administrative units) in the Transform intervention woredas as primary sampling units, drawing from the list of kebeles in the respective regions stratified by administrative zones and performance before 2017. In this manner, woredas, in which the randomly selected kebeles were located, were automatically included in the evaluation. The second stage of the sampling entailed the random selection of Gotts (neighborhoods) from the selected kebeles. Because of the difficulties and time-consuming exercise of developing a fresh list of households in a kebele, 2-3 Gotts were selected randomly from each kebele, to generate an average list of 150 households from those selected Gotts.

The third stage of the sampling was the selection of HHs from the randomly selected Gotts. A list of households from each selected Gott served as a frame to select 30 HHs per kebele. The key eligibility criterion for selecting the HHs was the availability of a woman aged 15-49 in the HH, regardless of marital status, who had residential status there for at least 6 months before the date of data collection. When more than one such eligible respondent was found in a selected household, the enumerator randomly selected one respondent from among the eligible women. A total of 2,703 households were surveyed and eligible respondents were interviewed in TPHC woredas, and 692 households in non-intervention woredas.

4.3 SAMPLING FOR THE HEALTH FACILITY SURVEY

All the primary health care facilities designated to serve the population of the sampled kebeles - health posts (HPs), health centers (HCs), and primary hospitals - were identified and included in the final performance evaluations. That is, the health post serving the population in the sampled kebele was automatically included in the study, and the catchment HC to which the selected health post is linked was also included. Similarly, if a primary hospital is attached to the selected HC, it too was included. Non-functional health posts were not included in the health facility survey. A total of 191 facilities were sampled: 80 HCs, 78 HPs, and 23 hospitals from Transform intervention woredas. Moreover, 49 facilities were surveyed in the non-intervention woredas: 23 HCs, 21 HPs, and 5 hospitals.

⁵ Sidama became a separate region in 2020, but for purposes of baseline and endline comparison, its data were analyzed together with Southern Nations, Nationalities and Peoples (SNNP) regional data.

4.4 SELECTION OF KEY INFORMANTS

Interviewees for KIIs were selected using purposive sampling. Gender balance was considered in the selection process, as was representation of various stakeholder groups: USAID, central and regional IPs technical staff, relevant directorates at MOH, Regional Health Bureaus (RHBs), and selected WorHO. A total of 32 KIIs were conducted as part of this performance evaluation (Table 3).

Table 3. Distribution of KIIs

Stakeholders	
USAID/Ethiopia	Interview with USAID Agreement Officer's Representative (AOR) for Transform activities
Ministry of Health	Interview with MOH Directorates <ul style="list-style-type: none"> ● Health System Special Support; ● Health Extension Program and Primary Health Care; and ● Policy, Planning, Monitoring, and Evaluation
IP's central office	KIs Transform PHC management and technical team (2)
IP's regional offices	Interview with Transform PHC four regional project coordination team
Regional Health Bureaus – MCH unit	KIs (1 KI per region) MNCH Department
Woreda health offices	Transform Intervention woredas (4): 7 KIs – Heads of Woreda Health Offices and/or MNCH officers Non-Transform Intervention woredas (2): 2 KIs – Heads of Woreda Health Offices or MNCH officers
Total	32 KIIs

4.5. DATA COLLECTION METHODS

4.5.1. Data Sources

This final performance evaluation used two main sources of qualitative data – document review and KIIs. Quantitative data came from several sources: household (HH) surveys, health facility (HF) surveys, and monitoring data as reported by Transform PHC. A wide range of documents were reviewed, including IP performance reports, IP-led research, MOH annual reports, the HSTP midterm review, Mini-Demographic and Health Survey reports, Transform baseline and midterm evaluation reports, and other relevant documents. The primary data collection involved HH and HF surveys, along with KIIs from USAID/Ethiopia, MOH, RHBs, IP, and WorHOs in all regions.

4.5.2. Data Collection Tools

The desk review was conducted on a list of documents. A data extraction spreadsheet was developed to gather the most significant findings. The findings from the desk review were then coded and triangulated with data from KIIs and HF and HH surveys.

The KIIs followed a guide to gather the views and experience of the interviewee in relation to the performance of the Transform PHC Activity. The questions were broad and open-ended to facilitate unbiased responses and were accompanied by probing questions to gather more detail under each EQ. Trained bilingual interviewers conducted the KII in the language of preference of the interviewee and took notes in English. The KIIs were recorded to facilitate notetaking. The KII notes were emailed daily to the focal person for review and quality control.

Household and HF surveys were conducted using pre-tested structured questionnaires that were uploaded to smartphones, generating electronically collected HH and HF data. Moreover, some open-

ended questions were used to collect relevant data from KIs at health facilities. In addition, Gott listing, HH listing, enumerator assignment and follow-up tools were used to guide the sampling and the data collection process.

The **household survey tool** included sections on:

- Household and women's demographics, household living conditions
- Enrollment in community-based health insurance plans
- Household decision-making practices
- Health service uptake including family planning, antenatal care, delivery and postnatal care, and newborn health child immunization and child health services

The **health facility survey tool** enabled collection of data on:

- Availability of MNCH/FP services and water and sanitation facilities
- Access to communication and power supply
- Health facility management and performance, human resources
- Gender responsiveness
- Provision of selected family planning, antenatal care, delivery and postnatal care, immunization services, and adolescent and youth health services

4.5.3. Data Collectors' Training and Quality Assurance

To assure high-quality data, a day-and-a-half training was conducted for qualitative data collectors and a three-day training took place for all survey coordinators and supervisors in Addis Ababa. Enumerators who administered HH surveys had at least a BA/BSc degree and were fluent in the local languages. Importantly, all data collectors had prior experience collecting similar data and understanding the culture and traditions of the communities they were visiting. Supervisors had an MA/MSc in health or social science fields and previous experience in similar activities. Given that the respondents were mothers of reproductive age, and to ensure that they spoke comfortably with interviewers, the survey team took gender balance into account. In addition, qualitative data collectors had a minimum of an MA/MSc in health or social science fields and extensive experience in qualitative data collection, transcription, and analysis.

The training covered topics such as research ethics, rights of human subjects during research, sampling procedures, informed consent, data collection tools, interviewing techniques, data handling, confidentiality and quality, and gender considerations during data collection. The structure of the training included presentation of and detailed discussions on survey instruments followed by a role-play activity. Data collectors received training on both the paper-based and electronic versions of the data collection tools. The survey tools were pre-tested by data collectors in the field in all languages at the end of the training, before the commencement of the actual data collection, to ensure consistency with the baseline and midline evaluation.

Before traveling to each of the selected woredas, supervisors and coordinators communicated with regional and local leaders about the evaluation. To ensure the quality of collected data, supervisors conducted spot-checks and reinterviewing, especially at the beginning (first three days) of the data collection. Moreover, supervisors reviewed a sample of completed questionnaires daily before uploading them to the server. All KIs were audio-recorded and transcribed and translated to English. Five percent of the transcriptions were checked against the audio file for accuracy. In addition to the KIs, Transform: MELA conducted limited interviews for nested case study vignettes on topics relevant to program goals of reducing preventable maternal and child morbidity and mortality.

4.6 DATA ANALYSIS

All HH and HF survey data were cleaned, checked, and validated to immediately identify and address any issues during data collection, a process that takes place directly with supervisors and data collectors. Once data collection was complete, an intensive cleaning was conducted that included

coding and recoding, consistency checks, addressing refusals and non-responses, and validating contents.

4.6.1. Quantitative Data Analysis:

Descriptive (frequency and percentage calculations) analysis was conducted to describe the characteristics of a select set of MNCH/FP key performance indicators (KPIs). The analysis of HH data compared KPI values between periods (baseline vs. endline), across regions, and against Life of Activity (LOA) targets for Transform intervention areas. It also assessed the difference in endline KPI values between Transform PHC and non-Transform intervention areas. Data management and analysis were done using STATA 14 (StataCorp LLC, USA).

4.6.2. Outcome measures

The evaluation used the results framework of Transform PHC and its KPIs to measure performance. Some of the KPIs considered in this analysis were: family planning indicators (contraceptive prevalence rate (CPR), long-acting family planning (LAFP) use, and postpartum family planning (PPFP) counseling and use), maternal health indicators (antenatal care (ANC), skilled birth attendance (SBA), early postnatal care (PNC), iron-folic acid supplementation (IFS), neonatal health indicators (early PNC, essential newborn care and early initiation of breastfeeding), child health indicators (Penta3 coverage, measles coverage (MCVI), exclusive breastfeeding, vitamin A supplementation, deworming, ARI treatment with antibiotics, diarrhea treatment with oral rehydration salts (ORS) and Zinc, and fever treatment within 24 hours of onset) and cross cutting indicators (access to basic sanitation, spouse accompany to ANC, spouse accompany to delivery, and women participation in decisions regarding their health). These KPIs were used in the measurement of achievement of intermediate results of the Transform PHC Activity.

4.6.3. Qualitative Data Analysis

Coding: A codebook was developed based on evaluation questions. In addition, part of the interview transcripts was reviewed, and the codebook was further refined as specific themes emerged. Next, the transcripts were coded using the codebook. Development of the coding framework was an iterative process based on an initial list of the codes developed by the analysis team, as identified from the evaluation questions. Through a series of meetings with technical specialists, preliminary codes were further refined by adding emergent codes and modifying the preliminary codes after careful reviews of a sample of field notes based on KIs.

Analysis: Thematic analysis was conducted using ATLAS.ti, a qualitative data analysis software. The selection of themes and the analysis of the data were framed by the EQs and key thematic areas related to MNCH/FP. The synthesis of various qualitative information was used to understand factors facilitating or hindering implementation as well as achievement of results.

4.6 ETHICAL CONSIDERATIONS

The evaluation received institutional review board (IRB) approval from the Ethiopian Public Health Institute (EPHI) at the outset of research, and all data collectors and supervisors were trained in research ethics. Key informants (KIs) were asked for their consent to be interviewed and for the interview to be recorded, and interview notes and recordings were coded to protect respondent confidentiality. Survey respondents were also asked for their informed consent; during that process, they were informed about choices regarding participation, responding or not to specific questions, and their right to request termination of the survey. Informed consent also covered the privacy and confidentiality of participants—respondent names were not captured; instead, coding was used to conceal their identity. All interviews were conducted privately, ensuring that information collected remained confidential. For women under the age of 18, additional parental permission and participant assent was obtained before data collection.

4.7 LIMITATIONS

Logistical limitations. Security issues in the country related to conflict limited access to certain regions. Security-related limitations were anticipated and were mitigated by careful planning. The household and health facility data collection took longer than initially anticipated because of security and conflict issues which required adjustments to the survey and interview schedules in all three regions. Despite these challenges, the selected informants were interviewed, facilities were visited, and the sampled data were gathered.

Methodological limitations. Non-Transform intervention areas selected to serve as the comparison areas should not be regarded as true controls due to complex factors. One of the principal ways that the design sought to control for “contamination” effects was to ensure that Transform intervention woredas were not contiguous with non-Transform intervention woredas. Such a design does mitigate contamination to some degree. Although these design issues pose methodological challenges, from a methodological standpoint the spillover would likely attenuate differences between the intervention and non-intervention areas, thus leading to conservative findings rather than overstated ones. Furthermore, because Transform program interventions are designed to support nationwide health-system building for improved MNCH/FP outcomes, from a “real-world” implementation perspective such “spillover” effects can be viewed as positive outcomes for the program.

The evaluation also designed rigorous controls based on Transform: MELA’s partner mapping studies, and for the evaluation of Transform PHC, it limited woreda selection in both Transform intervention and non-intervention areas to those that had two or fewer intervention types of a total of five MNCH/FP thematic interventions. However, this design allows for only an approximation of the effects of other MNCH/FP-focused development partners intervening in the non-intervention areas. There are limited data available, for example, on the level of financial investments that these other development partners made in both Transform-intervention woredas and non-Transform intervention woredas. Thus, measuring the actual effects of other partner investments remains a challenge.

In terms of triangulation with other data sources such as DHIS2 and IP random follow up visits, the evaluation recognizes that there are methodological and data quality issues with these sources. For this reason, comparisons of these data sources, and others, such as [PMA](#), with the Transform evaluation data, particularly with the quantitative data obtained through household and facility surveys, were not used as they may demonstrate divergent results due to different methodologies.⁶ Furthermore, because the qualitative data depends on the views and comments of those persons that made themselves available to be interviewed, selection bias can result. However, the careful selection and training of highly qualified qualitative data collectors and analysts helped to mitigate data quality bias to a large extent. Data from various sources were carefully triangulated to confirm the evidence and to mitigate recall bias as well as potential social desirability bias, whereby respondents give favorable or positive answers to please the interviewer.

5) FINDINGS

This section presents overall performance findings by evaluation question, by intermediate result and where appropriate, by region and by technical area: maternal health, newborn health, child health, family planning, and gender.

⁶ This evaluation does not triangulate findings with those from PMA because PMA survey data include large cities such as Addis Ababa. In contrast, the data from the current evaluation was collected primarily in rural areas which showed evidence of larger declines compared to PMA data.

5.1 How effective were Transform approaches in contributing to improving MNCH/FP outcomes?

In general, there was consensus among all KIs, who reported that TPHC implemented effective approaches that contributed to improved MNCH/FP healthcare delivery, and probably even helped prevent further deterioration due to contextual factors. Key MOH informants also reported that they appreciated the program's contributions and were able to list several effective interventions that contributed to improved healthcare delivery (Box 1).

Investments in system strengthening interventions such as woreda twinning, quality improvement, family planning program woreda planning, and linkages with hospital services were reported as most effective, along with the provision of equipment and other supplies. These are discussed in detail later in the corresponding section of the report.

Notwithstanding the positive perceptions and appreciation for the support received, survey data showed that the activity did not meet its targets for most indicators. Table 4 shows a summary of the activity's performance by key performance indicators.

Box 1: Most appreciated interventions by Key Informants

- Twinning partnerships of woredas and health centers
- Establishment of the clinical skill laboratories
- LMG local trainer pools
- Introduction of the V-scan ultrasound
- Coaching and mentorship support using the public system structures
- On-site training
- Woreda grants
- Family Planning Exercises
- Peer education approach
- "Her Space" initiative
- installation of the solar suitcases in selected health centers

The activity effectively contributed to improving skilled birth attendance (SBA), early Antenatal Care (ANC), newborn care, measles and Vitamin A coverage and long-acting family planning (LAFP). Other indicators showed a decline in comparison to midterm values (dark shaded figures), except for five indicators, some related to outreach campaigns (Vitamin A, deworming,) and the others being early ANC and exclusive breastfeeding along with Acute Respiratory Infection (ARI) treatment. In total, 11 out of 24 indicators showed an improvement in comparison to baseline values (light shaded figures). Each thematic area is discussed in detail later in the report.

Table 2: Summary of Activity Performance by Key Performance Indicators.

Shaded cells show indicators that improved from baseline, darker shades show improvement from midterm.

Thematic Areas	Key Performance Indicators	Baseline (%)	Midterm (%)	Endline (%)
Family Planning	MCPR among all women	36.6	41.6	32.6
	MCPR among currently married women	45.1	47.3	36.5
	LAFP methods among all women	9.7	12.5	11.4
	LAFP among currently married women	11.8	14.1	12.7
	PPFP counseling after birth	29.2	29.1	19.4
	PPFP use	34.6	42.8	27.7
Maternal Health	Early initiation of ANC	28.9	50.8	51.8
	IFA supplementation for at least 90 days	21.7	25.1	18.5
	ANC4+	56.1	46.5	40.6
	Essential components of ANC	32.8	35.7	28.4
	Skilled birth attendance	57.5	63.4	59.1
	Early PNC for mothers	43.5	51.8	41.9
Newborn Health	Early PNC for newborns	37.4	46.9	39.9
	Essential Newborn Care	8.9	16.4	12.0

Thematic Areas	Key Performance Indicators	Baseline (%)	Midterm (%)	Endline (%)
	Early initiation of breastfeeding	74.9	88.8	83.7
Child Health (under 5 years)	Full immunization	40.3	42.4	26.8
	Vitamin A supplementation in last 6 mo.	43.1	46.4	72.2
	Children with Symptoms of ARI	7.0	4.7	3.0
	ARI treatment	29.4	53.6	55.3
	Diarrhea incidence	9.0	14.1	12.1
	Diarrhea treatment	28.9	33.2	12.1
	Exclusive breast feeding	58.3	71.4	75.0
	Deworming in the last 6 months	36.9	43.2	60.5
	Fever treatment within 24 hrs. of onset	40.9	37.1	22.9

5.1.1 Were Transform activities implemented as planned? If not, why not?

At the beginning of the evaluation process, evaluators asked the IP to describe the implementation status of the TPHC activity. The IP indicated that most of the planned activities were implemented as planned, but certain activities that were not implemented as well as hoped included gender and community level activities, which were limited due to security problems. From the perspective of the IP, the government was not able to allocate a budget dedicated to implementing gender-related activities. Different external factors frequently mentioned as barriers to implementation were staff and leadership turnover, political unrest and security issues, and a lack of motivation and commitment among service providers and leaders.

KIs also frequently mentioned COVID-19 as one of the factors hindering program activities. COVID-19 disrupted most of the basic health services and TPHC activities. It also prevented health seeking among communities because of fear of acquiring the infection. As a result, most of the maternal and child health services were reported to have significantly dropped and, in some areas, they were completely interrupted. KIs also mentioned that in some areas COVID-19 seem to have minimal impact on health care provision and program activities. Despite this perception, quantitative data showed a decline of MNCH/FP outcomes, as well as significant differences by region. These differences in performance are noted below.

5.1.2 To what extent did the activity improve MNCH/PH outcomes and reduce inequities in different groups and intervention areas?

Despite the positive perception of how the TPHC Activity performed by most stakeholders interviewed, progress was not achieved in all technical areas and inequalities across regions persisted. The evaluation showed marked differences across regions that have not been addressed yet. The activity does not have an intermediate result or an indicator to measure reduction of inequalities, so this dimension remains to be addressed.

The summary (Table 4) shows that 11 indicators improved from baseline and five from midterm values. KIs reported several reasons for this, notably political and social unrest and COVID, which limited mobility and access to health facilities. Almost all KIs mentioned that war/conflict affected the program's implementation and overall health service provision. It was mentioned that the program's achievements were "wiped out due to the civil-war," and that several health facilities in war-affected areas were either destroyed or not functioning properly due to a shortage of the necessary supplies. As a result, the program activities were focused on emergency response and humanitarian assistance in lieu of planned activities. The effectiveness of the emergency response activities was not part of the final evaluation design.

FAMILY PLANNING PERFORMANCE

TPHC did not meet its life of activity (LOA) targets in family planning (FP) services. By the end of activity, it achieved an overall MCPR of 36.5% among currently married women in the interventions woredas which is about nine percentage points below baseline (Figure 1). Interestingly, the performance of the LAFP indicator slightly increased in comparison to the baseline, possibly showing preference for these methods in the current conflict context.⁷ In summary, overall MCPR declined, and one out of four FP indicators showed improvement in comparison to baseline: LAFP (Figure 1).

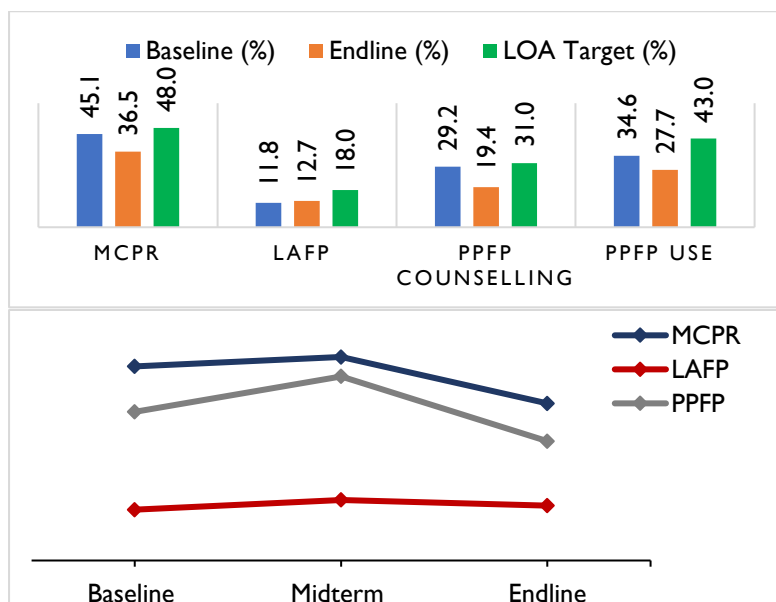


Figure 1: Family planning program performance at baseline and endline, and LOA target (Top) and performance trend (bottom) in Transform PHC intervention areas.

Most family planning indicators declined in all regions except for LAFP in Oromia and SNNP (Table 4). One explanation for this difference is that 13% of women in the intervention areas reported being turned away from health facilities when seeking FP services (data not presented). The percentage of women being turned away from health facilities was highest in Amhara (21.5%), followed by SNNP/Sidama (13.9%) and Oromia (8.3%). The main reason for turning away clients were commodity stockouts, facilities that were closed, or that service providers were unavailable. Further research at the facility-level is needed to confirm the finding that women reported to be turned away due to lack of commodities and trained staff. FP utilization by sampled facility would need to be compared with household data in the coverage area of each facility.

In addition, stockouts were frequent in surveyed facilities; 89% of them reported stockouts of at least one type of FP commodities in the last three months preceding the survey (Figure 2). FP commodities that were out of stock in many of the facilities included Progestin only injectable (Depo-Provera), Implanon and combined oral contraceptives.

Table 3: Family planning program performance at baseline and endline by region.

Indicator	Baseline (%)	Amhara	Oromia	SNNP
		48.2	42.0	45.2

⁷ A strong hypothesis for this result is that LAFP results are less affected by unrest in the country than other modern contraceptive methods; once LARC are inserted they typically remain for 3 to 5 years and thus are not as affected by external factors compared to short-acting methods such as pills and injectables.

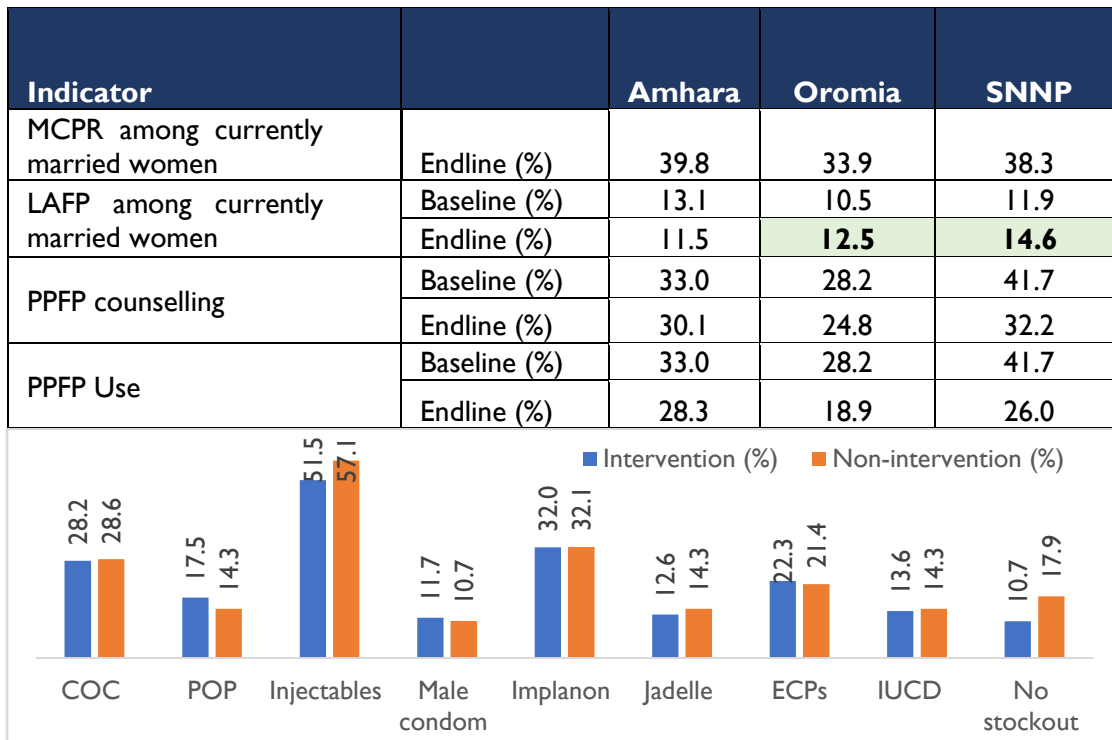


Figure 2: Reported stockouts of FP commodities in transform PHC intervention and non-transform intervention three months prior to the survey.

The health facility survey showed that 6.4% of surveyed health posts in intervention areas did not provide any modern FP methods. Aside from being turned away, the most frequently mentioned reasons for women not to use FP methods in rank order included: wanting to get pregnant, religious restrictions, fear of side effects/infertility, and partner refusal (limited autonomy women have over health care decisions). Despite the decline in FP coverage, KIs reported that attitudes towards FP services have improved.

“There were many women who have a fear to use family planning services during the previous time. However, they are currently using this service without any fear. Significant progress has also been made on youth Adolescent health through providing a youth friendly service program, especially for women.”
WorHO, SNNP)

Family planning indicators declined in both intervention and non-intervention areas except for LAFP, where they increased in intervention areas and remained the same in non-intervention areas (Figure 3). There were *no statistically significant differences* between intervention and non-intervention areas.

TI = Transform Intervention; NTI = Non-Transform Intervention

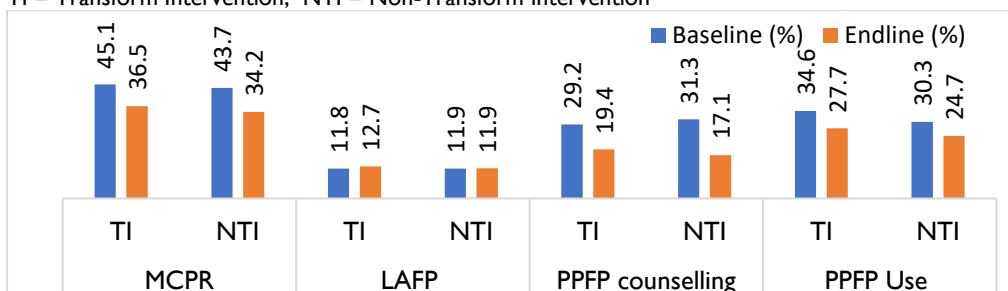


Figure 3: Baseline and endline comparison of FP services by intervention and non-intervention areas.

MATERNAL HEALTH PERFORMANCE

Maternal health performance showed improvement in early ANC and SBA coverage. All other indicators showed a decrease in coverage (Figure 4). The biggest decline in outcomes, for ANC4+, showed a 16-percentage point decrease and has been declining since baseline. The decrease in maternal health coverage was explained by reduced access to services due to unrest and COVID. Further operational research is necessary to fully understand the reasons for the decline and how to develop an effective causal pathway to increase ANC4+ coverage. No LOA targets were achieved.

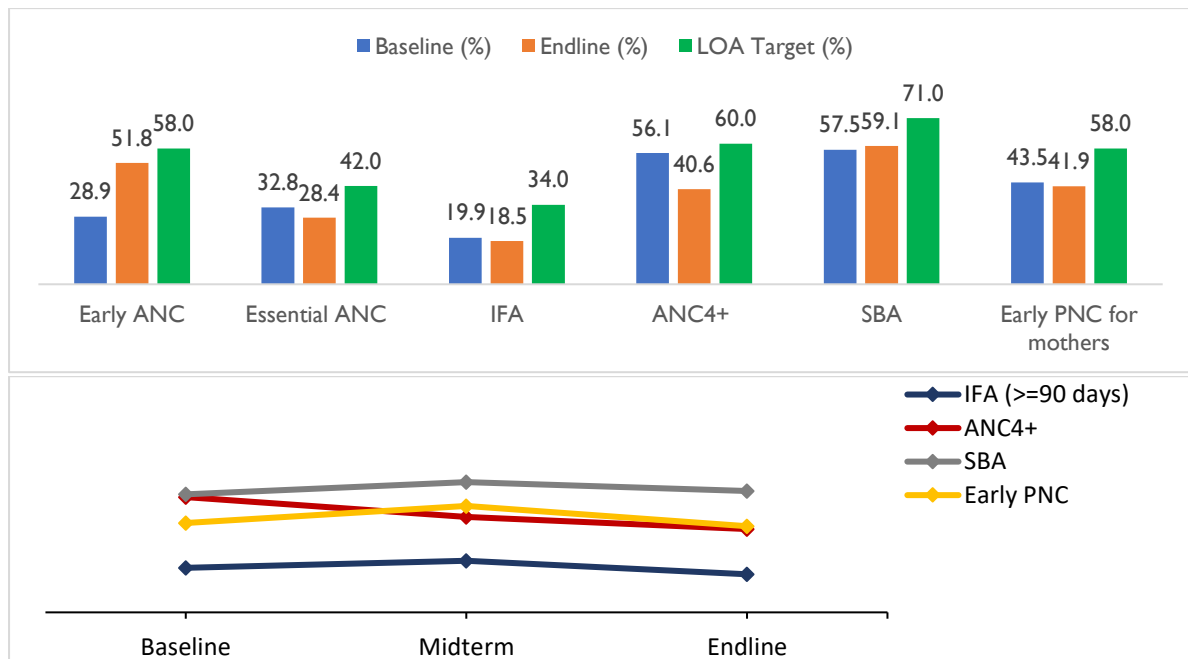


Figure 4: Maternal health outcomes at baseline and endline with LOA targets (Top) and performance trend (Bottom) in Transform PHC intervention areas.

Performance varied by region (Table 5). In particular, early ANC and SBA improved between baseline and endline in all regions, and the essential components of ANC and early PNC improved in Oromia and SNNP but declined in Amhara. ANC4+ declined in all regions. IFA coverage improved in Oromia only. Some of the reasons mentioned by KIs for the observed low performance for maternal health KPIs were:

- Weak community health programs; interruption of community structures that would have enhanced tracing and follow-up of pregnant women
- Weak and continuous reshuffling of health system leadership
- Long distance to the health facilities and disruption of maternity waiting homes during the COVID-19 pandemic⁸
- Recurring conflict in some parts of the regions e.g., east and northern Amhara, west and south Oromia, south-west SNNP
- Mothers' low health literacy (poor risk perceptions)
- Lack of counseling contributed to dropout from the continuum of MNCH care

Factors reported to have affected implementation such as high staff turnover and long distance to facilities were not easily amenable to TPHC interventions, but can be mitigated through MOH policies, as well as program support for ongoing orientation of new staff, mobile clinics,

⁸ Although the incidence of SBA improved, KIs said that COVID prevented women from use maternity waiting homes and affected SBA in some woredas. It is likely that SBA may have increased even more if COVID had not affected service delivery and access to maternity waiting homes.

teleconsultations, and strengthening of local health posts. The lack of counseling and mothers' beliefs they do not need to go to a facility if they feel well are amenable to further interventions.

Table 4: Maternal health program performance outcomes at baseline and endline.

Indicator		Amhara	Oromia	SNNP
Early ANC	Baseline (%)	35.8	31.3	21.9
	Endline (%)	49.6	52.5	52.1
Essential ANC components	Baseline (%)	50.5	23.9	28.1
	Endline (%)	29.2	26.1	32.9
IFA	Baseline (%)	34.9	7.0	21.7
	Endline (%)	16.8	18.6	19.9
ANC 4+	Baseline (%)	55.0	53.4	59.5
	Endline (%)	41.6	34.9	52.1
SBA	Baseline (%)	59.0	50.3	63.2
	Endline (%)	63.7	54.1	66.4
Early PNC for mothers	Baseline (%)	59.6	28.2	46.8
	Endline (%)	59.3	32.4	49.3

Early ANC increased in both intervention and non-intervention woredas, probably as the result of spillover due to systemic improvement that covered both. The improved performance observed in intervention woredas (Figure 5) was *not statistically significant*, however.

TI = Transform Intervention; NTI = Non-Transform Intervention

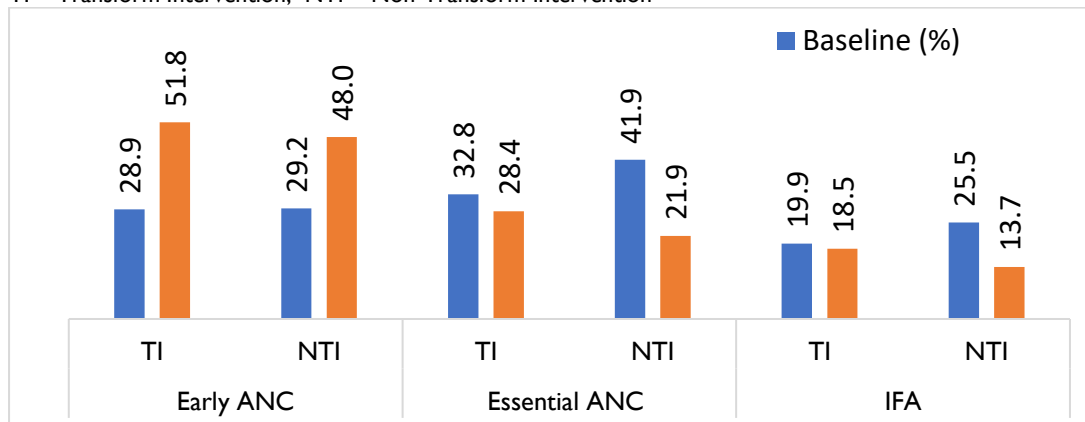


Figure 5: Antenatal care performance outcomes at baseline and endline by transform intervention and non-transform intervention areas.

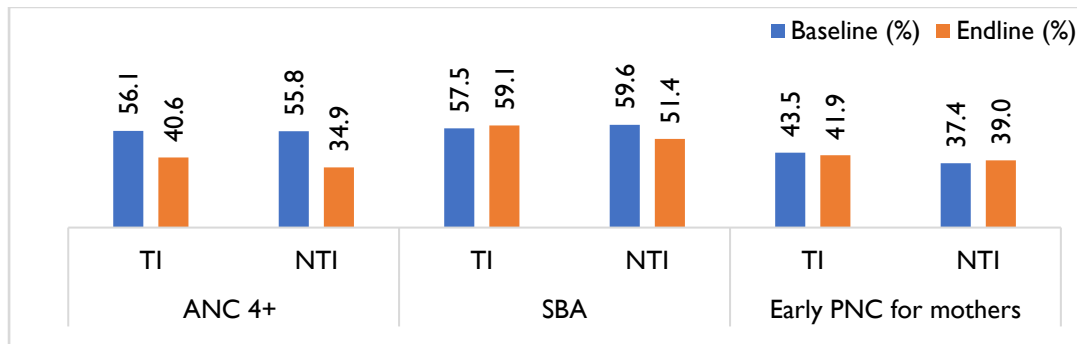


Figure 5: SBA, early PNC, and ITN outcomes at baseline and endline by Transform intervention and non-Transform intervention areas.

NEWBORN HEALTH PERFORMANCE

No newborn health outcomes met the LOA targets, but they all improved when compared to baseline (Figure 7). The rate of increase in newborn health intervention coverage was higher before the midline than after the midline. The most probable reason that LOA targets were not met was because IPs set targets based on the progress observed within the first two years of program implementation. It is important to note that 50% of the respondents did not know if their baby had received essential newborn care. Although improved, coverage of Essential Newborn Care was reported at 12%, which would leave about 88% of newborns not receiving the essential newborn care package. Early initiation and exclusive breastfeeding continued to be high.

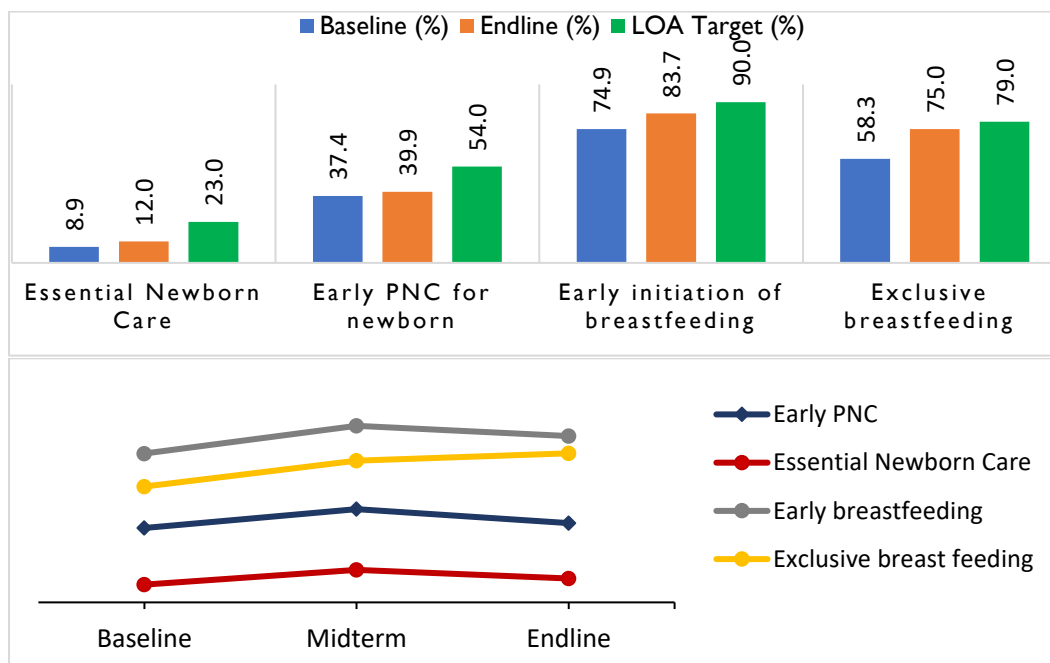


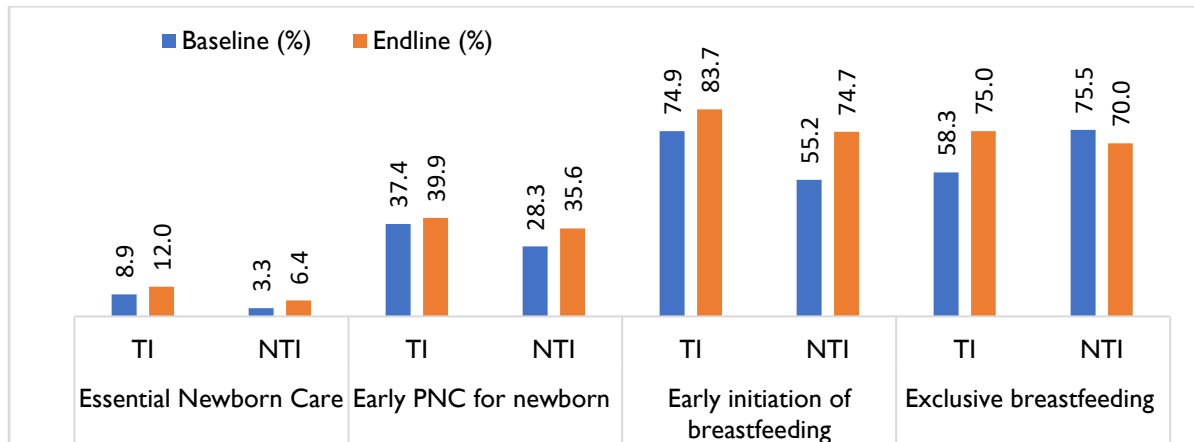
Figure 6: Newborn health outcomes at baseline and endline with LOA targets (Top) and performance trend (bottom) in Transform PHC intervention areas.

Despite improvements, regional differences in coverage deserve further study. Oromia region performed worse than others in the provision of early postnatal care (PNC) and Amhara's performance was the lowest (4.4%) in the provision of essential newborn care services (Table 7) when compared to the other regions. This was so because the baseline rate was the lowest in Oromia. However, the rate of improvement from the baseline is almost the same for all regions

Table 5: Newborn health performance at baseline and endline by region.

Indicator		Amhara	Oromia	SNNP
Essential Newborn Care	Baseline (%)	3.8	0.0	20.7
	Endline (%)	6.8	10.2	19.2
Early PNC for newborn	Baseline (%)	46.8	25.5	42.3
	Endline (%)	52.2	30.5	50.7
Early initiation of breastfeeding	Baseline (%)	78.7	79.2	69.2
	Endline (%)	84.1	84.3	82.2
Exclusive breastfeeding	Baseline (%)	44.7	59.7	66.7
	Endline (%)	75.5	68.8	86.4

As Figure 8 shows, newborn health outcomes increased in both Transform PHC and non-Transform intervention areas, except exclusive breastfeeding in non-Transform intervention areas. At the endline, a statistically significant difference was detected in early initiation of breastfeeding between Transform PHC and non-Transform intervention areas ($p < 0.01$).



TI = Transform Intervention; NTI = Non-Transform Intervention

Figure 7: Newborn health performance outcomes at baseline and endline by transform intervention and non-transform intervention areas.

The quality of newborn care was reported by KIs to have improved due to the creation of newborn intensive care units (NICU) in all district hospitals found in Transform intervention areas and the creation of 33 skills labs: 11 in Oromia, 9 in Amhara, 9 in SNNP and 4 in Tigray (Figure 9).

Figure 8: Skill lab in SNNP



CHILD HEALTH PERFORMANCE

Preventive services: The LOA of child health services targets were not met except for Vitamin A supplementation (Figure 10) and deworming (Figure 11).

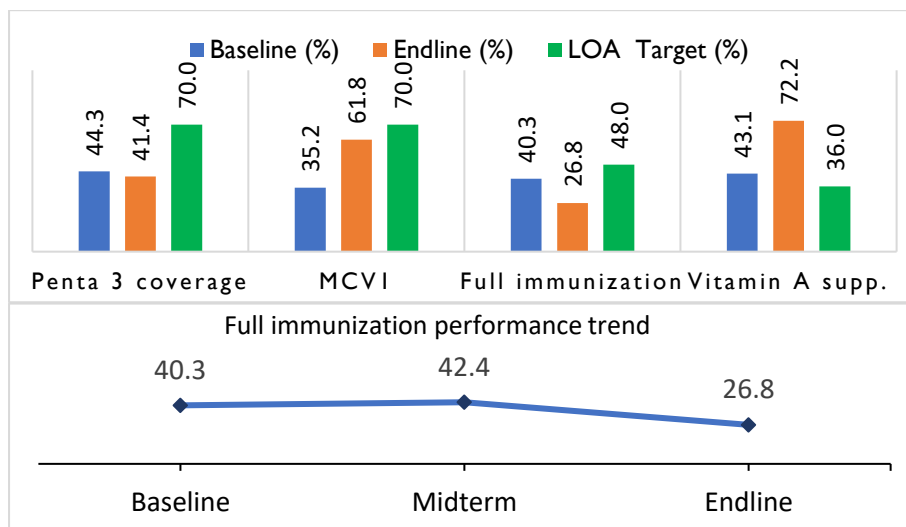


Figure 9: Expanded Program on Immunization and Vitamin A supplementation at baseline and endline with LOA targets (top) and full immunization performance trend (bottom) in Transform PHC intervention areas.

Measles vaccination coverage increased significantly ($p < 0.001$) by 24.3 percentage points from baseline, which KIs attributed to vaccination campaigns coupled with deworming that was also found

to have increased about the same percentage points from baseline. On the other hand, the performance of Penta 3 declined from 44.3% to 41.4%. Full immunization declined significantly (<0.001) and covered 26.8% of the children under 5 years of age. This suggests that the routine vaccination program did not perform as well as expected, probably due to contextual factors; now there are over 70% of children who did not receive all basic vaccines, suggesting that there is now a health emergency in terms of the health system’s ability to save children’s lives. KIs reported that vaccine campaigns have been effective in the past and will need to continue to be conducted until a routine vaccination program is restored to make up for the shortfall in the performance of the routine immunization program. The routine vaccination system has not been strengthened enough to withstand current shocks.

Coverage of antibiotic ARI treatment and deworming significantly increased significantly (p<0.001) from baseline (Figure 11). On the other hand, fever treatment within 24 hours of onset declined significantly (p<0.001). Diarrhea treatment with ORS and Zin decreased mostly due to a marked decrease in SNNP. This reflects the inequalities mentioned above. The decline in ORS and Zinc treatment is important due to the increase in diarrhea incidence. This finding deserves further study because the IP reported that 90% of health posts in intervention woredas provided CBNC service with trained staff at the end of 2021. A much better performance would have been expected. All hospitals/health centers also provide these services. The health facility survey found that 95% of HPs in intervention areas provide ICMNCI and 99% of hospitals/Health centers provide IMNCI services.

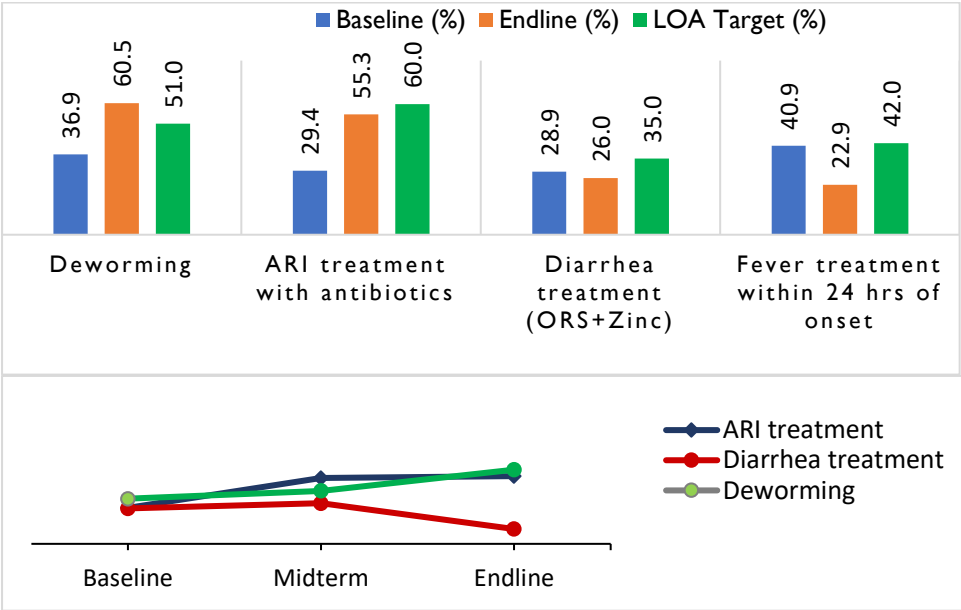


Figure 10: Baseline, endline and LOA comparison of access to preventive and curative childhood illness treatment (top) and performance trend (bottom) in Transform intervention areas.

The performance by region showed a low fully vaccinated indicator across all three regions. Measles and deworming service indicators nevertheless reached about two-thirds of the children. Access to ARI treatment improved in all three regions (Table 8). Shaded figures highlight the differences in child health performance by region.

Table 6: Baseline and endline comparison of child health indicators by region.

Indicator		Amhara	Oromia	SNNP
Penta 3 coverage	Baseline (%)	58.4	37.0	37.9
	Endline (%)	34.7	41.8	46.4
Measles	Baseline (%)	37.0	36.1	33.0

Indicator		Amhara	Oromia	SNNP
	Endline (%)	59.2	62.1	63.6
Full immunization	Baseline (%)	67.4	24.1	29.7
	Endline (%)	19.4	29.3	28.2
Vitamin A supplementation (6-59 months)	Baseline (%)	43.5	37.2	48.7
	Endline (%)	74.9	72.9	68.6
Deworming Last 6 months (L6Ms)	Baseline (%)	35.5	29.8	45.3
	Endline (%)	61.3	60.9	59.1
U5 children with ARI symptoms Last 2 weeks	Baseline (%)	11.4	5.9	4.8
	Endline (%)	3.2	3.1	2.8
ARI treatment with antibiotics	Baseline (%)	28.6	34.6	25.0
	Endline (%)	37.5	59.5	61.1
Diarrhea incidence_L2Ws	Baseline (%)	9.6	8.1	9.5
	Endline (%)	15.0	8.8	17.0
Diarrhea treatment with ORS+Zinc	Baseline (%)	18.4	27.5	38.0
	Endline (%)	32.9	34.2	12.0
U5 children with fever for who advice/treatment was sought within 24 hrs.	Baseline (%)	39.4	45.3	38.5
	Endline (%)	19.7	34.8	15.2

Measles coverage, Vitamin A supplementation, deworming, and ARI treatment increased in both Transform PHC and non-Transform intervention areas. However, no statistically significant difference was detected between Transform PHC and non-Transform intervention areas (Figure 12 and 13).

TI = Transform Intervention; NTI = Non-Transform Intervention

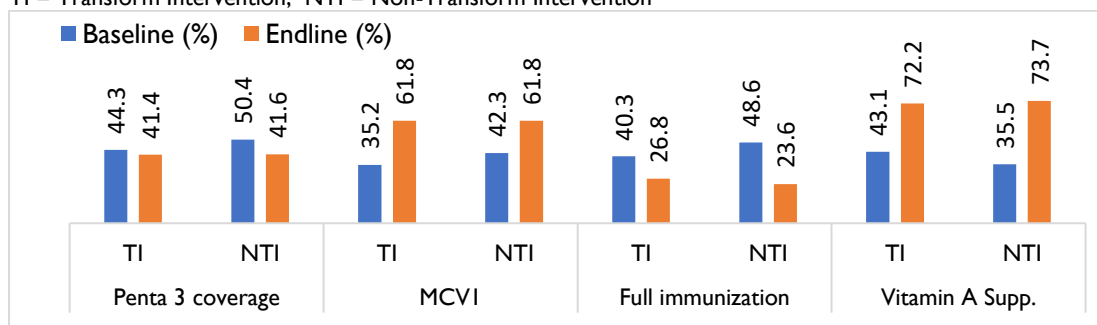


Figure 11: Child immunization performance outcomes at baseline and endline by intervention and non-intervention areas.

TI = Transform Intervention; NTI = Non-Transform Intervention

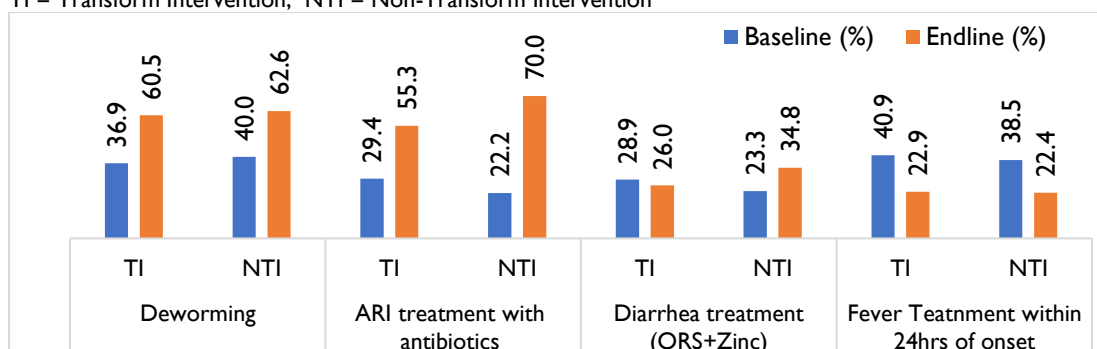


Figure 12: Child health performance outcomes at baseline and endline by intervention and non-intervention areas.

5.1.3 How effective are the Transform activity strategies and approaches?

KIs in the regions were asked to identify what they believed were the most and least effective interventions. The most effective reported were: Woreda Twinning, FP planning, Clinical Skills labs, capacity building through onsite training, coaching and mentoring, and Woreda Sub-granting, as well as providing equipment (V-scans and solar suitcases).

“The experience of the initiated Ultrasound service at the 27 health centers has been scaled up to cover a total of 70 health centers.” – (RHB respondent, Amhara region)

Findings from the health facility sample also indicated that the BEmONC, Adolescent Youth Health (AYH) services and community-based health insurance were effective. The evidence of effective strategies and approaches is described in the sections below.

However, under certain circumstances, interventions that were reported as successful in some regions were less successful in others. For example, some key informants described difficulties with the health information system that did not allow for continuous monitoring and quality improvement interventions that did not persist:

“We were not successful result in transforming kebeles into model kebeles. Of course, we have made some progress though it is not promising. In addition, there were major problems on ISS, data verification and connected woreda. In these areas, our performance was less than our target.” SNNP

“Regarding the Transform approaches which were the least effective, in our woreda context, we believe that the quality improvement training was the one we failed. We were proposing as it would be so productive and we got grant from the project, and the training was given as planned. But it did not work any longer. Our health workers who took the training did not get to action as proposed. Putting the reasons for the failure precisely demands researching and probing the workers, while in our opinion it can be linked with the lack of motivation. Surprisingly, when we communicate in person there are individuals replying as they lost the skills and demand more training of the type to rehearse.” Amhara

BEmONC

About 60% of the facilities reported being able to implement all seven BEmONC signal functions, representing a significant improvement from the baseline. Except for one signal function, the administration of corticosteroids, a large majority of facilities were able to perform all BEmONC functions (Table 7). As one important example, only 35% of facilities reported being able to perform an assisted vaginal delivery at baseline; this figure has now increased to 73%.

Table 7: Percentage of sampled health facilities that reported performing each BEmONC Signal function on the day of the survey.

BEmONC Signal Functions	Facilities with Functional BEmONC
Administration of parenteral oxytocin	95.1
Administration of parenteral anticonvulsants	84.3
Administration of parenteral antibiotics	95.2
Manual removal of placenta	89.3
Removal of retained products of conception	88.4
Newborn resuscitation using bag and mask	92.2
Administration of corticosteroids	35.6
Assisted vaginal deliveries	72.8
All signal functions (except administration of corticosteroids)	61.2

Adolescent and Youth Health (AYH)

Most of the sampled facilities (over 50%) reported that they provide AYH services on all ten criteria (Table 10), and the activity-supported facilities scored higher in all service categories in the intervention areas, thus demonstrating the effectiveness of the strategy implemented (Figure 14).⁹

Table 8: Percentage of key adolescent and youth health interventions reported to be provided in sampled facilities.

Key adolescent and youth interventions	Percent of facilities
Counselling through peer educators	61.1
Counselling through YFS trained health providers	63.9
Provision of modern contraceptives	90.3
Youth-friendly post-abortion care	84.7
Youth-friendly post-abortion contraceptives	88.9
Pregnancy testing	94.4
Treatment of sexually transmitted infections	93.1
HIV testing	94.4
Link to ART clinics	86.1
Life skill training	50.0

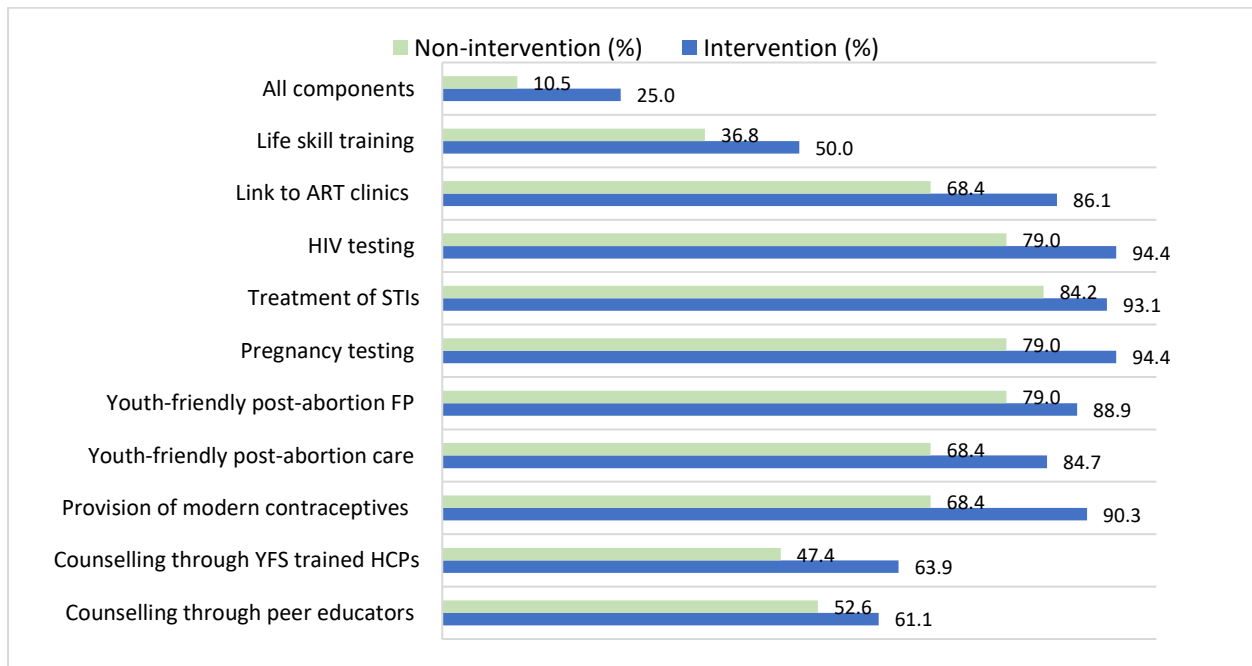


Figure 13: Comparison of available adolescent and youth health services in intervention and non-intervention areas.

Workforce Training

Key informants reported the usefulness of health-related workforce training. Because the activity implementer placed a high value on human resources as the “heart” of the healthcare system, about thirty-six thousand health workers received training (Figure 15). In addition, TPHC also reported to

⁹ These data show the supply side and not the demand side. Despite the large proportion of sampled facilities that report to provide youth-friendly services, pregnancy testing and contraceptives, ANC and FP outcome indicators have declined since midline. The evaluation did not collect data on change in the number of ANC and FP users among adolescents and further study of use patterns among both adults and adolescents is included in the recommendations.

have developed skill-based mentorship platforms, which were implemented to ensure capacity was built, using on-site-orientation and skill labs in selected health facilities.

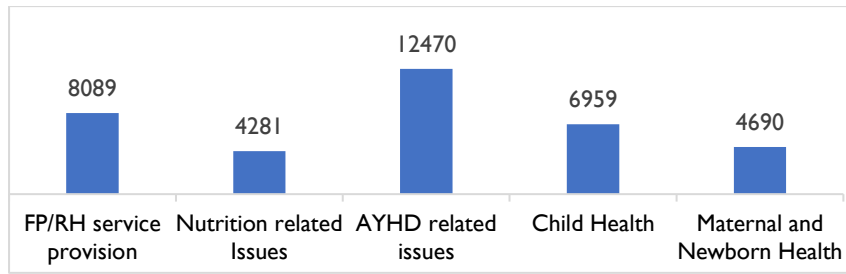


Figure 14: Number of health workers who received training provided by the transform program by thematic area (Source: TPHC training report).

Training was also reported to have enabled selected health facilities to effectively utilize their budgets towards quality improvement activities such as to purchase medications, to improve patient registries, and expand building activities. Moreover, training was also reported to have helped to ensure more effective utilization of health facility financial resources for improving quality of service, instead of what one IP regional manager termed the “old tradition of accumulating capital.”

“The [health care financing] training enabled the health facilities to utilize their budgets ... to improving the quality of their services, instead of the old tradition of accumulating capital.” (IP regional office, Amhara region).

The activity did not have a target that required it to measure the number of facilities that have trained and well-performing staff who apply what they learned. Consequently, the evaluation could not measure how effective this training was to improve health care provider performance, except indirectly through the views of KIs and the measurement of health outcomes, which are also influenced by other systemic variables (medicine supply, etc.) and contextual factors. Nevertheless, there is consensus that the activity effectively built capacity.

Woreda Twinning

KIs reported that TPHC successfully facilitated the implementation of twinning partnerships between high and low performing woredas¹⁰. TPHC facilitated the creation of win-win relationships between woredas that until now had worked independently of each other, thereby helping not only to create and strengthen health system linkages at the regional level, but also to create opportunities for collaboration and joint continuous improvement within the region. A total of 116 mentor and mentee woredas were included in the twinning program. The main goal of the twinning intervention was to help the low performing woredas to improve. However, it also helped the higher performing woreda to sustain their achievements and motivated their staff to continue improving and sharing their expertise. The twinning process took about five years and included a continuous cycle of repeating the implementation steps (Box 1) at higher levels of performance. TPHC provided the training, grant funding, supplies and facilitated the process of relationship building among twinned woredas.¹¹ An example of site observation of woredas in the SNNP Region is discussed below.

Box 2: Implementation Steps

1. Partnership Development
2. Needs Assessment
3. Gap Analysis
4. Action Planning
5. Action Implementation
6. Review and Evaluation

¹⁰ Argaw et al. BMC Health Services Research (2020) 20:892. [Accelerating the performance of district health systems towards achieving universal health coverage via twinning.](#)

¹¹ The final evaluation did not gather specific primary quantitative data related to improvements of this intervention. However, at the baseline, TPHC reported that “of 81 standards set for health centers, performance increased from 81 to 88 percent in one mentor woreda and from 58 to 78 percent in its mentee. (Transform PHC, Technical Brief, 2018).

Site visit observations: The Case of Kembata Tembaro Zone

As part of the evaluation, the Transform MELA team travelled to the SNNP Region to interview the local TPHC team and the local health authorities who implemented the Twinning program in Kembata Tembaro Zone and to document their experience. This Zone manages 11 woredas, five of which participated in the twinning program. The participating woredas signed Memoranda of Understanding (MOUs) to implement the steps in Box 2 and meet a number of standards (Box 3).

Box 3: Woreda Performance Standards

The woreda health office has core processes and case teams responsible to execute the following district management functions:

1. Planning, monitoring and evaluation of health promotion, disease prevention and curative health care activities in the woreda.
2. Coordinating mentoring and technical support among primary hospital, health centers, and health posts.
3. Planning and coordinating supportive supervision of primary health care facilities and monitoring quality of service.
4. Coordinate resource mobilization for primary health care.
5. Ensuring community engagement and ownership.
6. Disease surveillance and coordinating and planning and emergency response for public health emergencies.
7. Conducting regulatory functions.
8. Coordination with other sectors at the woreda level.
9. Provision of oversight on finance, human resources infrastructure and supplies to Primary Health Care Facilities.
10. Ensures quality service delivery (referrals and linkages, staffing and human resource management, medicine supply, etc. to provide an essential package of basic health care services at Primary Health Care Facilities
11. Community engagement activities and coordination with other sectors in the woreda (education, agriculture, etc.)
12. Performance management, monitoring and supervision

A district health system performance score was calculated that showed improvement a year later based on several programmatic outcomes, such as:

- a. Contraceptive prevalence rate (CPR)
- b. Proportion of pregnant women attending antenatal care clinics tested for syphilis
- c. Proportion of births attended by skilled health personnel
- d. Proportion of women who attended postnatal care at least once during the early post-partum period (within 7 days after delivery)
- e. Proportion of children who had Penta 1, but dropped from Penta 3
- f. Fully immunization coverage for children under one year
- g. Iron-folic acid supplementation
- h. Children attended Growth Monitoring and Promotion sessions
- i. Proportion of all forms of TB (*New and relapse*) cases detected during a specified period

The Kembata Tembaro Zone authorities emphasized the importance of the intersectoral solidarity and collaboration across woredas that created a true partnership among all the professionals that participated in the program. The Twinning allowed the zone to create model facilities and woredas that will be able to twin with and support the improvement of the remaining six woredas in the zone:

“This health center was in “red” in all indicators at the start of the program and now it is a model facility that has received national awards. The transformation is fantastic. Now over 80% of the facilities are meeting standards. We learned the importance of partnerships and solidarity to improve healthcare. It works because it is adapted to our culture.” (ZHD, SNNP)

Family Planning Exercises

Despite the decline in FP outcome indicators in the endline survey, it is also reasonable to assume with some KIs, that the decline would have been bigger without the support of TPHC. Moreover, the decline was not the same in all woredas. Some facilities in selected woredas like Halaba Woreda in SNNP showed improvement because of facilitated planning. TPHC developed an approach to help woredas plan and ensure that facilities can provide quality FP/RH services. The approach included a planning workshop (Box 4) in which each facility team used data and planning tools developed by the activity to

estimate the resources required to deliver the planned FP services. The planning tools also allowed facility teams to estimate and budget for FP commodity needs. Facility planning data were then consolidated into woreda, zone and regional plans and budgets. The planning workshop and tools were reported to improve efficient planning and budget allocation and spending of public resources.

Box 4: Planning Workshop Agenda

1. Definition of activities
2. Roles and responsibilities
3. Facility assessment
4. Service planning
5. Commodity quantification
6. FP/RH activity organization
7. Action Plan and budget

Box 5: Site observation: Halaba Health Center, SNNP

The Transform MELA team visited Halaba Zone and interviewed zonal staff and staff at Halaba health center. The health center covers an urban population of over 100,000 and 12 health posts for a total of over 360,000 in the woreda. FP outcomes reported by this facility included significant improvements:

- Adolescent and youth FP users increased from 8% to 40%
- Total women of reproductive age using modern FP methods also increased from 40% to 78%
- Immediate post-partum FP increased from 0% to 24%

Other woredas also reported improvements in FP outcomes, especially long-acting methods:

“We have seen remarkable progress in terms of increasing the number of women who use long-acting family planning services to 60%. In addition, the program was also effective in increasing the counselling skills of health professionals on family planning services.” – (WorHO, SNNP)

Subgrants

Among the most frequently cited intervention approaches, sub-grants to the Woredas were often reported as a mechanism that helped to close financial gaps and empowered local interventions. KIs indicated that the sub-grants eased the prevailing budget shortage of the woredas, and as a result, woredas were able to accomplish the goals they established, especially when they were twinned with a better performing “mentor” woreda. Sub-grants were given based on the priority needs identified by woredas themselves, differing from the approach of other projects, in which donor partners made decisions on who receives the funding and for what purpose. For this reason, the woredas felt empowered to make financial decisions. In addition, KIs reported that the Activity improved their grant proposal writing and grant management capacity and created a sense of ownership, and that they were able to draw on these skills to apply for funding from other donors.

In the case of Kembata Tembaro Zone, the Zone Director attributed their results and improvement to having received technical support and training to apply for and receive sub-grants. Several of their health centers were recognized at the national level for achieving over 90% of KPIs. Similarly, a respondent in Amhara region noted the contribution of the sub-grants in improving the capacities of the health system.

“The contribution of the Transform project brings a positive change compared to other partners, in that it performs the activities starting from the lower level at the community. For instance, the sub-grants are directly delivered to the woredas and [distributed from woredas to] the health facilities. It also attempted

to improve the technical capacities and the leadership along all levels, including those at the lower hierarchy. – (WorHO, Amhara region)

Table 9 shows the distribution of subgrants to Kembata and Halaba Zones in the LOA. Hadero TZ woreda, received subgrants for three years in a row and were able to improve and sustain their performance.

Table 9: Sub-grants by health facility and year in Kembata and Halaba Zone (in Ethiopian Birr – ETB).

Grantees	2018	2019	2020	Total
Damboya	483,042	501,020	455,420	1,439,482
Hadero TZ	635,334	326,310	400,874	1,362,518
Tembaro		506,931	481,145	988,076
Modula PHL			209,930	209,930
Angacha		214,890	510,275	725,165
Kacha birra		607,815	453,810	1,061,625
Shinshicho PHL			205,606	205,606
Kembata T. ZHD		574,415	1,001,970	1,576,385
Atoti Ullo WorHo			275,212	275,212
Werra WorHo			352,054	352,054
Wera Dijo WorHo			360,438	360,438
Halaba Kulito TA			131,525	131,525
Kulito PHL			203,791	203,791
Besheno PHL			206,061	206,061
Halaba ZHD	1,146,793	580,120	508,145	2,235,058
Total	2,265,169	3,311,501	5,756,256	11,332,926

Note: Approximately 50 Ethiopian Birr = \$1 USD at time of study.

Community-based Health Insurance (CBHI)

CBHI and public finance trainings for health center staff were reported to help improve outcomes. The endline survey found that the activity significantly increased ($p < 0.001$) and far exceeded the CBHI enrollment targets in the three regions. Of course, this achievement cannot be attributed to the activity only, but its contribution was recognized by KIs as significant (Figure 16).

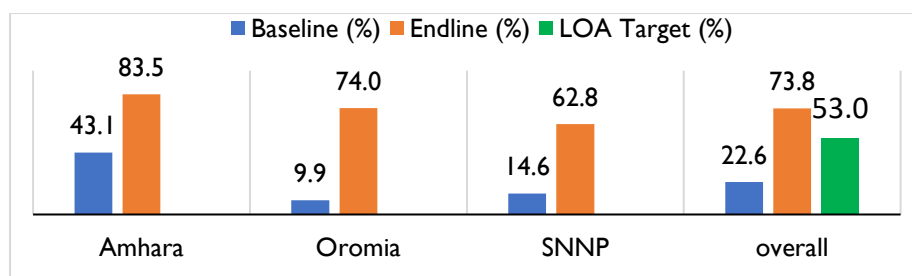


Figure 15: CBHI enrollment at baseline and endline by region.

In addition, community mobilization efforts were reported to have helped raise funds from community members for health facilities to improve quality of health services. TPHC also gave training and technical support on how to prepare effective budget proposals and how to tap available resources. According to one KI from Amhara:

“The activities of the Transform program include involving the community to contribute funds and improving their health facilities. For instance, this is notably done in one of our woreda called Gonji-Kollela. In this woreda, each member of the community contributes one hundred birr [approximately USD \$2] yearly. Then, the money collected from the community is utilized to improve the health center, given that the members of the community have believed in their ownership of the health facilities. As a result, we have a plan to appoint the experience of this woreda for regional accreditation. The project has also helped us to activate the health care financing system.” (ZHD, Amhara region)

Health facility performance

The total number of facilities that meet all MNCH/FP performance indicators is not known as this was not a performance target. However, numerous health facility performance indicators show the contribution of the TPHC activity. First, about one out of five surveyed facilities in TPHC areas provided all adolescent and youth friendly service components, unlike facilities in non-Transform intervention areas where fewer facilities provided similar services (less than one in ten). Overall, a higher proportion of health facilities in TPHC intervention areas provided adolescent and youth friendly services than non-Transform intervention areas.

Second, more health facilities in TPHC intervention areas provided all BEmONC signal functions than health facilities in non-Transform intervention areas. Except for parenteral oxytocin and antibiotics administration, other BEmONC signal functions were provided in more health facilities in TPHC than non-Transform intervention areas.

Lastly, at endline, the proportion of health facilities with a performance score of greater than 80% as per the EHSTG/EHCRIG (Figure 17) reached 59.2 % slightly higher than the LOA target (50%), as well as the implementation of quality improvement plan of health facilities (well over the threshold of 48%) exceeded the respective LOA targets, 74.8%. At endline, the percentage of surveyed health facilities women represented was around 79.8%, which is slightly lower than the LOA target of 86.0%.

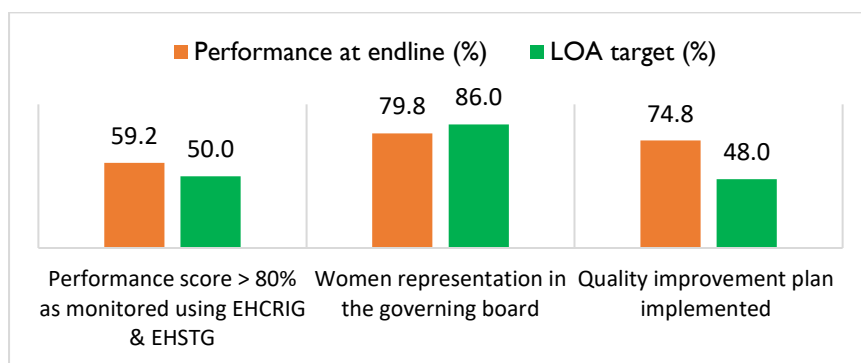


Figure 16: Health facility performance in Transform PHC intervention areas.

5.1.3 What interventions are replicable or can be scaled up in different settings?

TPHC worked closely with the MOH to institutionalize and scale up of all the interventions cited above. These interventions were widely reported effective and as having replicable approaches that should be further scaled up and sustained. For example, woreda twining was included as part of HSTP-II and scale up is imminent. In addition, key informants also reported that learning how to apply for grants empowered woreda staff to successfully apply for fundings from other partners and

continue improving. It was also reported that many of the TPHC interventions have been included in the MOH's budget for 2023 and will be continued or scaled up. When considering scale up, it is important to consider that it was reported that what drives improvement is not training alone but training in combination with other interventions such as mentoring, coaching and effective supervision, as well as other systemic strengthening (financial management, HIS, supply chain, etc.) The combination with effective health system performance improvement interventions was reported to ensure what is learned in training is applied and incorporated in healthcare delivery, and that it empowers health care providers to achieve better health outputs and outcomes on their own.

On-the-job training, BEmONC, woreda twinning, sub-grants, and clinical audit were among the most replicable. In fact, some KIs reported that all approaches employed by the Transform program were effective and potentially transforming:

“The first and important [effective approach] is the leadership and management training (LMG) given. Second, the open house meeting, a discussion which involves all stakeholders, was a good lesson that I must mention. The third and the most important initiative by this program is the increase the capacity of the professional staff on preparation of project proposal to get sub grant.” (WorHO, SNNP region)

5.1.4 What is the effect of context (conflict, COVID-19 pandemic, internal displacement) on the Transform interventions and achievements?

Several factors affected program implementation. The most frequently mentioned factors by KIs in in-depth interviews included war and conflict; political instability or unrest; COVID-19; and staff turnover. Almost all KIs mentioned that war and conflict affected activity implementation and overall health service provision. KIs mentioned that in many cases the activity's achievements “were wiped out due to the civil-war”—health facilities in war affected areas were either destroyed or not functioning properly due to shortage of the necessary supplies. As a result, because of the crisis, the TPHC focused on emergency response in conflict-affected areas, where implementation of previously planned activities was not possible.

COVID-19. The initial spread of COVID-19 was not as severe as many had feared. In Ethiopia, 1,054 COVID cases per million were reported and only 16 people per million had died from the condition in 2020¹². However, many KIs feared that by disrupting the health system, the pandemic could have devastating consequences on the public health system.¹³ A reduction in utilization of essential health services could have long-term effects by increasing preventable morbidity and mortality¹⁴. Some of the COVID-19 prevention measures taken in Ethiopia could have had adverse impacts on the utilization of essential health services. Prior to the pandemic, health care utilization and health outcomes were relatively poor in Ethiopia compared to other countries. For example, only 48% of women gave birth in health facilities at that time, and the neonatal mortality rate was 30 per 1,000 live births¹⁵. Restriction of movement, the conversion of selected health facilities into COVID-19 treatment centers and the redeployment of health workers to COVID-19 care likely further reduced access to and provision of essential health services, thereby adversely affecting population health.¹⁶

¹² Our World in Data. Ethiopian: Cumulative confirmed COVID-19 cases per million people. Our World in Data. Available from: <https://ourworldindata.org/coronavirus/country/ethiopia>

¹³ Inzaule SC, Ondoa P, Loembe MM, et al. COVID-19 and indirect health implications in Africa: IMPACT, mitigation measures, and lessons learned for improved disease control. PLOS Medicine. 2021;18(6).

¹⁴ Assefa N, Sié A, Wang D, et al. Reported barriers to healthcare access and service disruptions caused BY COVID-19 in Burkina Faso, Ethiopia, and Nigeria: A telephone survey. The American Journal of Tropical Medicine and Hygiene. 2021;105(2): 323–30.

¹⁵ EPHI and ICF. Ethiopia Mini Demographic and Health Survey 2019: Final Report. Rockville, Maryland, USA: Ethiopian Public Health Institute and ICF; 2021

¹⁶ Workicho A, Kershaw MJ, Berhanu L, et al. Essential health, and Nutrition service provision during the COVID-19 Pandemic: Lessons from Select Ethiopian Woredas. Current Developments in Nutrition. 2021;5(4).

Moreover, due to limited awareness and lack of proper preparedness of health providers, the community could fear exposure to the virus while visiting health facilities and thus avoid or delay needed care.

The pandemic caused a decline in reproductive, maternal and child health services. However, disruptions in these services rebounded to pre-COVID levels within a short period of time.¹⁷ The endline evaluation of the Transform Program in Ethiopia asked several key informants in the health system to describe the impacts of the COVID-19 pandemic on the health system. Almost all KIs said that there was a decline in the uptake of MNCH/FP interventions within the first two months after the index Coronavirus Disease was reported. The decline occurred because of the disruption of the health system as health workers were panicking to provide services and maternal waiting homes were closed to avoid COVID infections. Some facilities also served as COVID-19 isolation and treatment centers. KIs indicated that, while COVID-19 had a lesser impact on health care provision and program activities in some areas, particularly in the year following the outbreak of the pandemic, COVID-19 disrupted most of the basic health services and Transform PHC activities in many areas. The pandemic also limited health seeking behaviors among communities because of fear of potential patients acquiring the infection. As a result, most of the maternal and child health services dropped, and in some areas, services were completely interrupted. A health center director stated the following:

“The early days of the pandemic drastically compromised the service provision compared to the pre-COVID-period. Many of those who require the service did not visit the facility fearing the pandemic” (Haik Health Center, Amhara region).

Similarly, an Oromia RHB respondent mentioned that COVID-19, along with conflict and political instability, were bottlenecks MNCH/FP service delivery in the region:

“Conflict and political instability, the COVID-19 pandemic, and staff turnover were the major factors that potentially affected the implementation of the Transform program and other government activities.”

The impact of conflict. Health systems in fragile and conflict affected states (FCAS) often struggle to provide basic health services. Apart from direct casualties, war and civil strife disrupt health care delivery and thereby increase morbidity and mortality.¹⁸ Ethiopia was impacted by war, communal violence, and instability over the last two years of the Transform Activity. Most of the regions covered by the Activity experienced some form of disruption due to conflict and instability. A devastating war broke out in Tigray at the end of 2020, and later expanded to Afar and Amhara. Insurgencies were also reported in Oromia and Benishangul Gumuz regions. Many areas in Tigray and pocket areas of Amhara, Afar, Benishangul Gumuz and Oromia remained inaccessible to humanitarians because of conflict. In addition, repeated inter-communal violence and unrest was reported in Oromia, Sidama and SNNP. In Sidama, disruptions due to unrest reached a peak in 2019 and 2020. Conflict and violence across the intervention areas disrupted the movement of ambulances; health workers were displaced; health facilities were looted; and in the worst case, the entire infrastructure of health facilities was destroyed.

Key informants from RHBs, woreda health offices and health facilities reported the impact of the continuous conflict and unrest on the health system in their areas. There was a major health system disruption, and the impact was worse over the last two years and affected all regions, though the scale of the impact varied. A key informant from Oromia region reported that the health system in

¹⁷ Arsenault C, Gage A, Kim MK, Kapoor NR, Akweongo P, Amponsah F, et al. COVID-19 and resilience of healthcare systems in ten countries. *Nature Medicine*. 2022; 28: 1314–1324

¹⁸ Barry S. Levy, Victor W. Sidel. *War and public health*. 2008. 2nd ed

many parts of the region was disrupted due to conflict. “Security problems are more damaging to the health system in Oromia than the COVID-19 pandemic,” he stated. Key informants from several health facilities in Amhara also noted that health care delivery was disrupted for months because of the war in northern Ethiopia. A hospital director, for example, stated that the facility was out of service for a month because of war. Even after the war was over, much of the infrastructure was destroyed and the hospital was performing below its capacity, and even now, the hospital does not work in its full capacity. The situation has been particularly acute in the Amhara region, where war affected service delivery and stalled the progress within the health system:

“We should tell you our opinion along with the current contextual situations of our woreda. Our woreda is in a post-war time right now. We have lost all the progress we have made to improve the MNCH services in our woreda so far. As a result, many mothers are not coming to the health facilities” (Woreda health office head, Amhara region).

Even woredas in Amhara far from war affected areas reported that the conflict impacted service delivery in their areas because it shifted the attention of the government. In addition, health workers deployed to the war front and health facilities in non-conflict affected areas were unable to perform in their pre-war capacities:

“Many of our health workers working in the different health facilities were moved to the temporary stations to treat injured soldiers. ... The health professionals were leaving their regular duties, so affecting the service. There were also our health professionals assigned to go to the battlefields in order to treat wounded people” (WorHO, Amhara region).

Because of severe headwinds in the health system, including conflict, COVID-19 and other disease outbreaks, which shocked the health system and disrupted health system functions, many KIs who commented on the impacts of these contextual factors indicated that the contribution of TPHC should be interpreted in terms of how things would have been worse, if the activity had not been there.

5.2 HOW AND TO WHAT EXTENT DID TRANSFORM PROGRAM ACTIVITIES FACILITATE LOCAL OWNERSHIP, SUSTAINABILITY AND COHERENCE?

Improvements in management and in the performance of the health system were reported to have improved local ownership and facilitated measurable spillover to non-intervention areas. KIs also reported that sustainability has been built in as part of systemic interventions, but some question its success due to contextual factors. Coherence and collaboration with other partners working in the same technical areas and regions were reported to have been effective.

5.2.1 What mechanisms are in place to ensure government ownership of Transform health system interventions?

In addition to the approaches to ensure ownership and empowerment mentioned above, two main health system strengthening mechanisms were put in place to strengthen government ownership of PHC interventions: capacity building, especially in leadership, management and governance; and quality improvement.

Health workforce capacity building

Capacity building and mentorship represented the largest investment and included various MNCH/FP technical services (Box 5). KIs agreed that the TPHC activity significantly contributed to improving the leadership and governance.

“One of the supports provided by the Transform program was strengthening leadership and governance to ensure woreda transformation. They supported creating awareness among PHCU directors and HEWs

on Woreda transformation agendas. Orientations and training were provided on key performance indicators (KPI). Woreda health office management staff were training on management indicators.” (WorHO, Oromia Region)

According to KIs, Leadership, Management and Governance (LMG) training helped leaders to become more competent, and lead woredas to become better model health centers and model woredas. For instance, a respondent in Amhara’s West Gojjam zonal health department gave the examples of Bahir Dar Zuria, Degadamot and Finote Selam woredas, which succeeded in becoming model woredas for several consecutive years. The KI attributed these successes to improvement of the leadership at all levels of the health system. KIs mentioned that, after the trainings and orientations, most woredas regularly assessed their own woreda management standards using woreda management standards tool. Similarly, health centers and hospitals regularly assessed their performance standards.

Most KIs noted that PHC has contributed to building facility-level capacity. As a result of LMG training, one Amhara KI (Estie Woreda Health Office, Amhara Region) pointed to improvements in the management standards of the woreda health office. TPHC respondents also indicated effective support to MOH to implement the woreda standards.¹⁹ A TPHC regional manager in Oromia outlined a range of improvements because of Transform support as follows:

Box 6: Technical Training Topics

- ICCM
- IMNCI
- BEmONC
- Training on how to use mobile ultrasound (V-Scan)
- Malnutrition screening and management
- Family planning counseling
- Family planning provision (LAFP methods e.g., Implanon and IUCD insertion and removal)
- Compassionate and respectful care (CRC)
- Effective vaccine management, Cold chain
- Immunization micro-planning
- Training on youth friendly services
- Training on quality improvement
- Training on fistula management
- Training on health emergencies (COVID-19)
- Training on GVB service provision

“Ninety-four [all Transform intervention woredas] assess their own woreda management standards. [All] 517 health centers [in Transform intervention areas] are assessing their own health center performance standards, except for those health centers located in conflict areas of the region which were interrupted during the last two quarters. All the 2,190 Kebeles [found in Transform intervention areas] can measure their own community score card standards. There are [also] improvements that have made regarding using of the tools of identifying and solving own problems, and in assessment of the job satisfaction of [health] workers due to the training given.” (IP Regional manager, Amhara region).

However, although other KIs agreed that such practices brought performance improvement in the health system and that Transform PHC has built capacity at the facility level, sustainability will depend on future availability of resources for health workforce capacity building.

Quality improvement

According to KIs, the activity also supported the government’s reform agenda by improving quality through on-job trainings and orientations on the minimum national standards, such as the Ethiopian Health Center Reform Implementation Guidelines (EHCRIG),²⁰ the Ethiopian Hospital Services

¹⁹ The evaluation did not collect primary quantitative data to measure and compare trends in facility performance. Most KIs noted that PHC has built facility capacity.

²⁰ The EHCRIG has 10 chapters and 87 sets of minimum standards with 209 validation criteria. The tools were used to assess the availability of essential resources and services. The checklist used consists of ten chapters: (1) leadership and governance, (2) health center and health post linkage, (3) patient flow and service organization, (4) medical records management, (5) pharmacy services, (6) laboratory services, (7) clean, and

Transformation Guidelines (EHSTGs), and Woreda Management Standards (WMS). Selected health facilities reported to be linked via quality improvement projects and to share best practices. Linkages between primary hospitals and health centers were established through an initiative called “coordination for quality improvement.” Quality of care audit committees were reported to have contributed to improvements on client-provider communication while undertaking the regular observation of the service provision, such as the interaction between patients and pharmacist at health facility dispensaries.

5.2.2 To what extent did the government staff perceive that the approaches established by the project will be sustained by the government and continue to sustain improvements?

KIs indicated that the Activity’s achievements were likely to continue. They reported that the ways in which Transform PHC implemented its major strategies and approaches would ensure their sustainability and referred to specific elements of the approach that increased the likelihood of sustainability. For example, KIs emphasized that primary stakeholders from all levels of the health system were actively involved in the designing of the program and their suggestions were incorporated in the program plan. This created a sense of ownership among stakeholders and the program enjoyed widespread acceptance by stakeholders working in the public health sector. KIs also pointed out to the fact that Transform activities were in line with government plans and strategies and directly supported the activities of the public health system rather than implementing new or parallel activities implementing various capacity building activities. Because some primary stakeholders participated from the beginning of the program design and throughout the program implementation, certain KIs reported that despite government underfunding for health and declining health indicators since 2020, they believed that innovations such as sub-grants contributed to the likelihood of sustaining some of the program’s activities:

“In fact, as the program’s agendas are part of our responsibilities, we have no choice but to sustain the improvements. Therefore, we believe we will keep on sustaining the improvements, even with their burdens and shortage of resources. As well, we also believe that the improvements made, and the activities initiated by the Transform’s program will continue.”

“The woreda sub-grant is the major mechanism in place to ensure government ownership. In sub-grants, Woredas identify health problems in their respective Woredas, prepare plans, implement them, and make evaluations.” (Oromia region WorHO).

Furthermore, co-creation with stakeholders from all levels of the health system involved the designing of the program with the government’s suggestions incorporated in Activity plans, resulting in a sense that Transform PHC facilitated achievement of the government’s strategic plan on MNCH/FP, and increased ownership and acceptance among stakeholders in the public health sector.

Woreda technical support was reported to gradually shift from Transform PHC to Zonal Health Departments (ZHDs), providing ZHDs a leading role and responsibility in supporting the woredas. Coaching and mentorship support also helped in establishing a cadre of mentorship experts who are working within government structures to improve and sustain the capacity of health facilities and public health staff. However, documentation of standard operating procedures (SOPs) and other tools is not widespread.

Despite having a wide range of interventions to ensure sustainability, KIs at woreda health offices reported that they still have capacity gaps and insufficient resources to sustain some of the

safe health facility, (8) medical equipment management and biomedical engineering, (9) human resource management, and (10) quality improvement and health information system.

interventions, e.g., training and clinical mentorship of healthcare providers. Sub-granting program and Woreda Twinning were reported as instrumental, but the activity lacks indicators and targets that would provide the evidence to prove it. In addition, there was a lack of a handover and sustainability strategy and plan for each region, zone, and woreda.

KIs at RHBs noted that, despite some remarkable interventions to ensure sustainability, some woredas may face challenges, and some of the achievements may not be sustained. As turnover of health workers and managers at district health offices is high, the TPHC program organized training more frequently than previously anticipated, but it has not been able to develop a mechanism to ensure the orientation and training of new staff on an ongoing basis yet. In short, the TPHC activity became a gap-filling instead of system-strengthening program, and its sustainability is thus questioned. Key informants mentioned that some woredas developed dependency instead of working to fill their own gaps, such as strengthening of on-the-job-training mechanisms and development of in-house capacities. In addition to turnover, lack of resources may challenge the sustainability of the achievements. Key informants noted that sustainability cannot be realized unless the government allocates adequate budget resources to the health sector.

5.2.3 To what extent did the project improve community involvement and its role in accountability, transparency in decision-making, and advocacy for community health needs?

TPHC supported the use of community score cards (CSC). This is a social accountability mechanism that was implemented by the government nationwide to improve transparency, accountability and responsiveness within the health system was the CSC. The CSC was aimed at engaging community members in the management oversight of the public health facilities by promoting the engagement of community members in the planning, development, implementation, and monitoring and evaluation processes of health service delivery. Every quarter, client councils worked together with health service providers and local government officials to discuss problems and come up with solutions. These client councils were comprised of selected community members who identified problems related to health and provided performance ratings of health care facilities.

KIs reported that CSC results improved the health system responsiveness and performance. They also pointed to specific activities that they believed improved community involvement oversight of the health system:

“CSCs served us as one of the platforms for community engagement. A community forum has been organized to collect feedback on the health service provision. We have organized a community forum this year. There is a community council established in each kebele and [a typical] council has six members. Health center directors are trained on CSC, who in turn establish community councils and orient them. Orientation has been provided at the zonal and woreda levels.” (ZHD, Oromia Region)

Despite these efforts, however, challenges including conflict, civil unrest, and shifts in government priorities prevented Transform PHC and Ethiopia’s flagship community health program from achieving many of its MNCH/FP targets at the community level. Disruptions of the community health program was a factor for the slowdown of progress in key MNCH/FP interventions. For example, KIs in SNNP noted that the Women Development (WDA) and Health Extension Program (HEP) did not work as expected, and setbacks were observed in many of the community-based interventions, such as the pregnant mother’s conference.

5.2.4 To what extent did the project improve community engagement for advocacy and health service oversight? What capacity for community engagement did Transform build?

TPHC was reported to support community engagement activities through trainings, supportive supervision, and materials support. The KIs also reported that PHC conducted advocacy to improve awareness of the community about their rights. The Activity supported the “pregnant mothers’ conference” initiative. This is a forum where pregnant women gather regularly to discuss health and health-related issues during in pregnancy. KIs reported that the program support was critical to strengthening the functionality of the pregnant women’s conference. The Activity also supported an “open house health post” initiative where community members and HEWs jointly identified problems and proposed solutions to improve the health posts’ services. Numerous KIs believed that this approach improved the RMNCH/FP service utilization and quality.

“The health post open house program was also among the community engagement activities; it was launched in two of our kebeles. In our opinion, the health post open house program has made immediate improvements in the number of institutional deliveries and other indicators in those kebeles at the start of the program.” (Amhara, IP regional manager)

KIs also discussed other Activity interventions that improved community engagement: the community action cycle model, school engagement, male engagement in family planning, mass media engagement, and partnership defined for quality. Despite the positive views of KIs, the Activity did not establish indicators that would measure the effectiveness and coverage of these community-engagement interventions.

5.2.5 How does TPHC coordinate with other development partners and their activities?

The fact that the Transform program activities were aligned with the government plan, which facilitates a natural partnership between the program and government, is a sign in favor of alignment and coherence. Transform staff shared offices with the government staff, which was reported to have facilitated communication and collaboration. In addition, Transform staff actively participated in NGO forums and technical working groups, and they used these platforms to share research, experience, and resources. Partnership forums were reported to have been established at national, regional, zonal, and woreda levels to facilitate coordination among partners, harmonize activities, and avoid duplication of efforts. The forums were chaired by the government leadership, and in some of the forums the transform program served as a co-chair. According to KIs, these forums were functional, and regular meetings were conducted to harmonize plans, present reports, share experiences, and avoid duplication of effort:

“We were working with other development partners. There was a ‘Partner Forum’, a platform through which all development partners meet every six months. We are the co-chair for this forum. In addition, we were strongly working with the regional health bureau in several activities like gap strength analysis, woreda base plan and development of annual work plan. Creating a strong partnership with the regional health bureau helped us use their resources whenever we had budget limitations.” (SNNP, IP regional manager).

“The Transform program has been closely working with other partners operating in the same intervention areas. Woreda-based planning, technical working groups, joint planning, and participatory planning sessions are the mechanisms in place to strengthen the partnership among development partners. The RHB is involved in the selection of intervention sites to avoid duplication of efforts. Shifting of intervention sites is also one of the mechanisms we use to avoid duplication of efforts.” (RHB, Oromia).

At the zonal health department level, different partners were given responsibility over different areas based on need and avoid duplication of efforts. There were also government-NGO forums at zonal level where partners present their activity reports and harmonize activities.

“The zonal health department facilitates activities to harmonize the programs of other partners with the Transform’s program activities. For instance, if Engender Health plans to give training for health professionals at a given health center, we will check whether the training was given by another partner at that health center or not. Likewise, we are attempting to avoid duplication of efforts in any way. Besides, we use governmental-nongovernmental organizations (G-NGO) forum at the zonal level. In the forum, partners are allowed to present their activity reports. The G-NGO forum is also useful to avoid duplications of efforts.” (IP Amhara regional manager)

Despite these effective partnership interventions, KIs reported several challenges to effective partnerships that require effective leadership, planning and monitoring to be addressed coherently and collaboratively:

- Partners have different objectives, strategies and methodologies and are not open to changing their priorities or project implementation.
- The partnership forums are not strong enough to guide coordinated action and mutual accountability. Some are not active.
- NGOs sign project agreements with the RHB without coordinating with other partners, which creates overlapping of programs and gaps in some areas.
- There is no database of the health staff who have received training on specific topics. It is possible that the same person attends training on the same topic repeatedly.
- The Woredas to be supported were selected by the RHB. The problem is that the RHB did not involve the Zones in the Woreda selection process.
- Lack of accountability of development partners to follow through with their commitments and meeting community expectations.
- Reluctance among some of the development partners to cooperate and work together as they may be competitors for future projects.
- These inefficiencies lead to resources being left unutilized and significant duplication of efforts.

5.3 HOW DID THE ACTIVITY CONSIDER GENDER DYNAMICS IN IMPLEMENTATION?

Figure 18 shows that the activity did consider gender in its activities, but had limited effect:

- Women accompanied by their spouses during delivery increased slightly.
- Women’s participation in health care decision-making and women accompanied by their spouses during ANC showed a statistically significant decline ($p < 0.001$).
- Men accompanying their spouses during delivery remained the same, whereas women accompanied by their husbands during ANC showed a declining trend compared to the midterm.

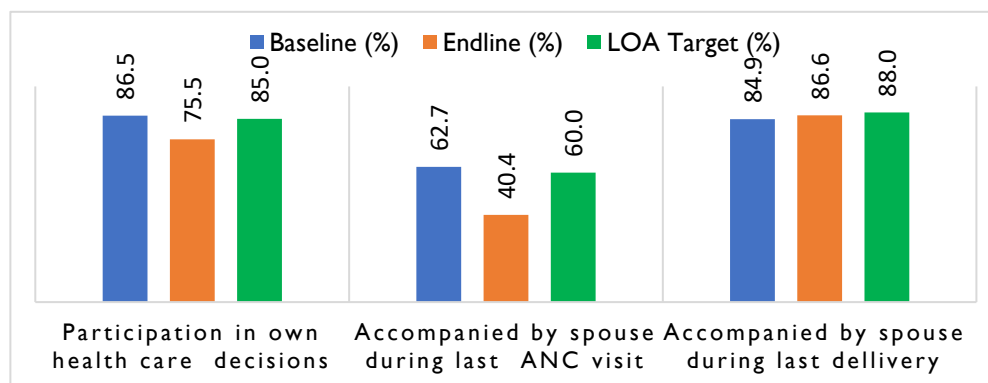
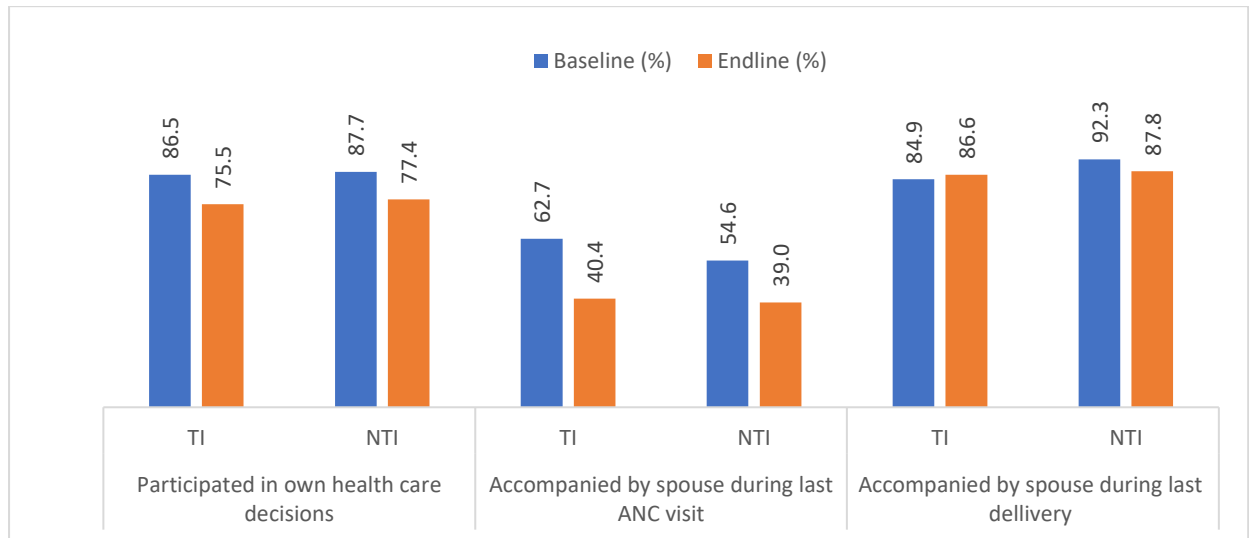


Figure 17: Baseline and endline comparison of selected gender-related indicators.

As Figure 19 shows, women’s participation in own health care decision making and the proportion of women accompanied by a spouse during delivery increased both in Transform intervention and non-Transform intervention areas.



TI = Transform Intervention; NTI = Non-Transform Intervention

Figure 19: Selected gender related indicators at baseline and endline

The endline survey uncovered regional differences that deserve further study. First, women’s participation in health care decision-making increased in Amhara, while it declined markedly in the other regions; in Amhara and SNNP women who were accompanied by their spouses during delivery increased; and women accompanied by their spouses during ANC declined across all regions (Table 10).

Table 10: Baseline and endline comparison of gender indicators by region.

Indicator		Amhara	Oromia	SNNP
Women participated in their health care decisions	Baseline (%)	91.3	88.5	79.7
	Endline (%)	91.5	75.0	58.1
Women accompanied by their spouse during at least one ANC visit	Baseline (%)	68.3	69.2	52.6
	Endline (%)	40.7	40.6	39.7
Women accompanied by their spouse during last delivery	Baseline (%)	81.0	87.3	85.2
	Endline (%)	84.2	86.2	89.0

TPHC conducted an assessment to identify gender issues and chose to also address the health needs of gender-based violence (GBV) victims and the provision of integrated GBV services in all woredas. By 2021, TPHC reported that 73% of the supported facilities provided post-GBV services and had created nine demonstration GBV centers. KIs reported that these centers provide a “One Stop Shop” service for GBV victims where professionals from justice, police, and health work together to help victims.

“Gender issues were one of the activities that we have in our checklist whenever we went to woredas for monitoring. Besides, gender issue was one of our routine activities. For instance, we have conducted gender analysis in more than 50 woredas and provided a psychological support for victims of gender-based violence (GBV), especially in the areas where there are IDPs. We were closely working with different governmental and non-governmental organizations which works on gender issues.” SNNP

The health facility survey during the endline showed that 67% of surveyed health centers/hospitals in the Transform intervention areas conducted GBV screening, and close to 60% referred victims for psychosocial support. TPHC also supported the training of health professionals on GBV service provision, including counseling. Moreover, the program provided materials such as “Dignity Kits” for GBV victims during the war. Figure 19 shows improvement for GBV indicators in intervention areas when compared to non-intervention.

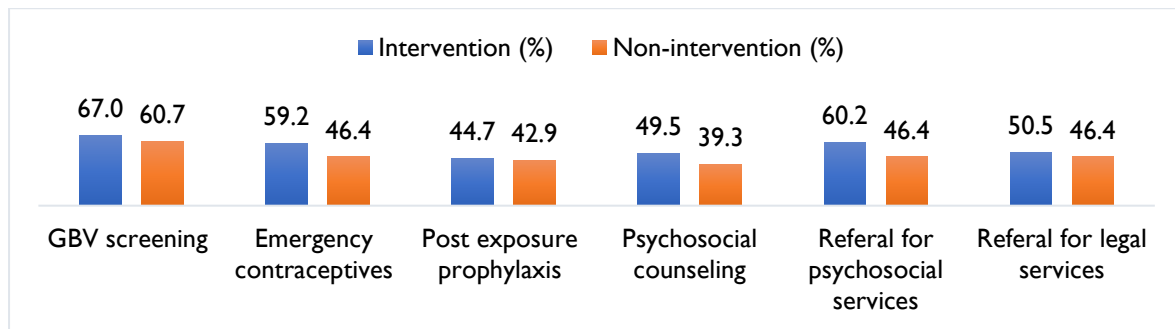


Figure 18: Percent of Transform PHC intervention and non-transform intervention health facilities providing specific GBV services at the time of the survey.

TPHC also introduced the “Her Space” initiative aimed at improving the knowledge, attitude, and practice of young girls regarding reproductive health and teaching essential life skills.

“The other one is the Her space program and the approaches involving the participations of the brothers and parents of the female members (the girls) in the learning sections. This program was launched in four kebeles of our woreda. This approach increases the knowledge, attitude, and practice of young girls in many aspects of reproductive health. This program helps young girls to acquire essential life skills which are valuable to their futures. And, looking at the biological brothers and parents of the member girls taking part in the learning section, tells us the increase in awareness of the brothers and the parents of the girls.” (WorHO, Amhara Region)

The further expansion and sustainability of these GBV centers and gender activities was unknown, as they were too new to be able to predict future programming.

5.3.1. To what extent did the government staff/people perceive that the project established processes are functional to track and address gender and inequitable health outcomes?

73% of the facilities surveyed as part of this evaluation reported providing some form of post-GBV services. KIs perceived several gender-related improvements such as the post-GBV guidelines and the establishment of nine GBV centers. However, the Activity faced challenges in deepening its contributions to gender-related improvements: First, it had only one gender expert to address this technical area and second, reportedly did not have gender-specific indicators, nor did it use HMIS indicators to monitor gender interventions to tracking the effectiveness of gender-related interventions. Use of such data would have better allowed for comparing regions, zones or woreda performance to support weaker areas to improve.

For some KIs, these challenges posed barriers to implementing deeper gender-based interventions that could contribute to effectively addressing gaps. For example, KIs reported that it was unclear how many victims have been treated at the GBV centers or how many woredas or facilities have improved their gender-related performance because of the TPHC activities. Moreover, MOH currently does not provide sufficient resources to tackle gender-based issues, particularly at lower levels. According to one regional IP manager:

“Tracking gender issues is still needs more work. It has many barriers for the implementation of gender. One thing there is no clear plan and guideline about gender integration in the system. The other is community’s perception about gender is low. Though gender seems getting better at the top with equal representations in Ministerial cabinet, the problem is still there when it comes to the lower level.” — (IP Regional Manager, Amhara Region)

5.3.2. What gender equity results did Transform Program Activities’ interventions achieve?

Informants reported that the gender assessment and landscaping analyses TPHC conducted helped inform policies and intervention. The Activity’s recent (2022) landscape analysis described its activities as “entry point” for integrate GBV prevention and treatment, which were intended to provide evidence for MOH to “propel GBV interventions.” Key informants also widely reported effective activities for youth. One respondent in South Wollo Zone in Amhara region stressed the contribution of the Activity to generating youth awareness as follows:

“There are effective processes that address gender issues. For example, there are activities done to address young girls. For instance, there was a program called ‘Act with Her.’ The program was given at schools to foster peer-discussion and build life-skills of young girls mainly on reproductive health issues. This youth friendly approach was effective. In the process, trainings were given to the youth; and peer-to-peer discussions were encouraged. In this regard, there were activities done to make both girls and boys become capable of utilizing the youth friendly services fairly. Besides, there were activities done to raise awareness of the girls, so as to enable them to prevent gender-based violence. Overall, the processes were assessed by the program at quarterly basis.” – WorHO health officer, South Wollo Zone, Amhara region.

5.3.3. What gaps exist in the current USAID/ Transform intervention design/programming in terms of addressing the key gender issues in the targeted regions of Ethiopia?

There are many gaps that remain to be addressed, both in terms of service provision and in monitoring the quality and effectiveness of gender related services. With only nine centers providing post-GBV services nationwide, access to services GBV victims is limited. A number of challenges were reported such as he still-prevalent practice of early marriage, the lack of gender equity indicators to monitor the Activity’s progress towards reducing gender inequity in supported woredas, and barriers to access to FP/RH services for unmarried and out of school youth represent current gaps,

The scale of “entry point” interventions conducted by TPHC is also not well documented; gender documents do not typically specify how many woredas or facilities are targeted, nor are improvements resulting from gender equity activities documented. KIs did realize that broader gender issues were a multi-sectoral issue needing more concerted effort and investment and more collaboration with other stakeholders. KI reported the following major challenges to addressing gender gaps in the health sector:

- Lack of documentation of gender interventions in woreda based planning, including use of MOH standard operation procedures (SOP) and manuals
- Lack of a set of targets to monitor effectiveness and coverage of implementing gender interventions
- Lack of technical staff to implement gender-related activities at large scale and to support scale up

For these reasons, clear gender targets for gender-based activities are needed and future baseline research disaggregated by locality is necessary to collect data on scale of investment, number of woredas using the MOH SOP and manuals, and the results of the use of these guiding materials.

5.4 INDICATOR TRENDS AT BASELINE, MIDLINE, AND ENDLINE

Figure 20 below summarizes the progress of the TPhC activity and its outcomes by technical area by baseline, midline, and endline. The downward trends in most indicators since midline indicate the need for further operational research and revised SOPs to ensure effective service delivery and coverage expansion during periods of external shocks.

Thematic Areas	Key Performance Indicators	Time frame			Trend
		Base line (%)	Midterm (%)	Endline (%)	
Family Planning	MCPR among all women	36.6	41.6	32.6	
	MCPR among currently married women	45.1	47.3	36.5	
	LAFP methods among all women	9.7	12.5	11.4	
	LAFP among currently married women	11.8	14.1	12.7	
	Family planning counseling after birth (PPFP counseling)	29.2	29.1	19.4	
	PPFP use	34.6	42.8	27.7	
Maternal Health	Early initiation of ANC	28.9	50.8	51.8	
	IFA for at least 90 days	21.7	25.1	18.5	
	ANC4+	56.1	46.5	40.6	
	Essential components of ANC	32.8	35.7	28.4	
	Skilled birth attendace	57.5	63.4	59.1	
	Early PNC for mothers	43.5	51.8	41.9	
Newborn Health	Early PNC for newborns	37.4	46.9	39.9	
	Essential Newborn Care	8.9	16.4	12.0	
	Early initiation of breastfeeding	74.9	88.8	83.7	
Child Health (under 5 years)	Full immunization (at anytime before the survey)	40.3	42.4	26.8	
	Vitamin A supplementation in the last 6 months	43.1	46.4	72.2	
	Children with Symptoms of ARI	7.0	4.7	3.0	
	ARI treatment	29.4	53.6	55.3	
	Diarrhea incidence	9.0	14.1	12.1	
	Diarrhea treatment	28.9	33.2	12.1	
	Exclusive breast feeding	58.3	71.4	75.0	
	Deworming in the last 6 months	36.9	43.2	60.5	
	Fever treatment within 24 hrs of onset	40.9	37.1	22.9	
Gender and women empowerment	Women who participate in decisions regarding their own healthcare	86.5	83.5	75.5	
	Women accompanied by their spouses/partner to at least one ANC visit	62.7	45.9	40.4	
	Women accompanied by their spouses/partner to a facility during birth	84.9	87.1	86.6	
CBHI	Households enrolled in CBHI scheme	22.6	45.9	73.8	

Figure 19: Indicator trends at baseline, midline, and endline

5.5 HOW AND TO WHAT EXTENT HAS THE TRANSFORM IP BEEN ABLE TO ADAPT THEIR INTERVENTIONS ABOUT LEARNINGS AND NEW EVIDENCE?

5.5.1. To what extent did the project make adaptive changes? Based on what evidence?

The Activity's drew heavily on its operational research based on the thesis that a strong and sustained quality health system that uses evidence-based decision-making requires evidence in health program interventions. Without such research, it is less likely to build successful practices, make evidence-based judgments, and design policies that can improve population health outcomes.

Transform PHC therefore conducted numerous studies and operational research surveys intended to improve and adapt its interventions in different thematic areas.

These included research on a wide variety of topics such as male engagement, leadership management, family planning, and post-partum family planning. The activity developed over 50 articles for publication in peer-reviewed journals to document evidence and share learning nationally and globally. These studies were used to improve programming and adapt implementation approaches. Examples of the utility of operational research and studies includes the use of research evidence to contribute to intervention planning in a number of areas, including supportive supervisions, referrals, integrated periodic outreach services, emergency response, service integration, strengthening of the health system, instillation of a culture of performance and quality improvement, facilitation of the introduction of technology and innovations, and informing manuals and policy at the national level.

The IP also conducted quarterly and annual review sessions to assess results and determine where gaps remain. Each technical review meeting begins with a discussion of the project's theory of change (TOC). During these meetings, government representatives discuss priorities and the role of stakeholders. As a result of these meetings the Activity confers with USAID on questions related to shifting resources, expanding budgets, and to seek advice on the extent of adaptation the project can support. During the annual TOC exercise, the IP conducted a strength-gap analysis and partners mapping to leverage resources and prevent duplication of effort before finalizing yearly implementation work plans. A comprehensive plan was then created in conjunction with the public sector and partners operating in each implementation region, and a final plan is created at the national level. Disseminating information from research through websites, journals, webinars, and national and international conferences was also a key important element to Transform PHC's approach:

“Doing research is only half the battle; without publishing the findings of research studies or program documentation, other researchers or decision-makers will not recognize the importance of the evidence produced, won't be able to see it or expand on it, and science won't advance as a whole. Without written records, knowledge is lost, and it cannot be broadly disseminated without an efficient process.”

From the IP's perspective, the primary and crucial step in the generation of evidence was choosing an appropriate and pertinent research topic. Prior to choosing the precise research topic, program staff were given training on how to identify relevant issues from prior experience, field observations, and critical reading of quarterly and annual reports, and how they prioritized areas of health promotion and the most pressing issues relating to reproductive, maternal, newborn and child health (RMNCH). The IP also provides training and orientation on how to identify the research questions that need to be addressed and how to communicate these to the scientific community. To facilitate the process, the IP created a guide for the implementation of research, which was distributed to all technical personnel so they can understand how and why we undertake research. Technical personnel then created concept notes that outline what will be explained or answered, why the evidence is significant and the process by which the issue will be investigated. Before creating a developed proposal, USAID was provided with a draft concept note to solicit additional input. The criteria that the IP used for selection of topics were:

- Will the research answer a relevant and important project intervention problem?
- Is the new knowledge potentially worth the cost of the research?
- Is there are clear research objectives and questions related to the TPHC project, and does the proposed research design answer these objectives?
- Does the research fit with a theory of change or causal chain in a coherent way? If not, what is the potential for generating new theories or questions?

- Will the research produce results that can be acted on in a timely way by the intended audiences?
- Does the research design reflect an understanding of whether the intervention is stable and simply replicable, or whether the intervention is expected to change?

Because the activity was carried out in collaboration with the government at all levels, data and program learning were shared with partners through a variety of venues and sources. These were perceived to have an impact on plans and policies, many of which are now owned and used by government. Important examples include the FP quality standards, which were tested at healthcare facilities and were found to be successful in raising the quality of care. Based on implementation at healthcare facilities, these standards were later incorporated into national health planning.

Similarly, the Activity introduced V-Scan obstetric ultrasound in a few health centers as a pilot, increasing service quality and usage. Later, as a prelude to wider scale up, MOH added V-Scan restricted obstetric ultrasonography to its HSTP-II. Other examples of changes noted by the IP because of Activity support include the revision of health care performance implementation guidelines, the creation of new job aids that took into consideration complex requirements and implementation of the twinning partnership model as a pilot, which enhanced partnership engagement. Later, to scale up twinning, the government also added this concept to the HSTP-II. Similarly, based on pilot projects, the community scorecard intervention was scaled up to bigger primary healthcare facilities. The Activity also used specific recommendations from the mid-term evaluation to modify implementation approaches and to improve results. For instance, a planning exercise on family planning (FP) was introduced based on the findings of the mid-term evaluation.

In addition to publication in peer-reviewed journals and presenting conference abstracts, the Activity developed webinar presentation on such topics as:

- Leveraging maternity waiting homes to increase the uptake of immediate postpartum family planning in primary health care facilities
- Accelerating the performance of district health systems towards achieving universal health coverage via twinning partnerships
- Practices and prospects for adolescent transition to adulthood through very young adolescent interventions
- Health system strengthening through investment activities across woreda FP/RH care systems
- Life expectations in early adolescence and the impact of clubs on reproductive health knowledge
- Coordinating efforts to decreased maternal death due to postpartum hemorrhages

In addition, the activity participated in three learning forums with the other Transform activities organized by the Transform MELA team. They also reported using information from different sources, including operational research, and DHIS2 data, to monitor progress and adjust strategies. According to KIs, findings from random follow-up visits provided gist for discussion between program staff and staff in the public health system.

“Every year, we conduct random follow up/visits to sampled woredas and health centers under these woredas. We used to conduct a forum and share these results for the public sector staff. Second, we have published much research in different thematic areas (male engagement, leadership management, FP, and post-partum FP). We have presented these findings in different international journals and at the Ethiopian Public Health Association Forum. Besides, we have been sharing all our data for different stakeholders found in our region. In general, we have been making continuous improvements on our program based on the evidence generated from our own work plan, MELA mid-term finding, random follow up and the evidence generated from different research findings.” (IP Regional Office, SNNP Region)

5.5.2. How did respondents perceive that these adaptations contributed to MNCH/FP outcomes?

KIs reported on several effective interventions that contributed to MNCH/FP outcomes. They emphasized the most important contributions made by TPHC: the leadership, management and governance (LMG) training, increasing the capacity of the professional staff on preparation of project proposal to apply for grants, the woreda twinning, the FP program planning exercises, the creation of linkages between hospitals and health facilities, and the provision of ultrasound machines:

“Among the best practices of the Transform program; the woreda-to-woreda twinning approach, the linkage created among health faculties such as health centers with health posts, again the approach called EPHCAQ (Ethiopia Primary Health Care Alliance for Quality) where hospitals are supporting the health centers, the budget allocation or the sub-grants approach, the activities done to improve the leadership such as leadership management system (LMS) and the woreda management standard trainings, the Her Space program, the custom of working in integration with the governments system, and generally, all the attempts made to increase accessibility, quality and continuum of care regarding MNCH service were all best.” (ZHD, Amhara Region)

“The provision of ultrasound [v scan] is the first intervention that should be considered a best practice. In the past, ultrasound service was provided at private clinics and hospitals only, and women should travel a long distance to get an ultrasound service. [Because of the success at Transform intervention areas], other health centers not supported by the Transform PHC are also requesting us to organize and provide training to midwives and that they will allocate the budget needed to purchase ultrasounds. This is the result of the interventions and the motivation created. I have been talking this to the RHB. This is a good practice the program introduced.” (ZHD, Oromia Region).

5.5.3. What lessons were learned for project future design, management, and monitoring?

After five years, numerous lessons emerged. In the view of the interviewed KIs, having a focused strategy for improving measurable MNCH/FP outcomes allowed for the success of the twinned woredas and facilities. Selected twinned woredas contributed importantly to improving measurable performance-based outcomes, according to the KIs. Woredas were able to apply for sub-grants from other sources and improve services. Some have been recognized as model woredas, as well.

“Those strategies that have the greatest effect on the MNCH/FP outcomes could be taken as a good opportunity for scale up and strengthen learning. For example: Ethiopian Public Health Institute (EPHI) of the Amhara region has taken twinning strategy as one of the agendas for its weekly meetings and contributed for MNCH/FP outcome. Through twinning, resources are shared across woredas. Example, through the twinning strategy woredas share V-scan and get technical support from one woreda to another or One PHCU to another within the woreda.” – (IP Regional Manager, Oromia Region)

From the design point of view, having measurable targets and indicators that capture the effectiveness and coverage of every intervention may help inform implementation decisions. For instance, and as recommended below, it would help to conduct operational research to improve coverage of ANC4+ and barriers to FP services. It would help monitor how many woredas are able to perform according to standards and thus “graduate” to be able to be twinned with lower performing ones. Ideally, the number of high-performing woredas should increase every project year. New indicators and monitoring can help to track the rate of improvements across various woredas to help those where the rate of improvement is slowing down.

6) CONCLUSIONS

Contextual factors affected the capacity of the activity to achieve its targets, as evidenced by the significant decline in achievements since the midterm. The final performance evaluation of TPHC evaluated the endline outcomes in relation to the baseline and midline and in relation to the Activity's intermediate results. The evaluation noted progress despite severe contextual constraints since the midterm and can be briefly summarized as follows:

- IR1. Qualitative evidence indicates that the activity has improved management but not enough to improve the performance of the health system as shown by the decline in performance on MNCH/FP indicators.
- IR2. The activity has improved the quality of services in several woredas, but this was not enough to overcome contextual and systemic factors that would ensure that quality improvements could be sustained.
- IR3. Household and community behaviors have had limited improvement, mostly due to contextual factors that require further study.
- IR 4. The activity has enhanced learning but faced with contextual headwinds, this did not prevent the decline observed since midline.

Despite challenges, the final evaluation demonstrated that TPHC has established innovative processes; helped to improve the functioning of regional public health systems and programs; and strengthened the leadership, management, and governance skills of staff in selected woredas and facilities. TPHC also demonstrated to have developed an iterative learning program that, among other results, helped expand CBHI and inform policy and programming. Sometimes, successful interventions such as training and twinning did not work as well in other woredas indicating the need to adapt interventions to different contexts.

The Activity achieved these results through a combination of technical support interventions to the public health system. The interventions included: establishing skill labs; provision of on-the-job training, mentoring, and coaching; post training follow-up visits and supervision; provision of equipment and supplies; and sub-grants. TPHC's technical support was reported to have improved quality and thereby increased coverage of high impact health interventions. Relatively few KIs discussed least effective interventions—generally, these related to cases in which interventions that were reported as successful in some regions were less successful in others; difficulties with the health information system that did not allow for continuous monitoring and quality improvement was cited as one example. This demonstrates that despite a wide range of interventions, lack of consistent quality across woredas and facilities is still a roadblock to the consistent delivery of MNCH/FP services. As described below, and likely due to contextual headwinds, household and community health practices and health-seeking behaviors declined, and continuity of MNCH/FP services remains a challenge. Nevertheless, comparisons between Transform intervention areas and non-Transform intervention areas were favorable:

- **Contextual factors including conflict, COVID, and systemic issues negatively impacted outcomes.** Conflict led to important regional and intra-regional variations in performance as measured by KPIs. Declines in KPIs at endline were, for example, most pronounced in the Amhara region, and particularly in conflicted areas of Eastern Amhara such as North Wollo, South Wollo, and North Shewa. COVID-19 disrupted many basic health services. Household and community health practices and health-seeking behaviors outcomes (IR3) also declined because of patients' fear of acquiring the infection at health facilities. Stockouts of medicines and equipment and high rates of staff turnover also negatively impacted progress towards targets.
- **Ownership and sustainability gains due to Transform interventions are at-risk because of high turnover of trained staff, which was compounded by the effect of war and insecurity.** Understanding the causes of this challenge warrants further study to

develop more effective and sustainable recovery and improvement interventions in the affected conflict zones.

- **Transform PHC intervention areas had better performance for facility-based services at endline when compared with the non-Transform intervention areas.** As examples, outcomes for SBA, LAFP, essential newborn care either improved or remained the same. However, most community-based service KPIs (MCPR, immunization, basic sanitation, diarrhea treatment) declined in both Transform and non-Transform intervention areas.
- **Transform PHC contributed to improvement in performance in some key maternal health outcomes** (SBA, early ANC coverage), and likely prevented deterioration in coverage of other maternal health outcomes (e.g., ANC4+).
- **Transform PHC contributed to improving some newborn and child health outcomes.** Treatment for acute respiratory infection (ARI) increased, contributing to improved newborn health outcomes as compared to non-intervention areas. Measles coverage also increased, but full vaccination and Penta 3 coverage remained low, indicating that immunization was not conducted as expected due to conflicts and COVID.
- **Transform PHC contributed to improving the coverage and quality of selected services of the PHCU's continuum of care** (IR2). These include early ANC, SBA, newborn healthcare, ARI treatment for children below five years of age, and LAFP use.
- **LAFP use increased, whereas PFPF and MCPR performance declined.** The decline in MCPR resulted from the decrease in use of short-acting methods, probably because of weak performance of health posts.
- **Continuity of MNCH/FP services remains a challenge** (e.g., ANC 1 to ANC4+ dropout). Lack of counseling on the importance of continuity of care was identified as the main driving factor for dropouts. A key informant, for example, stated that women usually come to health facilities for ANC and fail to return for the next visit because of the lack of good quality of care.
- **Transform PHC established and implemented innovative processes** (IR1.1) such as the twinning of woredas and FP program planning; improved the functioning of regional public health systems and programs in several woredas (IR 1.2), and strengthened the leadership, management, and governance skills of staff (1.3) in selected woredas and facilities.
- **Transform PHC demonstrated a high capacity for learning and adaptation in implementation** (IR3.1). The activity demonstrated good practices in use of evidence from studies and operational research in collaboration with MOH and integrated this evidence in their activity planning and implementation. As one example, Transform-funded research informed policy and programming which facilitated the expansion of CBHI in both interventions and non-intervention areas (IR 3.3).
- **Gender outcomes were generally positive but require further efforts.** As a positive outcome, the availability of post GBV interventions increased at health facilities supported by Transform PHC intervention when compared to non-Transform intervention areas. The activity was also able to increase the availability and range of adolescent and youth health services. However, the utilization rate and impact of such services on gender inequalities, such as early marriage and early pregnancy, requires further study.

7) RECOMMENDATIONS

Recommendations for MOH

- **Reinforce coordination of development partners to effectively implement woreda transformation.** HSTP II set goals for woreda transformation in the context of multisectoral development and a set of targets. It is essential that MOH work with development actors to demonstrate an effective model that can be implemented in a pre-determined number of model woredas in each region.
- **Revitalize community health programs.** Priority should be given to rehabilitating and revitalizing community health programs, especially in war-affected woredas. Health posts should be functional and provide services on all weekdays, and various community structures and platforms should be utilized to mobilize the community and ensure whole-of-society engagement. Key informants reported that community mobilization and engagement platforms have weakened, and this has resulted in declines in community-based performance due to weak community platforms. Community health programs such as ICCM and ANC service exist but community mobilization and follow-up is weak due to the non-functioning of the Health Development Army (HDR) or similar structures.
- **Assess woreda and health facility twinning partnership bottlenecks and make path correction measures before scale-up.** Transform PHC adapted the twinning partnership strategy in Ethiopia to improve health system performance. The result of the twinning strategy gave mixed results. While twinning was successful in some woredas and facilities, it did not result in significant contributions in other woredas and facilities. In some areas, lead woredas were unable to provide adequate technical support to their peers. In other areas, mentee woredas were not ready to accept recommendations from lead woredas. Future interventions in this initiative should properly support and strengthen both the roles of the lead and mentee woredas, closely monitor the proper implementation of the twinning program, and conduct path correction when implementation shortcomings are identified.
- **Integrate FP counseling across all contacts in the continuum of care:** Contraceptive use is low, and few women are counseled on FP during the postpartum period. Integrating family planning counseling during all contacts in the continuum of care (ANC, childbirth, postnatal care, immunization, etc.) will likely lead to increases in family planning use.
- **Commission supplemental operational research to explore the underlying factors contributing to the decline in performance of selected key performance indicators.** Determining the root causes for the decline in performance for selected performance indicators requires further research. With continued support from development partners, the outcome of such research can inform future design and programming such as ANC4+, which has been declining since baseline
- **Add and retain additional health facility personnel to ensure consistent provision of services, especially in difficult-to-reach areas.** Staff turnover can create gaps in service, and the evaluation suggests that distance is a factor in affecting activity performance. MOH should therefore develop personnel retention plans that motivate qualified health staff to remain in their posts.

Recommendations for USAID

- **Continue support for innovative approaches on social and behavior communication change (SBCC) to bring sustained behavioral change to MNCH/FP practices:** The findings of this evaluation showed that coverage for key

MNCH/FP indicators in Transform PHC regions is low despite some progress. Many women who participated in the survey noted that they did not visit health facilities during pregnancy and childbirth largely because it is still not customary for them to go for ANC visits. Many believe a pregnant woman does not need to have ANC visits unless there is a specific problem or disorder. These findings demonstrate that there are still gaps in women's awareness of the importance of ANC. Further work is therefore required to develop and implement effective SBCC approaches designed to change such perceptions.

- **Revisit target setting methodology and assumptions. Target against performance should be monitored continuously by a third party for course correction and adjustment of targets.** Most of the Transform PHC Life of Activity targets have not been fully achieved. Thus, continuous monitoring and timely adjustment are required to increase the likelihood of achieving targets.
- **Reinforce leadership capacity building:** This evaluation pinpointed that leadership is critical to performance of the health system. However, leadership turnover at woreda and regional levels remains a challenge. Thus, support for establishing a continuous leadership and management program should be further strengthened
- **Develop a dual health system strengthening strategy that 1) continues its support to the Health Sector Transformation Plan II (HSTPII) to keep advancing towards EPCMD goals, and 2) implements a recovery strategy to build resilience in conflict zones.** A focused and targeted health system strengthening strategy that measurably contributes to HSTP II and strengthens the health system to recover from recent shocks in the most affected woredas, will allow USAID to achieve greater impact. This health system strengthening recommendation follows USAID's health system strengthening strategy principles and the WHO's six building blocks model.²¹
- **Strengthen support for health posts and health centers with additional supplies and equipment.** Several factors have contributed to a continued deterioration of service delivery at the lowest levels of the health system, namely health posts. Despite challenges, important improvements came because of the provision of critical supplies and equipment to health facilities such as ultrasounds and V-scans. However, stockouts of supplies and lack of equipment continue to impede the effective delivery of MNCH/FP services, especially at health posts. Therefore, USAID should work with the MOH to prioritize supply provisions and to provide critical supplies and equipment.
- **Improve Ownership, Sustainability and Coherence:** the design of future activities should build ownership, sustainability, and coherent interventions should provide specific metrics to progressively demonstrate that woredas and facilities are “owners” and capable of sustaining improvements in coordination with all stakeholders and partners.
- **Continue Participatory Learning and Adapting:** The current activity recognized that these problems require study and prioritization and that solutions to emerging problems should be addressed as new challenges arise. It also recognized that the continuous cycle of learning and adapting is a “team sport” that needs to be participatory. There are however still many challenges and bottlenecks to the health system that vary among regions, zones, woredas, and facilities, including high staff turnover, that prevent the effective and efficient operation of health care delivery. Because each region has unique characteristics, health

²¹ Using the World Health Organization health system building blocks through survey of healthcare professionals to determine the performance of public healthcare facilities
<https://archpublichealth.biomedcentral.com/track/pdf/10.1186/s13690-017-0221-9.pdf>

system structures and resources, further operational research is needed to identify and monitor the factors related to staff turnover as well as family planning utilization and ANC 4+ uptake for adults and adolescents, and the impact of woreda twinning and gender-based services. Similarly, although CBHI has greatly expanded, it will be important to understand the effectiveness of CBHI and how it contributes to expansion of access to MNCH/FP services. Future activities should therefore develop an operational research agenda that includes these chronic problems and identifies the appropriate causal pathways to address them, taking into consideration regional differences. The expected outcome of such operational research should be: “An efficient health facility management model that solves operational problems in the supported regions, zones, woredas, and facilities.”

Recommendations for the current TPHC activity

Given that this is the final evaluation of the TPHC activity, the recommendation to the IP is to ensure the effective transfer and handover of its research reports, tools, and training manuals to all its GOE counterparts.

ANNEXES

ANNEX I. EVALUATION QUESTIONS AND DATA SOURCES

Key Evaluation Questions	Specific and Probing Questions	Design	Data Source
1. How effective were the Transform Program Activities' approaches in contributing to improving MNCH/FP outcomes?	<p>1.1. Were Transform activities implemented as planned? If not, why not?</p> <p>1.2. To what extent did the Transform improve MNCH/FP outcomes and reduce outcome inequities in different groups in intervention areas compared to control areas?²²</p> <ul style="list-style-type: none"> • To what extent did activities achieve their targets? • Which targets were met or exceeded? • Which targets were not met? <p>1.3. How effective are the Transform Activities strategies and approaches?</p> <p>1.4. In your opinion which of the Transform Activity interventions are replicable or can be scaled up/applied to a different setting?</p> <p>1.5. What is the effect of context (Conflict, Covid 19 pandemic, internal displacement) on Transform Activity interventions and achievement of intended results?</p>	Mixed methods	<p>- HH respondents</p> <p>- HF respondents and observation</p> <p>- KIs from USAID, MOH, IPs, RHBs</p> <p>- Transform IP reports and documents from MOH</p>
2. How did Transform Program Activities facilitate local ownership, sustainability, and coherence ?	<p>2.1. What mechanisms are in place to ensure government ownership of Transform health system interventions?</p> <p>2.2. To what extent did government staff/community perceive that the approaches established by the project will be maintained by the government and continue to sustain MNCH/FP improvements in the next 3 and 5 years?</p> <p>2.3. To what extent did the project improve community involvement and its role in accountability, transparency in decision-making, and advocacy for community health needs?</p> <p>2.4. To what extent did the project improve community engagement</p>	Qualitative	<p>- KIs from USAID, MOH, IPs, RHBs</p> <p>- Transform IP reports and documents from MOH</p>

²² Note: We intend to measure inequities in terms of geographic variations among regions, residential locations (urban/rural), age, educational status, and others.

Key Evaluation Questions	Specific and Probing Questions	Design	Data Source
	<p>for advocacy and health service oversight?</p> <ul style="list-style-type: none"> • What capacity for community engagement did Transform build? <p>2.5. How do Transform Activities coordinate with other development partners and their activities?</p>		
3. How did Transform Activities consider Gender dynamics in activity implementations?	<p>3.1. To what extent did the government staff/people perceive that the project established processes are functional to track and address gender and inequitable health outcomes?</p> <ul style="list-style-type: none"> • Provide examples to substantiate perceptions. <p>3.2. What gender equity results did Transform Program Activities' interventions achieve?</p> <p>3.3. What gaps exist in the current USAID/ Transform intervention design/programming in terms of addressing the key gender issues in the targeted regions of Ethiopia?</p>	Qualitative	<ul style="list-style-type: none"> - KIs from USAID, MOH, IPs, RHBs - Transform IP reports and documents from MOH
4. How and to what extent have the Transform IPs been able to adapt implementation approaches based on learnings and new evidence?	<p>4.1. To what extent did the project make adaptive changes? Based on what evidence? (e.g., responses to Transform midterm recommendations and IP-led studies)</p> <p>4.2. How did respondents perceive that these adaptations contributed to MNCH/FP outcomes?</p> <p>4.3. What lessons were learned for project future design, management, and monitoring?</p>	Qualitative	<ul style="list-style-type: none"> - KIs from IPs, - Transform IP reports
5. To what extent did the Transform program improve MNCH/FP outcomes in Transform intervention woredas compared to non-Transform intervention woredas?	<p>5.1. To what extent did the Transform program ensure improvement in MNCH/FP outcomes?</p> <p>5.2. Are there any unintended results (positive or negative) specific to Transform program interventions?</p>		<ul style="list-style-type: none"> - HH respondents - HF respondents and observation - KIs from USAID, MOH, IPs, RHBs - Transform IP reports and documents from MOH

ANNEX 2. DETAILED EVALUATION METHODS

DATA COLLECTION METHODS

Data Sources

The final performance evaluation used two main sources of qualitative data – document review, and KIIs, and drew quantitative performance data from HH survey and HF survey of the Impact Evaluation. A range of documents were reviewed including IP performance reports, MOH annual reports, Health System Transformation Program (HSTP) midterm review, Mini-Demographic, and Health Survey report, Transform baseline and midterm evaluation reports, and other relevant documents. The primary data collection involved a HH survey, HF survey, and KIIs from sampled woredas in all regions, except Tigray.

Data Collection Tools

KII followed a guide to gather the views and experience of the interviewees in relation to the performance of the PHC Activity. The questions are broad and open-ended to gather unbiased answers and were accompanied of probing questions to gather more detail on the themes raised by the interviewee. Trained bilingual interviewers conducted the KII in the language of preference of the interviewee and took notes in English. The KIIs were recorded to facilitate notetaking and report checking. The KII notes were emailed daily or on another pre-agreed basis to the Transform MELA Focal person for review and quality control. Data were coded and preliminary summarize were performed by a team led by a qualitative analyst.

Household and health facility surveys were conducted using pre-tested structured questionnaires. Structured questionnaires were uploaded to smartphones and the HH and HF data were collected electronically using Mobile phones. KIIs were conducted using semi-structured interview guides.

The **household survey** included sections on:

- Household and women’s demographics, household living conditions
- Enrollment in community-based health insurance plans
- Household decision-making practices
- Health service uptake including family planning, antenatal care, delivery and postnatal care, and newborn health child immunization and child health services

The **health facility survey tool** was designed to collect data on:

- Availability of MNCH/FP services and water and sanitation facilities
- Access to communication and power supply
- Health facility management and performance, human resources
- Gender responsiveness
- Provision of selected family planning, antenatal care, delivery and postnatal care, immunization services, and adolescent and youth health services

Data Collector Training and Quality Assurance

To assure high-quality data, a day and half training was conducted for qualitative data collectors and a three-day training for all HH data enumerators and supervisors. Enumerators who would administer HH surveys had at least a BA/BSc degree, were fluent in both the local language and English, had prior experience collecting similar data, and understood the culture and traditions of the community they were visiting. Supervisors, qualitative data collectors, and those who administered the HF surveys had an MA/MSc in the health or social science field and previous experience in similar research activities. Given that the respondents were mothers of reproductive age, and to ensure that they could comfortably speak with interviewers, the field team took gender balance into account.

The training covered topics such as research ethics, rights of human subjects during research, sampling procedures, informed consent, data collection tools, interviewing techniques, data handling, security

and quality, and gender considerations during data collection. The structure of the training included a review of survey instruments and role-play. Once the data collectors completed the training on the paper-based data collection tools, they were trained on how to collect data using the electronic data collection template and how to upload the collected data onto the server.

The survey tools were pre-tested by data collectors in the field in all languages at the end of the training, that is, before the commencement of the actual data collection, to ensure consistency with the baseline and midline evaluation.

Before traveling to each of the selected woreda, supervisors and coordinators communicated with regional and local leaders about the evaluation. To ensure the quality of collected data, supervisors conducted spot-checking, and reinterviewing, especially at the beginning (first 3 days) of the data collection. Moreover, supervisors also reviewed a sample of completed questionnaires daily before uploading them onto the server. All KIIs were audio-recorded, and interviewers' notes were translated to English. Five percent of the transcriptions were checked against the audio file for accuracy.

SAMPLING

Site Selection for Qualitative Data Collection

All regions were included, except Tigray, and a purposive sample of zones and woredas was developed to gather qualitative data. Quantitative data were also collected in all visited zones.

In order to measure effectiveness of the Transform PHC Interventions for IRs 1, 2, 3 and 4, woredas were selected based on their performance classification: high-, moderate,- and low-performing using the results of the Greatest Impact Assessment (GIA), which used a select set of 12 MNCH/FP performance indicators from HMIS 2016 that has been used for high level monitoring.²³

The purpose of the GIA is to categorize woredas based on their recent RMNCH performance data and prioritize woredas where the results of the PHC interventions could be evaluated. It was also a way to measure progress by analyzing the number of woredas that have moved up to a higher performance level and compare it to the initial percentage in each category.

Simple random sampling was used to select woredas in the Transform PHC targeted regions, with other development partner intervention data in the five selected MNCH/FP service areas: Maternal health, Child Health, Neonatal, Family Planning, and Immunization, and woredas that have GIA performance categorization information. Table 1 (below) shows the sampled woredas by GIA performance.

Distribution of sampled woredas by GIA performance.

Region	Low performance	Moderate performance	High Performance	Total
Amhara	8	12	4	24
Oromia	12	18	5	35
SNNP	7	11	3	21
Total	27	41	12	80

A total of 80 woredas were selected for the performance evaluation. All intervention woredas that received three or more interventions from other development partners were excluded. All woredas with no GIA woreda performance categorization information and woredas in Sidama Region, which

²³ Source: USAID GIA analysis summary (2016). Transform MELA used the woreda performance categorization in the GIA analysis to ensure that there will not be sample selection bias for the endline evaluation between Transform program intervention and non-Transform intervention woredas.

does not have data on development partners were excluded from the sampling frame. Conflict-affected woredas were excluded due to security reasons.

Sampling of Households

The household (HH) survey employed a three-stage cluster sampling technique. The first stage was a random selection of kebeles (wards) in the Transform intervention woredas as primary sampling units, drawing from the list of kebeles in the respective regions stratified by administrative zones and performance before 2017. Thus, woredas, where the randomly selected kebeles are located, were automatically included in the evaluation. The second stage of the sampling entailed the random selection of Gotts from the selected kebeles. Because of the difficulties and time-consuming exercise of developing a fresh list of households in a kebele, 2-3 Gotts were selected randomly from each kebele, to generate an average list of 150 households from those selected Gotts.

The third stage of the sampling was a selection of HHs from the randomly selected Gotts. A fresh list of HH for each selected Gott served as a frame to select 30 HHs per kebele. The key eligibility criterion for selecting the HHs was the availability of a woman aged 15-49 in the HH, regardless of marital status, who has residential status there for at least six months before the date of data collection. If there were more than one such eligible respondent in a selected household, the enumerator used a Kish grid method to randomly select one respondent among the eligible women.

Sampling for Health Facility Survey

Purposive sampling was employed to select zones and woredas for KIIs, with the following additional criteria:

- Zones and woredas in the sample were also selected for the HH survey. However, one exception was made to ensure representation (Silte Zone of SNNP was selected for KII even though the zone was not part of the Household Survey).
- Heterogeneity was one of the criterium to select woredas (We avoided selection of more than one woreda in a zone to ensure heterogeneity of woredas)
- All zones and woredas with security concerns were excluded from the sample.
- Resource implications were considered in the sampling process (even though heterogeneity of woredas was one of the criterium employed to select woredas; we balanced the distances between woredas and zones to reduce resource requirements during data collection).

All of the primary health care facilities designated to serve the population of the sampled kebeles - health posts (HPs), health centers (HCs), and primary hospitals - were identified and included in the final performance evaluations. That is, the health post serving the population in the sampled kebele was automatically included in the study, the catchment HC linked with the selected health post was also included and the primary hospital attached to the selected HC, if any, was also included. Primary hospitals were included whenever there are such facilities in the selected woredas.

Selection of Key Informants

KIs were enrolled using purposive sampling. Gender and representation of various stakeholder groups were considered in the selection process: USAID, central and regional IPs, relevant directorates at MOH, RHBs, ZHDs, selected WorHO, and selected HFs. A total of 65 KIIs were conducted as part of the performance evaluation (See Table 14 for distribution of KIIs by stakeholder and gender).

Proposed distribution of KIIs by stakeholder type across all Transform evaluations

Stakeholders	Key Informants
USAID/Ethiopia	1 KI
Ministry of Health	7 KIs from MOH - MOH directorates -

Stakeholders	Key Informants
Note: KIs from four directorates and one MOH agency will be interviewed on both PHC and HDR Activities. Therefore, the total number of KIs at MOH will be Seven (five directorates and two MOH agencies).	- Health Extension Program and Primary Health Care, Maternal, Child Health and Nutrition, Policy Plan Monitoring and Evaluation, and Women, Children and Youth Affairs - Human Resources for Health Development Directorate - MOH agencies (Ethiopian Health Insurance Agency and Pharmaceuticals Supply Agency)
IPs central office	2 KIs
IP's Regional offices	4 KIs – in four regions
Regional Health Bureaus – MCH unit	4 KIs (1 KI per region) MNCH Department
Zonal Health Department	9 KIs (1 KI per zone)
Woreda health offices	- Transform Intervention woredas (9): 18 KIs – Heads of Woreda Health Offices and MNCH officers (2 KI per woreda)
Health Facility – HC	20 KIs (1 per HC)
Total	65 KIs

ANNEX 3. DATA ANALYSIS

All HH and HF survey data were cleaned, checked, and validated to identify and address any issues during data collection, a process that was undertaken directly by supervisors and data collectors. Once data collection was complete, an intensive cleaning process was conducted that included coding and recoding, consistency checks, addressing refusals and nonresponses, and validating contents.

Quantitative Data Analysis

Descriptive (Frequency and percentage calculations) analysis was conducted to describe the characteristics of evaluation participants; and to estimate a select set of Transform program intervention indicators. The analysis of HH data also focused on comparisons of final performance vs. baseline key performance indicator (KPI) values. Data management and analysis were done using

Outcome Performance Measures

The evaluation used the Results Framework of Transform PHC. The Results Framework was used to identify key performance indicators (KPIs) and design qualitative and quantitative data collection tools to measure achievement of the IRs and sub-IRs. A **results-indicator matrix** was used to link the key performance indicators to measure intermediate results (IR) areas. The key performance indicators considered in this analysis are:

- **Family planning indicators:** contraceptive prevalence rate (CPR), long-acting (LA) contraceptive methods use, postpartum contraceptive use, and unmet need for family planning (FP),
- **Maternal health indicators:** (antenatal care (ANC), skilled birth attendance (SBA), postnatal care (PNC), iron-folic acid supplementation (IFS), cross-cutting issues (basic sanitation, spouse accompany to ANC, spouse accompany to delivery, and community-based health insurance (CBHI), and
- **Child health indicators:** (measles vaccine (MCV), exclusive breastfeeding).

Number of Woredas enrolled by Transform PHC in the two activity phases.

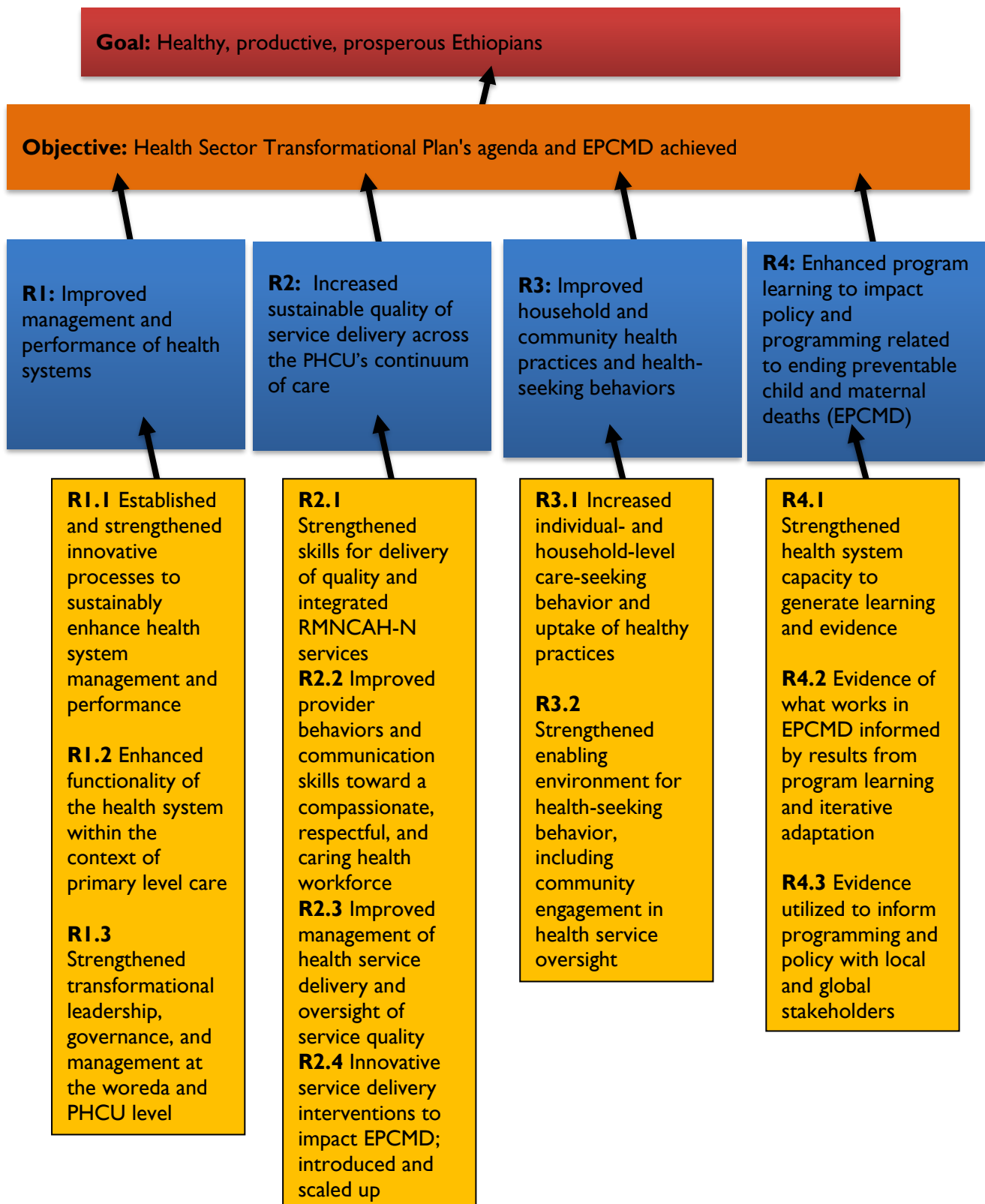
Regions	Phase I (FY 2017)	Phase II (2018)	Total
Amhara	76	18	94
Oromia	133	29	162
Sidama	13	1	14
SNNP	98	13	111
Total	320	61	381

Qualitative Data Analysis

Coding: A codebook was developed based on evaluation questions and the interview guides. In addition, interview transcripts were reviewed, and the codebook was further refined as specific themes emerged. Next, the codes were uploaded to the qualitative analysis software by the qualitative data analyst. Then, the interview transcripts were imported to the data analysis software and then thematic coding and summarization of preliminary KII findings was conducted.

Analysis: Thematic analysis was conducted using Atlas.ti, a qualitative data analysis software. Selection of themes and the analysis of the data was framed by the evaluation questions. In addition, the evaluation team used the results framework of the PHC activity to understand and assess whether the intervention theory of change had held in the implementation of activities, and whether there were explanatory contextual factors at play. Various qualitative information was synthesized to understand factors facilitating or hindering implementation as well as achievement of results. Other analytical methods employed included a comparison of specific themes between Transform intervention and non-Transform intervention woredas.

ANNEX 4. PHC TRANSFORM ACTIVITY RESULTS FRAMEWORK



ANNEX 5. GLOSSARY OF TERMS

Terms	Definition
Adaptive management	An intentional approach to making decisions and adjustments in response to new information and changes in context. <i>Adaptive management integrates approaches throughout the Program Cycle as the second of four core principles. (Program Cycle Operational Policy. ADS 201.6; 09/21/2021).</i>
Case Study	For the purpose of the Transform Program evaluation, we defined a case study as the study of public health problem-solution situation and the process to implement, evaluate, and learn from it. All the interventions selected to solve the problems identified by the PHC and HDR activities have demonstrated their efficacy elsewhere to prevent or treat disease, death, or disability. They had just not been adapted to be implemented in the Primary Health Setting in Ethiopia and are therefore considered innovations.
Coherence	The compatibility of the intervention with other interventions in a country, sector or institution.
Collaboration with the Ministry of Health	Collaboration is a practice whereby individuals, communities and organizations work together for a common purpose to achieve a shared benefit. For the purposes of this evaluation, collaboration between MOH and the Transform program encompasses working relations between central bureaus, regional, zonal and woreda health offices.
Effectiveness	The extent to which the intervention achieved its objectives and results, including any differential results across groups.
Gender equity	Fairness of treatment for women and men, according to their respective needs. In the development context, a gender equity goal often requires built-in measures to compensate for the historical and social disadvantages of women. (USAID Gender Terminology)
Health care quality	The degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. (Institute of Medicine: Crossing the Quality Chasm, 2001)
Health workforce capacity building	Actions intended to improve human resources for health, contributing to healthy lives and well-being, effective universal health coverage, resilience and strengthened health systems at all levels. WHO (2016:4). Global strategy on human resources for health: Workforce 2030
Impact	The extent to which the intervention has generated or is expected to generate significant positive or negative, intended or unintended, higher-level effects.
Intervention	A process developed with the objective of improving a health outcome. Interventions can be classified as preventive interventions such as vaccines, or curative, such as an improved diagnostic or treatment protocol or a more effective and efficiently streamlined service delivery, or both preventive and curative interventions such as CEmONC that detects and treats complications in a timely manner, thus preventing morbidity and mortality.
Medical equipment and supplies provision	<i>Medical equipment</i> is defined as a capital equipment and durable items that last for several years. <i>Medical supplies</i> are items that need replacing on a routine basis, including disposables and single use items. <i>Provision</i> encompasses procurement, delivery, and management of equipment and supplies based on requirements for preventive care, diagnostic tests, and treatment.

Terms	Definition
Non-Transform intervention woredas	Woredas which do not receive USAID investment through the Transform Program.
Ownership	The extent to which national partners have a stake in the implementation of programs and activities.
Performance improvement	The goal or benefit of focusing on individual and organizational change and business results. Caiola and Sullivan for USAID, Paper #9, page 2 (2000). Performance Improvement: Developing a Strategy for Reproductive Health Services.
Performance monitoring indicators	Measures intended to detect progress towards the results included in a Results Framework. (USAID: Performance monitoring indicators)
Performance standards for public health	Organizational or system standards, targets, and goals to improve public health practices. (Public Health Foundation: Performance Standards) In the Ethiopian context, this refers to performance standards at different levels of the health system. These are included in references such as the Ethiopian Hospital Services Transformation Guidelines (EHSTG) .
Public financial management	The set of laws, rules, systems, and processes used by sovereign nations (and sub-national governments) to mobilize revenue, allocate public funds, undertake public spending, account for funds, and audit results. Lawson (2015). Public Financial Management
Relevance	The extent to which the intervention objectives and design respond to beneficiaries, global, country, and partner/institution needs, policies, and priorities, and continue to do so if circumstances change.
Solution	A solution is a set of interventions that health managers have selected to solve a healthcare delivery or public health program problem. Solutions are usually implemented by development projects with donor support to improve the quality of healthcare and expand utilization and access to services and thus improve health outcomes. In the case of The Transform Program, both activities have implemented numerous solutions that have demonstrated improved outcomes and impact on the health of mothers and children in Ethiopia.
Sustainability	The extent to which interventions and their benefits will continue beyond the life of the program.
Transform intervention woredas	Woredas in which the USAID Transform Program implemented through the Transform PHC and HDR Activities.