

**USAID/ETHIOPIA INTEGRATED FAMILY HEALTH PROGRAM:
REPORT OF THE PHASE I REVIEW**

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Acronyms and Abbreviations

ACT	Artemisinin Combined Therapy
AED	Academy for Educational Development
AMTSL	Active Management of the Third Stage of Labor
ANC	Antenatal Care
ART	Anti-retroviral Therapy
ASRH	Adolescent Sexual and Reproductive Health
BCC	Behavior Change Communication
BPR	Business Practice Re-engineering
CBN	Community-Based Nutrition
CBRHA	Community-Based Reproductive Health Agents
CHP	Community Health Promoter
CM	Community Mobilization
CO	Country Office
CORHA	Consortium for Reproductive Health Associations
ENA	Essential Nutrition Actions
ENC	Essential Newborn Care
EPI	Expanded Program of Immunization
ESHE	Essential Services for Health in Ethiopia
FGC	Female Genital Cutting
FGM	Female Genital Mutilation
FMOH	Federal Ministry of Health
FP	Family Planning
FP/RH	Family Planning/Reproductive Health
GOE	Government of Ethiopia
HAPN	HIV/AIDS, Population and Nutrition
HEP	Health Extension Program
HEW	Health Extension Worker
HIV	Human Immunodeficiency Virus
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HMIS	Health Management Information System
HC	Health Center
HP	Health Post
IFHP	Integrated Family Health Program
IMNCI	Integrated Management of Newborn and Childhood Illnesses
IPO	Implementing Partner Organization
IRS	Indoor Residual Spraying
ISS	Integrated Supportive Supervision
ITN	Insecticide Treated Net
JSI	John Snow Inc.
KAC	Kebele Advisory Committee
LAPM	Long Acting and Permanent Method(s) [for FP]
LLITN	Long-Lasting Insecticide Treated Nets

LMIS	Logistics Management Information System
LOP	Life of Program/Project
MBB	Marginal Budgeting for Bottlenecks
MCH	Maternal and Child Health
MH	Maternal Health
MNCH	Maternal, Newborn and Child Health
MNH	Maternal and Newborn Health
MOH	Ministry of Health
NGO	Non-Government Organization
ORT	Oral Rehydration Therapy
PHCU	Public Health Care Unit
PMI	President's Malaria Initiative
PMP	Performance Monitoring Plan
PMTCT	Prevention of Mother to Child Transmission
PNC	Post Natal Care
PI	Pathfinder International
RHB	Regional Health Bureau
RDT	Rapid Diagnostic Test
SAM	Severe Acute Malnutrition
TAC	Technical Advisory Committee
TCN	Total Community Nutrition
TWG	Technical Working Group
USAID	US Agency for International Development
VCHW	Volunteer Community Health Worker
VCT	Voluntary Counseling and Testing
WAC	Woreda Advisory Committee
WASH	Water and Sanitation (for Health)
WB-HSP	Woreda-Based Health Sector Planning
WorHO	Woreda Health Office
ZHD	Zonal Health Department

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The Phase I Review Team is indebted to many people who made this exercise a success. We wish to thank all the staff of the Integrated Family Health Program (IFHP) who hosted us in the Country Office and in the regions, zones and woredas, responded to our many questions, assisted us in the site visits, and managed the logistics and other details required for the field visits. We thank the staff at all levels of the Ministry of Health, including the FMOH Directorate for Health Promotion and Disease Prevention, Regional Health Bureaus, Zonal Health Departments, Woreda Health Offices, Health Centers and Health Posts for your generosity with your time and thoughts on the Health Extension Program, health systems, and the IFHP. We especially appreciated our meetings with the Volunteer Community Health Workers and the homes and communities that made us welcome as we learned about the day-to-day operations of the HEP and the contributions of IFHP. Staff members of the Implementing Partner Organizations in the regions and development partners and other international organizations in Addis were very generous with their time and thoughts, and we thank them for sharing their experience and expertise with us. We want to give special acknowledgement to the skills, patience, and professionalism of the drivers from USAID and IFHP who were essential to the work of the Phase I Review Team. Finally, we extend our strong appreciation to USAID/Ethiopia's HAPN staff and in particular recognize the invaluable support we received from the Agreement Officer's Technical Representative (AOTR) Eshete Yilma. The team takes full responsibility, however, for the conclusions and recommendations herein.

EXECUTIVE SUMMARY

Section I. Introduction/Background

The Integrated Family Health Program (IFHP) is a \$50 million, five-year Cooperative Agreement with Pathfinder International (PI), signed in June 2008 with an end date of June 30, 2013. It is USAID/Ethiopia's comprehensive, integrated package of assistance for family planning and reproductive health, maternal, newborn, child health, nutrition, malaria, and, as appropriate, HIV/AIDS. It builds on two successful predecessor projects, John Snow Inc.'s (JSI) Essential Services for Health in Ethiopia (ESHE) child survival program and PI's Family Planning/Reproductive Health (FP/RH) Project. PI and JSI are implementing the IFHP in partnership with the Consortium of Reproductive Health Associations (CORHA) and the Academy for Educational Development (AED). The program is designed to support Ethiopia's third Health Sector Development Program (HSDP III) and its Health Extension Program (HEP) in the delivery of key services and products through a continuum of care from the community, to the health post and health center and with community mobilization to engage households and communities as partners in promoting health and changing behaviors. To achieve these ends, IFHP works at the Federal, Regional, Zonal and Woreda levels, in the four regions of Amhara, Tigray, Oromia, and SNNP (and selected woredas in Benshangul and Somali), to enhance government capacity to manage and improve the performance of the health care system and service delivery. Under a recently revised geographic allocation, IFHP supports 286 woredas, with about 30 million people or about 43 per cent of the population.

Under a Life-of-Program (LOP) Goal of "Improved Family Health," and a sub-objective of "Increased use of high impact family planning, maternal, newborn and child health practices, products and services," IFHP has four expected Results (and Sub-Results under each):

Result 1: Improved health practices at the household and community level.

Result 2: Improved availability and quality of health services, products, and information.

Result 3: Key elements of the health system strengthened to support health services.

Result 4: Systematic program learning to inform policy and program investment.

The IFHP Performance Monitoring Plan (PMP) established targets to be achieved by the end of Phase I (18 months of implementation) for selected indicators and the Phase I Work Plan set out operational objectives, adjustments from the prior projects to assure success of the new IFHP.

USAID/Ethiopia arranged for a team of Ethiopian senior officials, USAID/Washington technical and Africa experts, and an external team leader to conduct a Phase I Review of IFHP. The primary purposes were to assess whether the IFHP was on the right track to measure and achieve its objectives; assess its strengths, weaknesses and constraints to implementation; review the extent to which IFHP was supporting the HEP and integration of FP and MNCH interventions; and, recommend to IFHP and USAID/Ethiopia ways to build on strengths, correct weaknesses, and plan for Phase II, the next three-and-a-half years of the program. Given the limitations of time (just two weeks in Ethiopia for the team members from the U.S., and one week for the full team with the Ethiopian team members), the short implementation period being reviewed (i.e., 18 months), and other constraints, the Phase I Review Team did not conduct an in-depth assessment of the impact to date of the IFHP. However, team members read most IFHP documents, traveled to three of the Regions where IFHP works, and interviewed almost half of the 150 people contacted during the review period.

Section II. Phase I Review: Findings, Strengths and Areas for Attention

The Phase I Review team analyzed overall IFHP performance, IFHP's performance under each of its four results, the transitions in program modality, and management. The findings, strengths and areas for attention for Phase II planning are synthesized below.

Program Performance

Findings: IFHP has accomplished what it set out to do in Phase I. According to PMP indicators and evidence from the team's field visits, IFHP's overall performance is above its Phase I targets and well on the way to the end of program targets set to date. For the priority areas of family planning and immunization, service delivery levels have been maintained or increased from the prior projects. IFHP has integrated family planning, child health and nutrition interventions, and is expanding services to include maternal and newborn health, malaria, and, where appropriate, HIV/AIDS-related service delivery. Implementing Partner Organizations (IPO) are now integrated into support of the GOE HEP at the woreda and community levels. IFHP represents a comprehensive health program that is fully integrated into GOE programming at all levels.

In addition to results, IFHP intended two important shifts in implementation modality:

Service Delivery to Capacity Building - and - Parallel support to Embedded support.

From all the evidence available to the Phase I Review team, these shifts have been successful and the response has been extremely positive from GOE counterparts. These shifts represent a very positive evolution of USAID health and family planning programming, in Ethiopia and more broadly. IFHP managers achieved their primary operational objectives for Phase I.

Key Strengths

- **The overall approach for Community Mobilization (CM) and Behavior Change Communication (BCC)** (i.e., Health Extension Workers (HEWs) train "model families" and then recruit from them Volunteer Community Health Workers, VCHWs, for outreach and community conversations) **is working in IFHP woredas and communities.**
- **IFHP-assisted HEWs, particularly those where IPOs are active, appear to be highly effective in working with community volunteers.**
- **BCC materials, including the Family Health Card, flip charts for family planning, and other BCC materials, were available** at the health centers and health posts visited.
- **IFHP has counterpart cadres of master trainers** in FP, CH, and nutrition who very effectively conduct skills training and practicums.
- **Priority health interventions, e.g., FP, CS, and nutrition, are effective overall.**
- **Newer health interventions, e.g., maternal and newborn care, have platforms for their development.**
- **IFHP support is strengthening GOE capacity to plan, monitor, and supervise its health programming:** specifically Woreda-Based Health Sector Planning ((WB-HSP); Integrated Supportive Supervision (ISS); HEW supervision; and data for decision-making in Performance Review meetings.
- **IFHP provides flexible financial and support and contraceptives where needed.**
- **Mechanisms for sharing lessons learned and building on experience.**

Shifts in Operational Approach

Strengths

- **The GOE at every level is DEFINITELY in the lead.** IFHP personnel work within GOE systems (e.g., quarterly reviews, woreda/cluster planning) and initiatives
- **IFHP is “embedded in,” committed to, and providing important support to the GOE’s HEP and HSDP III.** Stepped back from doing to support for doing
- **More efficient use of program resources.** Not in parallel, non-sustainable approaches.
- **In some instances, managed progression for transfer of activities supported by IFHP to local government.** E.g., moving from support for four meetings/year to two/year.

Areas for Attention

- **Capacity of IFHP to support the GOE’s program.** Specifically, IFHP capacity at the Cluster office level and for CM/BCC and Programmatic Research.
- **Skills of and support for HEW Supervisors, HEWs and VCHWs.**
- **BCC materials are limited.**
- **Potential for mass media and the mobile vans.**
- **Weak referral linkages.**
- **Limited focus on quality and quality assurance.**
- **Community involvement in monitoring health activities** through kebele- and woreda-level committees is unclear.
- **Slow HMIS Roll out.**
- **Data quality, definitions, and use for assessing outcomes.**
- **Lack of key drugs/commodities/supplies for FP, MNH, malaria.**
- **Mechanisms for setting priorities for evaluative research topics and frameworks for analysis.**
- **Heavy reliance on baseline and endline measurements to demonstrate effectiveness and impact.**
- **Need for benchmarks of woreda competency.**
- **Need for sharing and extending IFHP-related skills with non-IFHP woredas.**
- **Functions without capacity-building approaches.** E.g., managing training.

Program Management

The Phase I Review Team looked at IFHP structure, staffing and decision-making, relationships and communications with counterparts, stakeholders and USAID, and M&E.

Findings: The IFHP organizational structure is complex with about 40 positions in the Country Office (CO) in Addis Ababa; four regional offices with 9-11 staff each, one in each of the four regions (Tigray, Amhara, Oromia, and SNNP); and, each Regional Office has from two-five Cluster Offices located at the Zonal level of their respective regions. The Regional Offices include staffing for technical areas such as MNCH and FP, as well as BCC/CM, M&E, and Finance & Administration. Almost all Regional Offices and Cluster Offices are co-located with their GOE counterpart offices at the Regional and Zonal levels. All staff members, except the Deputy Chief of Party, are Ethiopian. The CO has delegated significant responsibility to the Regional Managers, and they rely on their Cluster Offices. Despite the numbers and arrangement

of the CO and the Regional Offices, they appear to function as flat and lean with major decisions made in a collaborative approach. IFHP's relationships with its many counterparts at all levels of the GOE health system, with stakeholders, e.g., religious leaders, and with USAID, appear to be constructive and effective. Evidence that the Country Office-Regional-Cluster structure works well is seen in the results achieved as presented in the summary above and the full report.

Strengths

- **Strong staff competence and commitment.**
- **Role is support to the GOE.** The refrain was, "We do nothing alone."
- **Complementary expertise to GOE.** IFHP expertise is value-added to the program.
- **Consultative management style for programmatic decision-making.**
- **Mechanisms for stakeholder engagement.** IFHP reportedly makes effective use of TAC quarterly meetings to showcase selected woreda activities and community service sites.
- **Collaboration with IPOs extends reach of IFHP.**
- **Use of data for decision-making.**
- **Culture of program review and improvement.**

Areas for Attention

- **Some issues with roles and relationships with AED, CORHA and Jhpiego,** all of which provide important expertise to IFHP in BCC and training respectively.
- **The organizational chart for IFHP is out-of-date.**
- **Limited visibility and knowledge about IFHP at the national level and the FMOH.** IFHP's approaches and activities are not well known among the other development partners and FMOH officials asked for more information to better understand IFHP's contributions to health service coverage, systems strengthening, etc.
- **Documentation and materials development for non-IFHP audiences.** To promote lessons learned and best practices, as well as the impact of its program.

Section III. Recommendations of the Phase I Review.

The recommendations are divided into two groups: the first for senior management and staff of IFHP, as well as for USAID/Ethiopia; the second are for USAID/E and USAID/Washington. The recommendations respond to the Areas for Attention above, but they have been organized and synthesized under major action items to better guide the IFHP Phase II planning process.

A. Recommendations for IFHP Senior Management and Staff: Actions for Phase II

Recommendation 1: Keep doing what you are doing; build on IFHP strengths.

The Phase I Review Team was very impressed with the progress that IFHP had made in Phase I. The team recommends that IFHP stay focused on its 286 assigned woredas. The team is convinced that no woreda is a likely candidate for "graduation" in the short time remaining for IFHP support. Equally important, IFHP should continue its approach to the GOE as one of support to and embedded with its processes. IFHP should build on its strengths:

Technical strengths: Family planning, child health, nutrition (breastfeeding, ENA).

Service delivery approaches: extension to communities, support to HEWs, VCHWs, and IPOs.

Systems strengthening: woreda-based health sector planning, quarterly review meetings, ISS, training, follow up, use of data for decision-making.

Sharing of learning: quarterly review meetings, TAC meetings, exchange visits.

Management: collaborative style of decision-making; continue work on melding of the teams.

For the next five recommendations, in planning for Phase II, IFHP senior management and staff should note: the need for appropriate phasing (depending on factors such as GOE priorities and initiatives) and the need to act at national policy and operational levels.

Recommendation 2: Continue to strengthen and improve the functioning of the Health Extension Program and Woreda, Zonal, and Regional health management. Priority areas:
For the HEP:

- **Improve the HEW supervision system.**
 - At the national level, work with the GOE on: selection criteria for HEW supervisors; training programs; viable solutions for transport and incentive schemes.
 - At the operational level, consider local solutions for HEW supervision issues.
- **Strengthen HEW capacity in BCC and community mobilization.**
 - At the national level, work on relevant Technical Working Groups to update, improve, and harmonize BCC materials; assure appropriate roles for VCHWs and HEW support.
 - At the operational level, through IPOs and others, strengthen HEW and VCHW capacity in community conversation, supervision, supports for KACs.
- **Strengthen and standardize training for HEWs.**
 - At the national level, work with the GOE to improve the HEW curriculum and training.
 - At the operational level, ensure effective pre-service training.
- **Explore use of mass media, especially radio, and strengthen use of mobile vans.**

For health systems management:

- **Assess and strengthen referral systems from health posts up and back down.**
- **Improve data quality and consistency.** With or without roll out of the reformed HMIS, assist in reviewing and revising definitions (e.g., deliveries) and reinforcing their use.
- **Improve analytic and problem identification and problem solving skills.** All woreda and zonal managers and staff need more skills in use of the data available to them.
- **Increase use of outcome measures across the program.**
- **Support use of health financing funding generated at Health Centers for the PHCU.** Health post needs should be considered in decision-making about their best use.

Recommendation 3: Support the roll out of important initiatives.

The FMOH has an ambitious agenda of initiatives for improved health services and health systems. Given IFHP's role in supporting operations in 286 woredas of four regions, IFHP will be involved with their roll out whether or not it has primary responsibility; IFHP has important roles to play at the national level as well. General suggestions for IFHP are presented below. (See the full report for actions regarding technical interventions, i.e., family planning, child health, nutrition, maternal health, newborn care, youth, gender and harmful traditional practices.)

At the national level:

- **Assure technical quality** of the strategy, system, approach, and/or intervention by being involved with the relevant Technical Working Groups.
- **Assure feasibility (and technical quality)** of roll out plans by participating in the micro-planning processes and offering IFHP woredas for implementation learning phases.

At the operational level:

- **Support roll out implementation** in IFHP woredas.
- **Phase implementation and structure evaluative research to assess quality and effectiveness.** IFHP should help to build in evaluative research for high priority initiatives, such as maternal health and newborn care, and into BCC activities.
- **Support complementary technical inputs.** If USAID arranges for complementary support for areas such as maternal health, IFHP should facilitate the work of other TA providers through its regional and cluster offices and counterpart relationships.

Systems Strengthening Initiatives:

These will include those already developed, but not yet rolled out: reformed HMIS; LMIS; and, new logistics distribution system. Likely to come up in Phase II are: implementation of community health insurance and financing; quality assurance approaches.

The Review team strongly recommends that IFHP address training as a system by:

- Identifying the appropriate focal points for training organization and management at the national level and regional and zonal levels;
- Developing their capacity in planning, organizing and managing training.

Recommendation 4: Increase and systematize program research and learning.

As GOE health intervention and systems initiatives roll out, IFHP should build in evaluation approaches that allow assessment of their progress and impact. Key steps:

- Use a collaborative process with the FMOH, regional, and peripheral levels to identify priority areas for program or evaluative research.
- Contract local experts (universities, schools of public health) for program-based research.
- Go “beyond baselines and endlines,” using other methods (cluster surveys, LQAs) to collect data on outcomes.
- Document and disseminate qualitative and quantitative findings; share lessons learned and best practices from technical programs and systems strengthening interventions.

Recommendation 5: Support operational level counterparts in problem solving, resource mobilization, and leveraging to address key issues.

By supporting planning, the quarterly reviews, and the like, IFHP can play an important role in assisting woreda and other health managers in identifying and solving problems. IFHP can:

- Assist GOE health managers at all levels in identifying and anticipating problems. Among the recurring problems are: lack of water at health posts; transport for HEW supervisors; reliable sources of consumables; and, support for ISS and woreda meetings.
- Assist GOE health managers in identifying solutions and possible sources of funding, such as the local woreda council, other partners, local businesses, PHCU income.
- Offer support in pursuing the solutions and following up.

Recommendation 6: Reconsider IFHP staffing numbers/composition: right size for tasks ahead.

Given IFHP successes, needs in the HEP program, and the large agenda of GOE initiatives, the Phase I Review Team strongly recommends that IFHP implement its plan to add more staff to the Cluster level of its organization. IFHP also should revise its organigram to reflect actual positions and practice and eliminate organization designations. The team proposes that IFHP:

- Add a limited number of clusters in each region and staff (1 or 2, to the 2 positions now) to each cluster.
- As a high priority, strengthen staffing in the Country Office for BCC and CM.
- Strengthen staffing in the Country Office for program research and evaluation and documentation. This is a growing need as new initiatives are designed and roll out.
- Continue to use “outside” partners’ capabilities in selected technical areas, for example, the IPOs for community mobilization at the operational levels; UNICEF for IMNCI.
- For MNH, consider including a Jhpiego staff member resident in the Country Office as part of the sub-agreement now under negotiation.

B. Recommendations for USAID/Ethiopia and USAID/W: Actions to support Phase II.

Both USAID/E and USAID/W should advocate for and disseminate IFHP successes. IFHP experience should inform policy-making as the Global Health Initiative (GHI) gets underway.

Recommendation 1: Support the efforts of IFHP.

IFHP will need active USAID support to succeed. In particular, USAID should:

- **Increase funding levels for IFHP.** Staffing increases at the Cluster Offices and the Country Office and investments in more programmatic research require funding.
- **Participate actively in Technical Working Groups.** USAID participation provides a strong endorsement from USAID and indicates the value USAID places on policy issues.
- **Stay as involved as possible with the planning for HSDP IV.**
- **Facilitate linkages with other USAID programs and sectors.**
- **Leverage PEPFAR to support the GOE PHC platform.**
- **Visit IFHP sites regularly.** Visits from USAID encourage IFHP staff, signal USAID’s interest in the program, and help USAID to promote IFHP to the GOE and stakeholders.

Recommendation 2: Promote the successes of IFHP.

IFHP is exceptionally well-aligned with Paris Declaration and GHI principles. USAID should:

- **Develop (with IFHP) success stories** and “best practices” from IFHP experience, document them, and disseminate them widely.
- **Raise the profile of IFHP** (in part by using the success stories and best practices) with the GOE, other donors, and in all appropriate fora.
- **Use IFHP as a vehicle for providing complementary technical (and systems strengthening) support** to the health sector in Ethiopia. Use IFHP’s infrastructure and relationships within the health system rather than a parallel delivery mechanism.

Recommendation 3: Encourage other programs and activities to adopt IFHP-type (“Paris-friendly”) implementation modalities.

Recommendation 4: Take other actions to facilitate IFHP’s activities.

USAID/W and USAID/Ethiopia also should:

- Under the GHI, revise the standard indicators.
- If requested by the FMOH, consider secondment of policy and/or technical advisors at the Central level.
- With IFHP, plan for increased CSGH nutrition funding.

USAID/ETHIOPIA INTEGRATED FAMILY HEALTH PROGRAM: REPORT OF THE PHASE I REVIEW

Section I. Introduction/Background

In late 2009, USAID/Ethiopia arranged for a team of four Government of Ethiopia staff from Regional Health Bureaus, USAID/Washington health and family planning specialists, and an outside consultant team leader to conduct a review of its Integrated Family Health Program (IFHP) at the end of Phase I, the first 18 months of implementation. The primary purposes of the review were to assess whether the IFHP was on the right track to measure and achieve its objectives, and to make recommendations to IFHP and USAID/Ethiopia on how to build on strengths, correct weaknesses, and improve implementation for Phase II.

A. Integrated Family Health Program: Summary Description

The Integrated Family Health Program is a \$50 million, five-year Cooperative Agreement with USAID/Ethiopia and Pathfinder International. Signed in June 2008, the IFHP end date is June 30, 2013. Pathfinder International (PI) and John Snow Inc. (JSI) are implementing the IFHP in partnership with the Consortium of Reproductive Health Associations (CORHA) and the Academy for Educational Development (AED). It is a follow on from the former Pathfinder Family Planning/Reproductive Health (FP/RH) Project and the JSI Essential Services for Health in Ethiopia (ESHE) child survival program.

Health Sector in Ethiopia: Program Context

Ethiopia presents many challenges for effective health services delivery. It has the second largest population in Sub-Saharan Africa (79 million people), with 44 per cent under the age of 15 and 84 per cent living in rural areas. Despite recent improvements, infant and under-five mortality remain high (77 and 124 per 1000 live births respectively), the maternal mortality ratio remains stubbornly high (673 per 100,000 live births), and fertility is high with a total fertility rate of 5.4. Although modern contraceptive use has increased, unmet need for family planning is estimated at 33.8 per cent of married women of reproductive age. Skilled attendants deliver fewer than 6 per cent of births. Infants and children under five continue to die from diarrheal disease, respiratory infections, malaria, and neonatal complications. Under-nutrition is a major underlying cause for maternal and child death and disability; 57 per cent of children suffer from chronic under-nutrition.

To address these challenges, the Government of Ethiopia (GOE) has mounted an aggressive strategy under the Health Sector Development Program (HSDP), now finishing its third phase, to expand coverage of basic primary preventive, promotive, and selective curative health services to the community level. Since 2005, through the HSDP III's Health Extension Program (HEP), the GOE has trained approximately 30,000 female Health Extension Workers (HEWs) who are recruited from and deployed to underserved rural areas. Two HEWs serve each local community (kebele) of about 5,000 people from a community-built Health Post. More recently, the GOE has recruited a cadre of HEW Supervisors to support the HEWs. Under the HEP, the GOE has merged all former community-level volunteer workers (Community-Based Reproductive Health Agents, Community Health Promoters, Nutrition volunteers) into one cadre called Volunteer Community Health Workers (VCHWs) who extend the outreach of the HEWs and who are trained and work under their supervision. Health center construction is also underway so as to

reach the GOE objective of having one health center as the referral point for every five health posts, and to have a Primary Health Care Unit (PHCU: one health center and its five health posts) for every 25,000 population.

The expansion in primary health care coverage has been accompanied by major initiatives to strengthen management and capacity in Ethiopia's decentralized health system. Responsibility for health system and program performance is at the woreda (district) level, where Woreda Health Offices (WorHOs) plan for, manage, and supervise health curative and prevention services and activities. WorHOs are, in turn, supported by Zonal Health Departments (ZHDs) and Regional Health Bureaus (RHBs); the offices at each level report to the respective local administrative authorities, as well as respond technically to higher levels of the health system.

Other important developments in the health sector that have affected IFHP include the following:

- GOE and Federal Ministry of Health (FMOH) restructuring and substantial role changes from undergoing Business Practice Re-Engineering (BPR). The BPR has affected operations to the woreda level with all staff taking on new roles and responsibilities.
- Development and anticipated roll out of new structures and reforms for: Health Management Information System (HMIS); the logistics system; and the Logistics Management Information System (LMIS).
- New strategies and support to improve maternal and newborn health.
- Continued emphasis on effective implementation of Woreda-Based Health Sector Planning (WB-HSP) using the Marginal Budgeting for Bottlenecks (MBB) methodology.
- Expansion of development partner and other organizations supporting GOE health programming, including a number of U.S.-based foundations. As a result, the GOE has re-assessed and re-allocated geographic locations among partners to reduce overlap. The woredas assigned for IFHP focus were reduced from 370 to 286; however, many more of them are new to IFHP and more difficult to reach.

Integrated Family Health Program: Purpose, Results, and Areas of Focus for Phase I

USAID/Ethiopia has supported the GOE's FP/RH, child health, and health systems strengthening programs since 1995. Building on the success of the two predecessor projects, one focused on FP/RH implemented by Pathfinder, and the other for child health implemented by JSI, the IFHP is USAID/Ethiopia's flagship program of support for a comprehensive, integrated package of assistance for family planning/reproductive health, maternal, newborn, child health, nutrition, malaria, and, as appropriate, HIV/AIDS. The program is designed to support HSDP III and the HEP with a focus on the delivery of key services and products through a continuum of care from the community, to the health post, and to the health center. Central to the HEP and IFHP are community mobilization and empowerment to change behaviors and the engagement of households and communities as partners in promoting health. To achieve these ends, IFHP works at the Federal, Regional, Zonal and Woreda levels, primarily in the four regions of Amhara, Tigray, Oromia, and SNNP (as well as selected woredas in Benshangul and Somali), to enhance government capacity to manage and improve the performance of the health care system. As noted above under the revised allocation of woredas, IFHP provides this support to a total of 286 woredas, reaching approximately 30 million people or about 43 per cent of the total population.

IFHP supports USAID/Ethiopia's Strategic Objective "Investing in People," which covers the program area of health. Its overall Life-of-Program (LOP) Goal is "Improved Family Health" with a sub-objective of "Increased use of high impact family planning, maternal, newborn and child health practices, products and services." IFHP has four expected Results (and Sub-Results under each):

Result 1: Improved health practices at the household and community level.

Result 2: Improved availability and quality of health services, products, and information.

Result 3: Key elements of the health system strengthened to support health services.

Result 4: Systematic program learning to inform policy and program investment.

The joining of the two prior projects, FP/RH and the Essential Services for Health in Ethiopia (ESHE), not only involved the integration of health interventions, namely family planning and child health and nutrition, but also, in negotiating the Cooperative Agreement for IFHP, the marriage of two former project structures, staffing, philosophies and approaches into a coherent, new programmatic and effective structure and operation. The FP/RH Project supported FP/RH services using Community-Based Reproductive Health Agents who were trained and supported by local NGO partners using GOE service delivery points for referrals. ESHE worked more closely with GOE structures and promoted healthy behaviors in communities through a cadre of Community Health Promoters. IFHP called for expanding the technical interventions to include maternal and newborn health as well as malaria and HIV/AIDS as appropriate. It also called for a significant shift in approach to working within and in support of the GOE Health Extension Program. More specifically, IFHP needed to:

- Shift the roles of all program staff from direct implementation to support for improved management and implementation by government officers and providers, including HEW Supervisors, and HEP preventive and curative services into the community. IFHP was expected to build capacity of GOE staff, not implement activities on its own.
- Apply government planning, supervision, coordination, and management approaches and procedures rather than creating and using parallel approaches and procedures.

The Revised PMP Indicators and Targets Based on the New Allocation of Woredas by MOH/RHB, dated July 2009 established numerical targets to be achieved by the end of Phase I for selected indicators. The IFHP Phase I Work Plan and Monitoring and Evaluation Plan (for the period July 1, 2008 through December 31, 2009) revised on October 3, 2008, describes program adjustments from the prior projects to assure success of the new IFHP. These were set out in the Phase I Work Plan as operational objectives¹, namely:

- Build IFHP's performing teams in: the Country Office; Regional Offices in the four principal regions, with specialized program officers led by a Program Manager; and Cluster Teams of two professionals, usually covering several zones in each region.
- Ensure that achievements of the prior projects are maintained or increased during transition, i.e., family planning, immunization, and promotion of complementary feeding.
- Synchronize IFHP annual planning with government planning processes.

¹ These are not in the same order or format as the Work Plan document.

- Ensure FMOH and RHBs receive support to implement the reformed HMIS and LMIS.
- Design interventions to support the new cadre of HEW supervisors with the necessary skills; this cadre is a relatively recent and important addition (since 2008) to the HEP, aimed at strengthening the performance of the PHCUs.
- Mainstream gender into relevant program activities with emphasis on reducing harmful traditional practices (e.g., FGM and early marriage) and increasing male involvement.
- Develop and test IFHP's new Implementing Partner Organization (IPO) partner model, shifting their roles from support for direct service delivery and supervision of volunteer health workers at the community level, to supporting the GOE's HEWs and their work with volunteers and community mobilization in their communities.
- Design a strategy to support maternal and newborn health interventions in a limited number of woredas.

B. Phase I Review: Purpose, Objectives, and Review Team

The purpose of the Phase I Review was to implement an independent external review as IFHP nears completion of the first 18 months of implementation. The review findings and recommendations are intended to guide the planning for Phase II, the next three-and-a-half years. The objectives of the review were the following:

- Assess whether IFHP is on the right track to measure and achieve its objectives.
- Assess IFHP's strengths, weaknesses and any constraints to implementation.
- Review the level of integration of FP and MNCH that has occurred without compromising key activities.
- Review the extent to which the IFHP community activities are supporting and integrated with the HEP.
- Make recommendations to build on strengths, correct weaknesses and improve implementation to enable USAID, partner staff and managers to develop an action plan.

The Scope of Work suggested questions for each section of the review, Program Implementation and Program Management, with a greater emphasis to Program Implementation.² With a start date of February 15, 2010 for the Team Leader, just two weeks in Ethiopia for the team members from the U.S. (February 20-March 5, 2010), and one week for the full team with the Ethiopian team members, the Review Team worked within a compressed timetable and some constraints given the time required to travel to the three regions selected for site visits and to various sites. (See Appendix B for the Phase I Review schedule.)

The Review Team included: the team leader, an external consultant with prior USAID and Ethiopia experience; four Ethiopian senior Regional Health Bureau officials, one from each of IFHP's four priority regions; five technical and Africa health programming experts from USAID/Washington's Global Health Bureau; and the M&E Advisor from the USAID/Ethiopia Health team. Three of the team members had participated in the 1993 health sector assessment that launched USAID's support to the GOE's health sector and had made subsequent visits to support the USAID/Ethiopia health program.

² See Appendix A for the Scope of Work for the Review.

Section II. Methodology

Given the limitations of time, the short implementation period being reviewed (i.e., 18 months) and other constraints, the Phase I Review team did not conduct a thorough, in-depth assessment or evaluation of the impact to date of the IFHP. However, the team did all possible to maximize its exposure to IFHP sites, staff, beneficiaries, and data in the time available.

A. Data Sources.

IFHP documents.

The team reviewed many IFHP documents including: the Cooperative Agreement document with Pathfinder's and JSI's Technical Proposal; the Work Plan and Monitoring and Evaluation Plan for Phase I; the Revised PMP (dated July 2009); the Report on Phase I Performance per the revised PMP (dated February 20, 2010); and the first annual report, quarterly reports, and other documents shared with the team. (See Appendix C for a list of the documents reviewed.)

Site visits.

During the first week of the Phase I Review, from February 23-26, 2010, the team divided into three sub-teams and traveled to IFHP implementation sites in the Amhara, Oromia and SNNP Regions. In some cases, these sub-teams also divided up into smaller teams so as to expand their coverage of sites and opportunities to interview IFHP staff, counterparts, and beneficiaries. In all, the team visited more than 20 health facilities (Health Centers, Health Posts), more than 12 Woreda Health Offices, four Zonal Health Departments, and three of the four Regional Health Bureaus supported by IFHP. The teams also met IFHP Regional and Cluster teams during site visits and in separate meetings. (See Appendix B for a the list of sites visited by team members.)

Key informants through in-person individual and group interviews.

The team interviewed individually and in groups many IFHP staff in Addis and in the three regions; key partners and counterpart staff at the Regional, Zonal, and Woreda levels; service providers and facility managers, beneficiaries and model families in the communities served by the Health Posts; staff of Implementing Partner Organizations (IPOs); and the USAID Agreement Officer's Technical Representative (AOTR) and other members of the Health Team of USAID/Ethiopia, including the Team Leader. More than 150 people were contacted and at least half were interviewed using interview guides to assure that key points were covered. (See Appendix D for a list of persons interviewed; see Appendix E for the Guides.)

B. Process.

To ensure that the team's findings and recommendations would be responsive to the Scope of Work requirements, the team launched its work on Sunday, February 21, with a review of the SOW, draft interview guides, and a draft outline for the report; the USAID/AOTR also provided background information about IFHP and the priorities for Phase I. On Monday, February 22, the full team received a formal briefing from USAID in the morning and a briefing from IFHP in the afternoon. After returning from the field visits of February 23-26, the team met for a full day on Sunday, February 28, during which the team identified and listed its primary findings and preliminary recommendations. These recommendations were fine-tuned during a team meeting (without the Ethiopia team members) on March 3; the team then prepared a briefing presentation for USAID/Ethiopia and IFHP, delivered on March 4. A shortened briefing presentation was given to the USAID Mission Director on March 5, 2010.

C. Limitations on Findings.

As noted earlier, the Phase I Review Team had limited time and exposure to IFHP sites. Although the data sources were very informative, the team has taken care in preparing its findings and recommendations given the following constraints:

- Site visit locations were selected as a convenience sample, not a random sample.
- Given two weeks for the Phase I Review, the team could conduct only a limited number of interviews and had limited interactions with IFHP, counterpart, and stakeholder staff.
- Although the Phase I Review Team traveled to the field, distances and road conditions by necessity limited the number and possible locations of sites visited. It was not feasible to directly observe clinical activities, fully verify the quality of IFHP work, and observe many relationships with counterpart and stakeholder staff;
- At times, language barriers were a challenge: most beneficiaries spoke local languages requiring translation from the local language to Amharic, and then from Amharic into English. The team members from the RHBs during the field visits aided this process. However, some information may have been lost in translation.

III. Phase I Review: Findings, Strengths, and Areas for Attention

As guided by the Scope of Work, the Phase I Review Team focused on the technical and programmatic implementation of Phase I of the IFHP and used the questions posed in the SOW, the Phase I Work Plan, and USAID/Ethiopia guidance to identify areas of emphasis: whether the IFHP is on track overall to achieving its objectives; the extent to which the IFHP had achieved what was anticipated regarding its four Results and the operational objectives noted above; and how the IFHP had made the transition from the two projects to the new IFHP entity and shifted its approach from doing to supporting GOE in doing. In addition, the team looked at priority management issues that can affect technical and programmatic performance not only in the short term, but also for the next three plus years of implementation.

A. Program Performance

The Integrated Family Health Program is USAID/Ethiopia's principal means for supporting family planning and reproductive health, child health, maternal and newborn, nutrition, and malaria health interventions and health systems support for the GOE's decentralized health system. The health needs are great and expectations have been high for IFHP as reflected in an ambitious Performance Monitoring Plan with 35 indicators.³

1. Overall Program Performance: Findings, Strengths, and Areas for Attention Findings

In Table 1 below, which shows selected indicators from the revised PMP, IFHP's overall performance is well above its targets for Phase I. Given that the end of Phase II is more than three-and-a-half years away, IFHP is well on its way to achieving the targets that have been set to date. These data and evidence from the team's visits to RHBs, ZHDs, and WorHOs, where team members also saw data on performance for IFHP-assisted woredas, the team concluded that IFHP is on track to measure its performance according to its PMP and achieve its objectives.

³ See "Integrated Family Health Program: Revised PMP Indicators and Targets Based on New Allocation of Woredas by MOH/RHB," dated July 2009.

The data in Table 1 also demonstrate that for Phase I priority thematic areas, especially family planning and immunization, service delivery levels have been maintained or increased from the predecessor projects. Data are not reported for exclusive breastfeeding and complementary feeding, two other priority thematic areas for Phase I. However, anecdotal information from the team's field visits and interviews indicates that these nutrition interventions have also been maintained, at least at the level of the previous projects.

Table 1. Selected PMP Indicators, by Result⁴ and Phase I, Phase II Achievements

Selected Indicators, by Result	Phase I Expected/ Targets	Phase I Actual	Per cent achieved	Phase II Expected	Per Cent to date
1.1 # trained in FP/RH	5,674	5,847	103.0	TBD	
1.3 # trained in child health and nutrition	5,674	4,619	81.4	TBD	
2.2 # medical and para-medical practitioners trained in evidence-based clinical guidelines	4,851	6,583	135.7	TBD	
2.3 # trained in maternal/newborn health	2,302	3,813	165.6	TBD	
2.4 # trained in child health and nutrition	2,602	3,813	146.5	TBD	
2.8 # USG-assisted service delivery points providing FP counseling or services	2,638	4,317	163.7	5,275	81.8
2.13 # antenatal care visits by skilled providers from USG-assisted facilities	1,857,159	1,537,727	82.8	6,190,529	24.8
2.15 # children <1 year who received DPT3 from USG-supported program	1,103,960	1,145,593	103.8	3,679,866	31.1
3.5 Per cent of health facilities (including health posts) submitting HMIS reports on time	45	85	188.9	95	89.5
3.6 Per cent of WorHOs using HMIS data for planning and decision-making	45	42	93.3	95	44.2

In accomplishing these objectives, IFHP managers also successfully achieved their primary operational objectives for Phase I that required reorienting all staff to a new organizational structure, new approaches for working with the GOE and HEP at all levels, new roles for the IPOs, integrating family planning, child health and nutrition interventions, and expanding services to include maternal and newborn health, malaria, and, where appropriate, HIV/AIDS-

⁴ Note that there are no clear targets or data available for Result 4.

related prevention and service delivery. The IFHP's support for community level services is fully integrated into the HEP. These achievements and areas that still need attention are elaborated in Sections below. In brief, IFHP has accomplished what it set out to do in Phase I.

Strengths

- **IFHP is “embedded in,” committed to, and providing important support to the GOE’s Health Extension Program** and Implementation of HSDP III.
- **IFHP represents a comprehensive (USAID-supported) health program that is fully integrated into GOE programming at all levels.** The hard work of developing a joint program and high performing teams within IFHP and with the GOE has paid off.
- **IFHP support is strengthening GOE capacity to plan, monitor, and supervise its health programming.**
- **IFHP facilitates coordination of and communication with all partners** from the Regional level down to the community.
- **IPOs are now integrated by supporting the GOE HEP** at the woreda level and below.

Areas for Attention

Although the Phase I Review Team was very impressed by IFHP's progress, team members identified important areas that will need priority attention from IFHP (and USAID) for Phase II. These are summarized below and are presented in greater detail in the following sub-sections. Some areas for attention are the direct responsibility of IFHP; others are directly affected by GOE policy and action, but will require some IFHP action; other areas require USAID attention.

For IFHP attention:

- **Quality and consistency of BCC interventions.** Given that the Health Extension Program is primarily a behavior change program for prevention and health promotion, IFHP needs to give more emphasis to BCC quality and consistency, especially community mobilization and community conversations.
- **Continued support for woreda-based planning and the MBB process** as well as other health systems implementation (e.g., HMIS, LMIS⁵).

In conjunction with GOE:

- **Quality of BCC and service delivery and the supervision system for the HEP,** specifically the selection, role, training and support for the HEW Supervisors, will require review and significant support from IFHP.
- **Strengthening of VCHWs’ roles, capacities, and supervision.** Improved training, supervision, and follow up from the HEWs and the IPOs are critical to expanding the outreach and improving the impact of the VCHWs.
- **Strategies and planning to address important service delivery weaknesses.** Under development by the GOE and IFHP, implementation support will be needed for: maternal health, newborn care, community case management for pneumonia, and long-acting and permanent methods (LAPMs) of FP, including removals for implants.

For USAID support to IFHP:

- **The indicators and data collected for IFHP PMP are not useful** for assessing IFHP's performance and progress. Many are now mandated by requirements for annual reporting

⁵ The Operational Objective for supporting implementation of HMIS and LMIS were not completed due to delays outside the control of IFHP in the implementation of these systems.

- **IFHP will need more staffing at the Cluster level and greater Country Office capacity in key technical areas** for IFHP to provide the support for the GOE HEP and the systems required to effectively manage it.

2. Program Results 1-4⁶: Findings, Strengths, and Areas for Attention

Result 1: Improved health practices at the household and community level.

Findings

IFHP approaches for accomplishing this result are fully aligned with the GOE's Health Extension Program, which is fundamentally a community mobilization (CM) and behavior change communication (BCC) program for promoting improved health and health care seeking behaviors in the rural areas of Ethiopia. Under the HEP, the two Health Extension Workers assigned to the kebele health post identify prospective "model families." Over the next 4 months, the HEWs provide them with training during two 2-3 hour sessions per week in a standard set of healthy behaviors such as latrine building and use, hand washing, family planning, nutrition, and immunization. Once graduated, one or more individuals from the model families may become Volunteer Community Health Workers (VCHWs), who assist the HEWs in community outreach and conduct community conversations aimed at changing community norms with respect to family planning, harmful traditional practices, and the like; they also promote healthy behaviors and timely use of health services. During a 3-4 year period, the HEWs and the VCHWs are expected to train all kebele families as model families.

The PMP indicators for Result 1 are not directly relevant to either the outputs or outcomes expected, as demonstrated in Table 1 above. The training being tallied is not specific to the model family training, and no outcomes were measured for Phase I except for the number of early marriages deferred or cancelled, 2006 against a target of 2000. Therefore, the Phase I Review team relied on its observations during the field visits, interviews with key informants, and other documentation to identify important strengths and areas for attention in Phase II.

Strengths

- **The overall approach for CM and BCC is working in IFHP woredas and communities.** HEWs have trained many model families in their communities; these families typically have high quality, usable latrines with hand-washing facilities near-by, separate their animals from sleeping areas, immunize their children, etc.
- **IFHP-assisted HEWs, particularly those where IPOs are active, appear to be highly effective in working with community volunteers.** In areas where ESHE and FP/RH programs supported volunteers and where IPOs are active, the VCHWs appear to have higher levels of skills, are active in community mobilization, and can provide community members more health messages on a wider range of topics than other VCHWs.
- **"Community conversations" appear to be an important influence on community awareness, behavior, and norms.** They are sessions facilitated by HEWs and VCHWs that provide a venue for discussing health issues such as FP, harmful traditional practices, and gender.
- **BCC materials, including the Family Health Card, flip charts for family planning, and other BCC materials, were available** at the health centers and health posts visited.

⁶ Note that the findings for the results below are presented as a synthesis, not according to IFHP sub-results.

- **Awareness in the communities visited by team members appears to be high,** particularly in regards to the priority health issues of family planning, immunization, and breastfeeding and complementary feeding. High demand for FP methods and open discussion of FP methods and personal experience by community members, including men, are good indicators that family planning is now a community norm.
- **Involvement of religious leaders has been encouraged by the HEWs and VCHWs** who in a number of communities have successfully garnered the support of religious leaders for use of family planning. When religious leaders have been early acceptors of family planning, they are often very influential in generating change in community norms and behavior towards family planning services and in involvement of more men.

Areas for Attention

Although the overall approach to Result 1 seems to be very effective, it has potential for even greater impact on the health and well being of beneficiary communities if more attention is given to these concerns. These areas are important priorities for IFHP.

- **IFHP capacity in CM/BCC.** Given the prominent role of CM/BCC in HEP and the need for significant support for CM/BCC from IFHP, the role of AED and the staffing in the Country Office appear weak. IFHP needs to consider more long-term and short-term support for BCC/CM in order to reinforce its efforts in CM/BCC, and to have a strong voice at the Federal, policy level on the BCC/CM Technical Advisory Committee, which sets the BCC/CM agenda and harmonizes messages.
- **Skill building for HEW Supervisors, HEWS and VCHWs.** They need more training in CM/BCC, including community conversation. Community conversation is an effective technique; however, its use requires competency in facilitation of group discussions.
- **Varying skills of and support for VCHWs.** All VCHWs are supposed to receive training from HEWs using a standard curriculum. However, the team found differences in skills and knowledge among the VCHWs even within the same region. In some cases, the number of VCHWs may be beyond the management ability of the HEWs.
- **BCC materials are limited.** At most, the VCHWs and the model families are provided with the Family Health Card. At the health facilities, for the model family training, and in other venues, more materials on more topics in local languages would be helpful. This will be especially important as new initiatives are launched on maternal and newborn health, community case management of pneumonia, and to reinforce topics in malaria and HIV/AIDS. Each health post should also have a poster in the local language (at least Amharic) on family planning choices (often referred to as the Tiaht chart).
- **Limited information on community practices and data to link interventions with behavior changes.** The Phase I Review Team did not learn of studies on community norms and behaviors related to IFHP intervention areas, such as practices related to maternal and newborn care. Moreover, the PMP does not link monitoring of the BCC interventions with outcome indicators for the desired behaviors, except for family planning and several HTPs (e.g., early marriages prevented).
- **Mass media and use of the mobile vans.** Although mobile vans are identified as a community mobilization resource for each region, the team had no opportunities to observe the van or fully understand its possible uses. The team also could not inquire into the possible role for radio and other mass media in IFHP BCC strategies. It appears, however, that regional and community radio is accessible and relatively low cost.

Result 2: Improved availability and quality of health services, products and information. Findings

For Phase I, IFHP was expected to focus on maintaining, and if possible, increasing coverage and use of family planning, immunization, and nutrition counseling on breast feeding and complementary feeding. As noted above and shown in Table 1, key PMP indicators for these areas, except for the number of antenatal visits by skilled providers (which was not an area of emphasis), were achieved or exceeded in Phase I. In regards to family planning, the GOE was a driving force through its Implanon initiative, launched in July 2009. The GOE planned to introduce and scale up quickly the delivery of Implanon (a single rod contraceptive implant) by a trained HEW in every kebele. IFHP assisted the GOE to design a learning phase and build in evaluation during implementation. IFHP proposed and then provided training to 72 master trainers (clinicians as well as nurses serving as HEW supervisors) in eight pilot woredas. Training conducted by these master trainers was then rolled out to over 200 HEWs who inserted more than 10 Implanon implants during training. (Each woman was counseled on all available FP methods; other methods, both long term and short term, were available and in some cases chosen by women who originally sought Implanon during the training roll out.)

The Phase I Review Team noted some important lessons from this experience in addition to other strengths for IFHP to build on for Phase II and the challenges ahead.

Strengths

- **IFHP has cadres of master trainers in FP, CH, and nutrition who very effectively conduct skills training and practicums.**
- For **FP**, a relatively wide variety of methods is now available at the community, health post level, including condoms, pills, Depo, and Implanon; post-abortion care is available at many health centers.
- **Nutrition** assessment and counseling are strong in many health posts; many HEWs have had training in the Essential Nutrition Actions (ENA).
- For **Child Health**, focus has been maintained on immunization. ORT is available for management of watery diarrhea. Child health tools are used correctly.
- There is a platform on which to build stronger **Maternal Health** programming, including promotion of antenatal care (ANC), facility delivery, and postnatal care (PNC). With help from VCHWs, the HEWs register pregnant women, recently delivered women, and their newborns in their catchment areas. HEWs track ANC, delivery care, and PNC visits. Some HEWs have received additional, one-month training in clean and safe delivery.
- For **Newborn/PNC**, the HEWs and VCHWs can identify households for targeted follow up for PNC to include newborn care, maternal check up, FP, etc. The IMNCI platform is also available for Essential Newborn Care (ENC) at Health Centers.
- HEWs carry out annual utilization surveys to assess **Water & Sanitation (WASH)** effectiveness and to inform woreda-based, health sector planning (WB-HSP).
- For **malaria**, the PMI's focus areas and management processes are being applied with respect to coverage of LLITNs, IRS, RDT, and use of ACTs, even in some woredas where PMI is not being implemented.
- FP is being integrated into **HIV-related** services, as appropriate, including some VCT and ART.

General Areas for Attention

During Phase II, starting almost immediately, the IFHP will face many challenges in not only addressing areas that need attention in the present program interventions, but also taking on high priority initiatives as the GOE strives to improve maternal and newborn health. These areas for attention all require working with the GOE to resolve.

- **Weak referral linkages.** Although health providers from the health posts and health centers mention referrals, there is little evidence of a system for referrals that conveys critical information up and down the referral chain and provides support along the way. Timely access to referral level care appears severely constrained by limited access to transport.
- **Availability of important supplies and consumables is irregular and/or relies on gap filling by IFHP.** Supplies of contraceptives and vaccines are monitored carefully. However, other supplies, such as misoprostol, oxytocin, magnesium sulphate, and cotrimoxazole, are often not available, even when they are approved for use at the health post or health center level.
- **Health posts in particular lack access to clean water and hand washing supplies.**
- **Problems with data and tracking procedures.** In tracking performance at all levels, there is confusion about definitions, for post-natal care, family planning acceptors, users, and clients served, clean and safe delivery and skilled birth attendant(s), and others.
- **Lack of information and tracking of intervention outputs and linking them with outcomes.** At best, the PMP measures some outputs of the program, but these are not linked to outcomes, so that the effectiveness of the interventions can be monitored and adjustments made. This will be especially important as new initiatives promote new interventions for which there will be plans to roll them out as quickly as possible.
- **Limited focus on quality and quality assurance.** Although ISS is practiced regularly, there are limited data and analysis on quality of care for all interventions. This is being proposed as a major systems strengthening area of HSDP 4.
- **Community involvement in monitoring health activities.** Woreda Advisory Committees (WACs) and Kabele Advisory Committees (KACs) are supposed to have a role in monitoring health programs at the woreda and community level. The team received differing responses as to whether guidelines and tools are available to support these groups and had few opportunities to inquire into their actual roles and functioning.

Specific Areas for Attention, by Intervention

In addition to the general areas of service delivery that will need attention during Phase II (see above), there are specific areas for attention for each intervention IFHP will be supporting; these all will require close collaboration with the GOE.

- **Family planning.** Specific concerns are:
 - On-going vigilance to ensure voluntary and informed choice, and adherence to USAID legislative and policy requirements.
 - With the rapid scale-up of Implanon, continued attention to balanced counseling during training, service delivery and supervision to ensure that women are counseled on all available contraceptive options and choose the one that best suits their needs.

--All women with implants need access to removal on demand. Four brands of implants are in use: Norplant, Jadelle, Implanon, and several thousand Sino-Implants brought in for pre-introductory use. Women with Norplant will need removals soon.

--Increased access to IUDs, tubal ligation, and vasectomy should be available over the life of the project.

- **Child health.** Community case management of pneumonia has recently been approved by the GOE. IFHP should address (with the GOE):
 - Recurring need for training of providers in all CH interventions due to turnover
 - The need for training, supervision, and monitoring of community case management of pneumonia as it rolls out in the woredas it supports.
- **Nutrition.** The many nutrition interventions (TCN, ENA, CBN, SAM) being implemented in Ethiopia constitute a veritable alphabet soup, and are a source of confusion for providers at the community level. Moreover, some tools for assessing nutritional status were sufficiently complex as to challenge Review Team members. The team is not aware of any studies that evaluate their relative cost-effectiveness.
- **Maternal Health.**⁷ As more HEWs are trained in clean and safe delivery, the policies on use of misoprostol and other drugs, how deliveries are counted (clean and safe vs. skilled birth attendant, etc.), and the role of active management of the third stage of labor (AMTSL) need to be clarified and reinforced through the training, the HMIS, and supervision. As maternal health interventions are rolled out at PHCU levels, on-going evaluation on their effectiveness is needed to adjust policy and implementation strategies.
- **Newborn Care/Postnatal Care.** Little is known about the skills of the HEWs, the actual practices of PNC and newborn care, and their effectiveness. Essential Newborn Care (ENC) and, apparently, some limited content on post-natal care are included in the HEW “Clean and Safe Delivery” training; however, training in integrated post-natal delivery care has not yet been developed. HEWs are trained to provide information about newborn care to families and identify and refer newborn complications; however, they have no capacity to manage any newborn complications.
- **Malaria.** More analysis of trends and seasonal epidemics of malaria would assist WorHOs and affected communities anticipate and take action in advance. In some highly endemic areas, the ITNs distributed 3-4 years ago need replacing. In non-PMI woredas where malaria is seasonal or endemic, health providers’ training should include malaria prevention and treatment skills.
- **HIV/AIDS.** In addition to integrating FP into HIV/AIDS services, VCT needs to be fully integrated into antenatal care (ANC) and in the labor and delivery units at hospitals and health centers. Follow up of HIV-exposed mothers and infants is also needed and both provided with the diagnostic tests and care and support they need.

Result 3: Key elements of health system strengthened to support health services.

Findings

Currently, the IFHP systems strengthening component provides support to overall performance improvement systems, including woreda-based planning, integrated supportive supervision (ISS), a strong emphasis on data for decision-making, and capacity building. IFHP helped launch the new HEP supervisory system, which has encountered problems with recruitment, transport

⁷ See Appendix F for more information about the context for IFHP strategies on maternal and newborn care.

and morale. IFHP also supports and strengthens other health systems components through its collaboration with projects that have specific mandates for their design and implementation, including: logistics improvement and LMIS, scale-up of the reformed HMIS, and health care financing. Because IFHP's work is undertaken within and for the government's health system, IFHP is well-positioned to support many health system strengthening initiatives. However, just as other projects responsible for selected components are outside of IFHP's control, many elements of the GOE system are beyond IFHP's control. In these circumstances, IFHP must do all possible to influence design and planning for roll out, while at the same time, assist the managers within the system to adjust, revise, make do, and fill in as needed.

Result 3 PMP indicators and targets (see Table 1) have limited data available, but are on track.

Strengths

The Phase I Review team identified numerous strengths in the health systems strengthening components of IFHP, and its support for the following.

- **Woreda-Based Health Sector Planning (WB-HSP).** The GOE's policy on woreda-based planning uses the Marginal Budgeting for Bottlenecks (MBB) analytical framework. By strengthening this evidenced-based planning system, IFHP builds capability at the woreda level for analysis of systems constraints (availability, access, resources, use and quality) and for delivery of high-impact health services (EPI, FP, malaria, MNCH). WB-HSP puts responsibility, accountability and power to manage health programs to woreda health officials and providers. At GOE request, IFHP regional staff trained in WB-HSP provides training and mentoring to IFHP and no-IFHP woredas.
- **Integrated Supportive Supervision (ISS).** Developed by ESHE and now adopted by the FMOH, ISS is a participatory, problem-solving approach to improving staff performance. Supervisors use a comprehensive checklist of activities that promotes documenting and sharing findings with facility staff through verbal and written feedback and planning for follow-up actions at the end of each visit. IFHP supports ISS visits to health posts, health centers, and WorHOs in its target woredas; issues from the visits are discussed and resolved at quarterly review meetings. Examples include ISS identification of equipment gaps and training needs that were quickly corrected.
- **HEW Supervision System.** The deployment of HEW supervisors in each PHCU was a critically important step by the GOE to strengthen the work of the HEWs. IFHP has contributed to the improvement of HEW supervision by developing and supporting training for the HEW Supervisors and supporting their activities by incorporating them into ISS processes. IFHP-supported IPOs also contribute to HEW Supervisor training.
- **Performance Review Meetings.** The performance review meetings are held monthly at Health Center and Health Posts, and quarterly at management levels. IFHP supports the organization of these meetings and availability of ISS, HMIS, and other reports for them. The WorHOs, ZHDs and RHBs review progress against planned goals, compliance with health policies, and problems affecting performance. Strategies are developed for overcoming problems and an agreed on action plan is outlined at the end of each meeting.
- **Capacity Building for Health Systems Managers.** IFHP strengthens health service systems through building the capacity of GOE health managers at all levels with targeted training, technical assistance, the provision of guidelines and manuals, and financial support where needed. A significant strength of IFHP is its systematic training for HP,

HC, WorHO, Zonal and RHB levels in: quality standards for health care providers; ISS guidelines and checklists; and use of data for planning and monitoring. For example, to develop and institutionalize ISS capacity, RHB and IFHP staff was trained as trainers who then trained ZHD and WorHO health managers and HEW supervisors. Training sessions were followed by joint follow-up visits and mentoring.

- **Flexible Financial and Logistics Support.** IFHP's ability to be flexible in its support to the GOE at all levels has resulted in extremely effective gap filling. When the GOE budgeting system fails in meeting an urgent need, IFHP has stepped in with necessary resources. This ability to provide resources quickly has been particularly important for transport, costs for meetings, and for shifting commodities from one zone (or one region) to another to avoid critical stock-outs and any breaks in service delivery.
- **Contraceptive Commodities.** Along with EPI, the GOE's contraceptive commodity logistics system appears to be quite strong. Nonetheless, IFHP is filling gaps based on requests and needs of the regions. At every site visited, contraceptives supplies were available and no stock-outs in the recent past were noted.

Areas for Attention

The areas for attention presented below represent general concerns of the Review Team. Many are not under direct IFHP control. However, because it is so integrally involved with the GOE health system at the regional level and below, IFHP has the contacts and relationships with GOE officials that can help all parties test solutions to problems, analyze the results, and make significant changes in practice or policies.

- **Limited and Weak Supervision of HEWs.** Although the addition of HEW Supervisors has been an important addition to HEP, a number of issues remain:
 - Selection of Supervisors: The supervisors are clinical nurses or environmental sanitation officers. Given the evolving nature HEW's work in clinical interventions (e.g., Implanon insertion), the background of some does not correspond with the HEWs role.
 - Missing Incentives: When the HEW supervisor positions were initially outlined, individuals were promised promotion potential and other incentives that made the positions sound attractive.
 - Transportation: Supervisors must travel to the five HPs within the PHCU. Distances between the Health Center and the Health Posts can be very long and no means of transportation is often available or provided to the supervisor.
 - Training: The training for HEW supervisors is for one month, much shorter than HEW training, which is for 1 year; by now, many HEWs have held their positions for 4-5 years. As a result, their knowledge of the work and skill levels can be above their supervisors.
- **Supervision of the VCHWs.** Included in the role of the HEWs is training and supervision of the VCHWs from the community. Although a strong VCHW system, with VCHWs who are respected in the community, can facilitate access to households, help in the outreach of the HEW, and assure regular visits to households far from the HP, HEWs need more training and support to help them develop and maintain their VCHW systems.
- **Training Un-system.** It appears to the Review Team that IFHP initiates and organizes the training at each level. Given the importance of training for the short to long-term in the GOE health system, IFHP, as part of building the GOE capacity, needs to strategize on where (i.e., within which part of the GOE structure at the Regional and Zonal levels) and how it can strengthen the GOE's ability to plan and organize trainings so that these

capabilities are institutionalized in the GOE system. Training needs to be considered as a system, just as logistics and health information.

- **Slow HMIS Roll out.** The very slow roll out of the reformed HMIS is a concern of all development partners and the GOE. Although this is not IFHP's role (for which it also does not have the resources), IFHP nonetheless will need to support the roll out of the HMIS given its integral role with the RHBs, ZHDs, and WorHOs and the need to use the data from the HMIS for decision-making and planning.
- **Data use, quality and definitions.** From all accounts, data collection and quality have significantly improved at all health system levels with the IFHP support. IFHP has promoted data use and quality in the Performance Reviews and ISS. However, as in any system, consistent training and technical support are needed to further improve the collection and use of data. More attention is needed at HPs where the HEWs lack consistent definitions for what they should count and track for the wall charts and reports.
- **Lack of key drugs/commodities/supplies for FP, MNH, malaria.** IFHP in partnership with the FMOH and through an MOU with DELIVER is working to roll out an integrated logistics system, with an LMIS, that will handle all supplies for the health system. While these await full implementation, due to policy and/or supply issues, some essential drugs and equipment are missing or unavailable, e.g., misoprostol, kerosene, resuscitation devices and consumables needed for LAFP, deliveries, and ENC. Hand washing supplies and clean water are also essential, for deliveries, EPI, and FP.
- **General Support for Woreda-Based Health Sector Planning.** Although WB-HSP is a highly effective health system intervention, when IFHP staff time and resources are drawn on for WB-HSP in non-IFHP woredas, it is a significant strain on IFHP and affects IFHP's activities in their 286 assigned woredas.

Result 4: Systematic program learning to inform policy and program investment.

Findings

As noted above, the PMP set no targets and IFHP has presented no data for this result for Phase I. The Review Team found that the program's application of these approaches has been limited to date. Result 4 therefore needs more focused attention in Phase II.

This Result represents USAID's expectation that IFHP's contributions will extend beyond implementation and capacity-building for Ethiopia's health sector program, to program learning that will benefit other partners and programs in Ethiopia, Africa and beyond. Through the application of structured, program-based research approaches, along with analysis and use of existing data, the IFHP should help determine the effectiveness of new and existing program approaches, identify solutions to overcome programming weaknesses and "bottlenecks," and provide objective evidence to guide policy and program development at federal, regional, and operational levels. Because of its unique at-scale involvement in the GOE health sector program and in development and roll out of new initiatives, the Review Team believes that through such documentation and evidence production, IFHP can have important influence at all levels (for example, in phased roll out of new initiatives and in the GOE/Partner Joint Annual Review of the HSDP). This influence could extend to the global level. Thus, the achievements under this result can be one of the program's important value-added contributions.

Strengths

Although IFHP has not completed any evaluative or program research analyses or studies, there are some examples of program learning and sharing and on-going activities that are noteworthy.

- **Use of inter-regional and regional meetings to exchange implementation experience and “best practices,”** which appear to have been useful to the operational staff from regional and cluster level. These experience-sharing processes will continue to be important as the program engages in roll out of new initiatives, from woreda-based planning to maternal and newborn health.
- **Awareness of the importance of lessons/best practices at multiple levels of the program,** along with a culture of data use and the belief that good documentation will facilitate allow transfer of practices. Several IFHP staff at regional and cluster level identified program areas in which they felt such program-based research would help identify solutions to problems. Technical Advisory Committee (TAC) visits to the regions created greater awareness of best practices among GOE officials.
- **Availability of potential resources to support evaluative or program research,** in the form of universities and schools of public health.
- **Two studies were planned or ongoing, supported by the Country Office,** specifically evaluations of the Implanon roll out and on the sustainability of “Model Families” behavior change. Also, SNNPR reportedly is gathering data on several best practices and supporting experience sharing among health posts and kebeles. Two additional examples of development and use of program evidence were the documentation of the “best practice” in scaling up the HEP model in remote areas (in Oromia) and documentation of FGM reduction in Darramie. Both were cited as having had important local impact.

Areas for Attention

In discussing this result with IFHP leadership at the Country Office and Regional levels, IFHP capacity and the scope of evaluative research undertakings were recognized as concerns. In addition the following will need attention.

- **Staffing and skills gaps.** While able to identify important topics for evaluative research, IFHP staff at the regional level needs both technical assistance and extra person-power to design, implement, and analyze such research. Regional and cluster staff believed that providing such support was an overall responsibility of the Country Office. The Country Office staff position for Operations Research Coordinator is vacant.
- **Mechanisms for setting priorities for evaluative research topics and frameworks for analysis.** Given the many possibilities for studies and limited time and resources under Phase II, IFHP will need to set priorities (with GOE participation at all levels) and build evaluative research to the extent possible into the design of initiatives with clear linkages identified between inputs, outputs, and outcomes.
- **Heavy reliance on baseline and end line measurements to demonstrate effectiveness and impact.** While surveys (if well designed and executed) can produce evidence of outcome change and impact, they seldom do so in a timely way so as to associate changes with specific programmatic approaches. Data-gathering approaches, such as cluster surveys, LQAS, and qualitative approaches used for BCC research, could be considered.

3. Shifts in Operational Approach.

Findings

In addition to progress in the results specified under the program agreement and PMP, IFHP intended two important shifts in implementation modality. These shifts were to build upon and extend management and implementation approaches not seen in most other programs. They involve shifts that move from:

Service Delivery to Capacity Building - and - Parallel support to Embedded support.

From all the evidence available to the Phase I Review team, these shifts have been successfully carried out and the response has been extremely positive from GOE counterparts. These shifts represent an important positive evolution of USAID health and family planning programming, both in Ethiopia and more broadly.

The other important shift made by IFHP and recognized by the review team is that the principal implementing partners overcame institutional and operational differences and approaches to harmonize with each other and with the GOE. As a result, the team found that most program staff in the field identified themselves as “IFHP,” not as staff from an implementing partner.

Strengths

- **The GOE at every level is DEFINITELY in the lead**, with IFHP personnel working within GOE systems and building capacity as they partner with the GOE. GOE officials at regional, zonal, woreda levels consistently said “They are part of us.” The approach is Paris-friendly, i.e., follows the Paris Declaration of AID Effectiveness that calls on development assistance to be “country-led” and aligned with government systems.
- **IFHP participates in government processes** (e.g. quarterly reviews and woreda/cluster planning) in ways that support quality analysis of data and lead to development of good quality plans, but in ways aimed to strengthen capacity. Through this approach, application of project resources is carried out in the context of government plans and IFHP negotiations with government regarding best use of community/woreda/clusters’ own resources, project resources, other partners’ resources (“gap-filling”).
- **More efficient use of program resources**, since all activities are in context of government plans, rather than being used in parallel, non-sustainable approaches.
- **Systematic step back from doing to support for doing.** In the area of training, for example, IFHP has moved from direct training to teaching training, for example, training woreda staff and HEW supervisors to train HEWs to train and organize community volunteers, rather than directly training those volunteers. The use of systematized approaches such as guidelines and checklists allows for replicable application and transfer of management and implementation approaches.
- **In some instances, managed progression for transfer of activities supported by IFHP to local government.** One example was support for quarterly review meetings: moving from supporting all four meetings each year to supporting only two of four (with local government funding the other two) as the value of these reviews is established.

Areas for Attention

The Review Team identified several areas where this “embedded” program approach might be strengthened in Phase II. These areas need direct IFHP (and USAID) attention.

- **Need for benchmarks of woreda competency.** Although the team accepted the IFHP position that a “graduation strategy” for program-supported woredas was not consistent with field realities, given the wave of new demands and expectations for woredas and the HEP in general, the team saw the need for tracking progress in developing woreda-level management and leadership competency and gradual reduction in support.
- **Need for sharing and extending IFHP-related skills with non-IFHP woredas.** The team and IFHP noted that its program support was leading to some inequity among woredas (those receiving support versus others). The team recognized the limitations of IFHP’s capacity and resources, but suggest that approaches such as including non-IFHP woredas in TOT and other over-arching activities be pursued when feasible, to facilitate the development of competencies now being strengthened only in IFHP woredas.
- **Functions without capacity-building approaches.** The team also noted that some project functions do not seem to have a transition/capacity building approach, e.g. organizing and managing training (noting *training as a system function* as mentioned under Result 3), and transport for Integrated Supportive Supervision.
- **Capacity of IFHP to support the GOE’s aggressive program.** A major constraint on project support is clearly the “thinness” of program staff at the Cluster level. The team noted that the IFHP has only two public health generalist professionals in each Cluster Office. This fact, along with the large geographic extent of some Clusters and the GOE intention to roll out new technical programs, suggest to the team that IFHP and USAID should consider selectively increasing Cluster staffing, possibly sub-dividing some larger clusters into two, and adding technical backstopping in some areas in the Country Office.

B. Program Management

The Phase I Review Team examined three areas of IFHP management: the structure, staffing and decision-making of the Country Office and Regional teams, including the relationships of the partners (Pathfinder International, JSI, AED and CORHA); relationships and communications with counterparts, stakeholders, and USAID; and the M&E plan, with an emphasis on knowledge management and documentation. Findings for each of these areas as well as strengths and areas for attention are presented below; recommendations are presented in Section IV.

1. Structure, staffing and decision-making: findings, strengths, and areas for attention.

Findings

The IFHP organizational structure covers many locations: the Country Office of close to forty positions is located in Addis Ababa; there are four regional offices, one in each of the primary regions (Tigray, Amhara, Oromia⁸, and SNNP) with 9-11 staff each including an IFHP Regional Manager; and, each Regional Office has from two-five Cluster Offices located at the Zonal level of their respective regions. The Cluster Offices are staffed with two public health generalists and two drivers. The Regional Offices include staffing for technical areas such as MNCH, Nutrition, FP and Gender, and HIV/AIDS/ASRH, as well as BCC/CM, Logistics, M&E, and Finance & Administration. Almost all of the Regional Offices and Cluster Offices are co-located with their GOE counterpart offices at the Regional and Zonal levels. All staff members, with the exception of the Deputy Chief of Party, are Ethiopian.

⁸ Due to the central location of Addis to Oromia region, the RHB for Oromia and the IFHP Regional Office for Oromia are located in Addis.

The leadership of the Country Office includes the Chief of Party, the Deputy Chief of Party, and two Deputy Technical Directors. They represent the two former projects and implementing partners evenly, two each from JSI and Pathfinder. They meet together along with the Team Leader for Finance and Administration and the Team Leader for Monitoring and Evaluation as the Executive Team. Each Deputy Technical Director manages a technical team; the primary technical areas of responsibility of the Deputy from Pathfinder are family planning, ASRH, HIV/AIDS, gender and reduction of HTPs, and BCC and CM. The Deputy from JSI covers the technical areas of child health and nutrition, MNH, malaria, systems strengthening, and training. The two Deputy Technical Directors also divided up responsibilities for Regional Office support and oversight. Each took a familiar region (where their respective organizations of origin had substantial experience) and an unfamiliar region (where they had more limited experience). Thus the Deputy from Pathfinder is now responsible for SNNP Region, a former stronghold for JSI, while the Deputy from JSI is responsible for Tigray, where JSI had no experience in the past.

Despite the numbers and arrangement of IFHP's organizational structure for the Country Office, it appears to function as a flat and lean operation, in a form of matrix management, with technical staff working across the structure as needed. At least monthly staff meetings of the two technical teams and of the whole staff appear to be effective in maintaining communications and cohesiveness. The Country Office has delegated significant responsibility to the Regional Managers, and, in turn, they rely on their Cluster Offices. One Regional Manager noted that he has frequent, direct contact with his Deputy Technical Director; he also contacts the technical advisors for advice without going through any layers or bureaucratic processes. The Regional Offices are responsible for planning their activities in concert with their regional counterparts and for implementing them once their plans are approved by the Country Office. Similar to the Country Office, the Regional Offices appear to work as teams with a collaborative decision-making approach. Evidence that the Country Office-Regional-Cluster structure works well comes from the results achieved as presented in previous sub-sections of this report.

Overall the Phase I Review Team was impressed by the professionalism, commitment, and effectiveness of IFHP staff at all levels. They have melded two seemingly diverse organizations, cultures, implementation approaches and philosophies, and intervention focus areas into an IFHP identity. Feedback from many staff members indicates that they see themselves as IFHP staff; counterparts also see them as IFHP, not Pathfinder or JSI. IFHP staff spoke of their appreciation for working on a more comprehensive set of interventions and their partnership with the GOE.

In their joint planning with the GOE, IFHP makes commitments to support review meetings, ISS visits, training sessions, agreements with IPOs, etc. Evidence from the RHBs, ZHDs, and WorHOs shows that the IFHP lives up to its commitments. The Review team members heard no complaints regarding timeliness, or other problems with IFHP support. One Zonal Health Department manager compared IFHP with other partners implementing health activities in his zone and declared: "IFHP is the best!"

Feedback from Country Office senior staff members (at least JSI and Pathfinder) indicate that they receive relevant and timely backstopping from their respective Headquarters offices in Boston. At the time of the Review, the Senior Vice President for Program from Pathfinder was visiting as well as the PI Country Backstop, an indication of HQ attention to the Review results.

Strengths

From the Phase I Review Team interactions with staff during site visits, interviews with staff at all levels, and observations, the team identified important strengths.

- **Strong staff competence.** The team was very impressed by the competence of those we met. Because they spend much of their time in the field, IFHP staff understands field issues and program constraints. Despite the challenging work, it appears that IFHP has been able to retain (and, when needed, recruit) well-qualified staff. The IFHP partners are supporting staffing that is relevant to the technical strengths of that organization, e.g., AED with staff for BCC.
- **Commitment to IFHP.** The dedication of the staff to the IFHP approach and objectives is commendable. All staff indicated their primary allegiance to IFHP as a team rather than their “parent” organization.
- **Consultative management style for programmatic decision-making.** The team heard of examples of joint decision-making by the Country Office and regional teams.
- **Complementary expertise to GOE.** IFHP brings additional expertise to the GOE HEP, which is value-added to the program.

Areas for Attention

- **Professional staff indicated a need for a professional development policy** that would support their continued growth and skill development as well as more exposure to cutting edge research and information on key technical and systems strengthening areas.
- Although Pathfinder and JSI appear to be working well together, the Review Team learned of **some issues with roles and relationships with AED and CORHA**, both of which provide important expertise to IFHP in BCC and training respectively. The role of AED to support for the substantial BCC component of IFHP, in particular, was not clear.
- **The organizational chart for IFHP is out-of-date.** Cluster designations, at least for one region are inaccurate. Staff members are identified by their home organization, which is not consistent with IFHP approach or philosophy at this time.

2. Relationships and communications with counterparts, stakeholders and USAID: findings, strengths, and areas for attention.

Findings

IFHP’s relationships and communications with its many counterparts at all levels of the GOE health system, particularly at the regional level and below, with a wide variety of stakeholders, including religious leaders, IPOs, and others at the community level, and with USAID, appear to be constructive and effective. These relationships are evident in Addis, at the national level; in the Regional capitals; and at the Zonal, woreda, and community levels.

Relationships and communications with counterparts

The Review team was not able to assess the relationships and communications of IFHP staff with counterparts in depth; the team visited only a sample of the woredas and zones, and three of the four major regions, and had limited time to observe and/or interview counterpart staff at each level. As noted above, IFHP must work closely with all levels of the health management and service delivery structures. Among the challenges for IFHP in relating and interacting with counterparts is the high turnover of staff, particularly at the woreda level and among service

providers at the health centers. At the time of the Review team visits, the team met with some health center staff members who were newly appointed or were “acting” health center managers.

Overall, the Review Team learned that communications and relationships of IFHP management and staff with its counterparts are excellent. By being co-located with GOE health program senior managers at the regional and zonal levels, IFHP management and staff are accessible and responsive to Regional, Zonal and woreda needs. RHBs, ZHDs, and WorHOs praised the working style of IFHP as one of close collaboration and support; “IFHP works with us.” Respondents gave unusually consistent and appreciative responses to queries about the contributions of IFHP to their work: support for woreda-based planning, quarterly program reviews, integrated supportive supervision, guidelines and manuals, provision of BCC materials, training, and follow up of training.

Relationships and communications with counterparts in the FMOH are also strong. IFHP participates in many of the FMOH Technical Working Groups that develop policy and strategies for major technical areas. For example, IFHP advisors are taking an active role in several Technical Working Groups that are reviewing and revising the National Reproductive Health Strategy of 2006-2015, which addresses family planning, adolescent RH, and maternal health policies and strategies. Despite the recognition for IFHP’s technical expertise in these groups, because so much of its substantive contributions are made at the regional, zonal, woreda, and community levels, there is potential for the GOE and others to undervalue IFHP (and USAID) and its role in supporting the GOE’s health sector program.

Relationships and communications with stakeholders

During the transition from the two projects to IFHP and in developing closer ties with the GOE/MOH, IFHP worked out new roles and relationships with key stakeholders: the Implementing Partner Organizations (IPOs), with which Pathfinder, in particular, had longstanding relationships; kebele advisory committees and woreda advisory committees; and other Ministries, organizations receiving funding for related interventions from other sources (e.g., EngenderHealth), and community and civil society groups. The Review Team was not able to explore how well these transitions evolved or how effective the new relationships are at this time. From the team’s interactions with the IPOs, it appears that, after a difficult transition period, their new roles and relationships are working quite well. IFHP has started using its TAC, which includes representatives from other Ministries, key health sector donors, and civil society groups, to strengthen its relationships with these stakeholders. It now holds quarterly meetings of the TAC and rotates locations among the IFHP regions and sites, so as to keep TAC members informed of IFHP activities and its service delivery and systems strengthening programming.

Relationships and communications with USAID/Ethiopia

The USAID management unit responsible for technical oversight and management of IFHP is the Health Team of the Office of Health and HIV/AIDS (H/HA) of the USAID/Ethiopia Mission. The Agreement Officer’s Technical Representative (AOTR) is a member of the Health Team, and has been the AOTR since the award. He is very supportive of IFHP; he, the team leader, and the Office Chief consider IFHP responsive to their needs for information and reporting and would encourage IFHP to take on a higher profile and better disseminate its successes. USAID staff that have visited IFHP field sites has been impressed by IFHP’s results and reputation.

Strengths

In their relationships and communications with counterparts, at all levels, stakeholders, and USAID, the Review team considered these to be particularly effective.

- **Approach to partnership with GOE.** IFHP staff members see themselves as a “support” to the GOE HEP at all levels. The refrain was, “We do nothing alone.” All IFHP processes are linked with GOE processes, starting at de-centralized levels.
- **Mechanisms for stakeholder engagement.** IFHP has drawn on experience with the previous projects to engage key stakeholders at all levels. At the national level, IFHP reportedly makes effective use of TAC quarterly meetings to showcase selected woreda activities and community service sites. At the local level, IFHP has continued to support kebele advisory committees (KACs) and woreda advisory committees (WACs) to engage other ministries and civil society groups to promote health services and behavior change.
- **Collaboration with IPOs extends reach of IFHP.** The partnerships with IPOs, which have taken on roles in training, follow up and support to WorHOs, PCHUs, and communities, including the VCHWs, help the IFHP Cluster staff to provide more assistance and technical support and follow up than would otherwise be the case.

Areas for Attention

Although IFHP relationships and communications are overall strong, the Review Team identified some areas that need reinforcing from IFHP directly.

- **Limited visibility and knowledge about IFHP at the national level.** Because IFHP is active primarily at the regional level and periphery, its approach to partnership and activities are not well known among the other development partners and even the FMOH. The low profile of IFHP does not appear benefit the reputation of IFHP or USAID.
- **Need for more reporting to the FMOH.** During a meeting with the Phase I Review Team, FMOH officials indicated a desire for more information on IFHP, so as to better understand its contributions to health service coverage, systems strengthening, etc.

3. Monitoring and evaluation and use in decision-making: findings, strengths, and areas for attention.

Findings

IFHP’s Performance Monitoring Plan (PMP) was approved by USAID as part of the Phase I work plan documented in The FP-MNCH Program: Work Plan and Monitoring and Evaluation Plan (for the period of July 1, 2008 through December 31, 2009) revised on October 3, 2008. An updated PMP with revised indicators and targets was approved in July 2009. The Work Plan for the period of October 2009 to September 2010 includes indicators and targets for the FY 2010 planning and funding period. The PMP relies on standard indicators approved for Operational Plans, which are essentially counts of people trained, people reached by messages, and activities for BCC, etc. Reliance on the PMP for monitoring and evaluation is recognized by IFHP as posing serious limitations for understanding its results and impact. The indicators and data do not require analysis with denominators based on the populations and needs in the regions, zones or woredas. Moreover, the outputs are not linked with desired outcomes.

From the outset, IFHP agreed to utilize the GOE’s HMIS rather than establish another, parallel system. From all reports, IFHP has been diligent in developing approaches and providing support

to enhance the quality of the data produced by the HMIS; the Review Team heard a number of compliments for their work and received positive feedback about improved timeliness and accuracy of data reporting. Use of the data has also improved; all health managers noted that they, along with IFHP staff, review progress quarterly and update plans for the subsequent quarter based on these reviews. In addition to the HMIS, IFHP Cluster Offices also keep records of training participants and the training they received, ISS visits, and follow up visits. These are used in quarterly reviews with woreda and zonal staff.

In terms of documentation and knowledge management, IFHP submits Quarterly Reports and an Annual Report that present achievements according to PMP indicators, and provide highlights of accomplishments and challenges. Quarterly Reports, however, are not available to or in a format useful for those outside of IFHP management who would find the strategies, approaches and successes of IFHP of interest and use. For IFHP to have a higher profile and share the important lessons it has learned, it needs to prepare materials that will facilitate sharing with others.

Strengths

- **Use of data for decision-making.** IFHP has established itself as a promoter of strong program management with a reliance on analysis and use of data for decision-making.
- **Culture of program review and improvement.** Just as the IFHP staff participate in and guide program reviews with their woreda, zonal and RHB counterparts, they participate in quarterly reviews for IFHP as a whole. By rotating review sites among the regions, the Regional Managers become familiar with and share experiences with other Regions.

Areas for Attention

Many PMP indicators are mandated and not under the control of IFHP. Nonetheless, the importance of strong M&E and program research (see Result 4 above) should not be ignored.

- **PMP indicators and targets of limited utility.** Simple counts of people trained (and other tallies required by many indicators) are almost useless in assessing the effectiveness of IFHP without denominators for the total population of people needing training and/or sub-categories of health providers and others trained. IFHP needs an approach that facilitates calculating coverage and quality of the relevant services and desired outcomes.
- **Outputs need to be linked with outcomes.** To fully understand the contributions of the strategies and approaches used to effect change in behavior and health outcomes, the output indicators need to be linked with and analyzed with outcome indicators.
- **Documentation and materials development for non-IFHP audiences.** To promote lessons learned and best practices, as well as the impact of its program, IFHP needs to invest in more documentation in formats accessible to many audiences.

IV. Recommendations of the Phase I Review.

The recommendations presented below are divided into two major groups. The first set of recommendations are primarily for the senior management and staff of IFHP, but apply as well to USAID/Ethiopia as they are meant to be taken into consideration in the planning for Phase II of the IFHP. The recommendations build on the Areas for Attention identified in Section III of this report (some of which were mentioned under several results), but they have been organized and synthesized under major action items to better guide the IFHP Phase II planning process.

However, given the scope and complexity of the Integrated Family Health Program, the list of follow up items may appear long. The Review Team also had limited time to examine some issues in depth, so some recommendations are general, and will require IFHP to work out specific actions for follow up. It also should be noted that some Areas of Attention refer to opportunities that the team believes IFHP should not miss.

A. Recommendations for IFHP Senior Management and Staff: Actions for Phase II

The Phase I Review team was very impressed with the progress that IFHP had made in the first 18 months of implementation; the number of areas for attention identified in the review of the program and management should not detract from that primary conclusion. Therefore, the first and foremost recommendation is the following:

Recommendation 1: Keep doing what you are doing, the way you do it; build on IFHP strengths.

The team recommends that IFHP stay in the 286 woredas now assigned to IFHP as the primary focus of IFHP implementation. The team is convinced that no woreda is a likely candidate for “graduation” in the short time remaining for IFHP support. Equally important, IFHP should continue its approach to the GOE as one of support to and embedded with its processes.

As noted in all aspects of the program and management presented in Section III, IFHP should build on its strengths:

Technical strengths: Family planning, child health, nutrition (breastfeeding, ENA).

Service delivery approaches: extension to communities, support to HEWs, VCHWs, and IPOs.

Systems strengthening: woreda-based health sector planning, quarterly review meetings, ISS, training, follow up, use of data for decision-making.

Sharing of learning: quarterly review meetings, TAC meetings, exchange visits

Management: collaborative style of decision-making; continue work on melding of the teams.

In implementing the next five recommendations, the IFHP senior management and staff will need to consider the following:

- **Appropriate phasing.** The recommendations provide a synthesis and list of actions that cannot be implemented at once. The timing and sequence will depend, in part, on GOE priorities and initiatives, funding and timing of contributions of other development partners, and availability of IFHP staffing and funding.
- **Acting at national and operational levels.** In almost all cases, the recommendations imply or explicitly specify a role of IFHP at the national level, in providing input and technical advice for policy-making and guidance that will affect field programming, and at the operational level, in facilitating and supporting the implementation of the policies and guidance.

Recommendation 2: Continue to strengthen and improve the functioning of the Health Extension Program and Woreda, Zonal, and Regional health management.

While IFHP should continue to do what it does well, the Phase I Review Team identified a number of areas in the present scope of IFHP activity that need priority attention and improvement. The team had less time to work out exactly how IFHP should make the

improvements, but considers that IFHP is better positioned to develop workable strategies than the team. The priority areas are:

For the HEP:

- **Improve the HEW supervision system.**
 - At the national level, work with the GOE on: selection criteria for HEW supervisors, including consideration of promoting excellent HEWs as supervisors; training programs appropriate to their needs; viable solutions for transport; viable incentive schemes.
 - At the operational level, with WorHOs and PHCUs, consider local solutions for transport and incentives for HEW supervisors; train and follow up all HEW supervisors.
- **Strengthen HEW capacity in BCC and community mobilization.**
 - At the national level, work on the relevant Technical Working Groups to update, improve, and harmonize BCC materials and adapt them as needed for IFHP regions.
 - At the national level, participate in Technical Working Groups as needed to assure appropriate roles for VCHWs and HEW support for them.
 - At the operational level, through IPOs and others, strengthen HEW capacity to train and support VCHWs and/or extend training directly to VCHWs; train HEWs and possibly more experienced VCHWs in supervising VCHWs; work with and strengthen KACs.
 - At the operational level, improve training for both HEWs and VCHWs in facilitation of community conversations.
- **Strengthen and standardize training for HEWs.**
 - At the national level, participate in forums for reviewing and strengthening the HEW curriculum and training.
 - At the operational level, ensure that the pre-service training they receive is as effective as possible, emphasizing quality and consistency in service delivery.
- **Explore use of mass media, especially radio, and strengthen use of mobile vans.**

For health systems management:

- **Assess and strengthen referral systems from health posts up and back down.** The effectiveness of referrals from health posts to health centers (to district hospitals) and reporting back is not well known. As HEWs take more active roles in health services, such as ENC and CCM for pneumonia, referral linkages will be even more important.
- **Improve data quality and consistency.** With or without roll out of the reformed HMIS, there are issues with definitions and data collection at the health post level and above. IFHP can assist at the national and operational levels in reviewing and revising definitions (e.g., family planning and deliveries) and reinforcing their use.
- **Improve analytic and problem identification and problem solving skills.** All woreda and zonal managers and staff need more skills in how to use the wealth of data available to them. IFHP should consider developing short courses (or finding relevant short courses in epidemiological data analysis, trend analysis and the like) for these managers.
- **Increase use of outcome measures across the program.** As noted earlier, the PMP does not include adequate outcome measures for many of the intervention areas, including many health-related behavior changes. Some outcome measures are difficult to collect without access to population surveys. The Review Team learned that many woredas undertake an annual survey of the local villages to assess use of latrines and safe water. One option may be to add other behavioral indicators and questions to this survey.
- **Support use of health financing funding generated at Health Centers for the PHCU.** Under the new health care financing policies, funds generated from selected services

provided at the health center are retained by the health center to support its operations. For those health centers that are PHCUs, with related health posts, needs of the health posts should also be considered in decision-making about their best use.

Recommendation 3: Support the roll out of important initiatives.

The FMOH has an ambitious agenda now for initiatives to improve maternal and newborn health, child health (through CCM of pneumonia), and expand access to family planning; certainly others will emerge over the next few years. In addition, new systems for commodity distribution and management, HMIS, LMIS, and health care financing are in the works. IFHP has important roles to play at the national and operational levels for all of these, and, given IFHP's position in supporting the operational levels in 286 woredas of four regions, IFHP will be implicated whether it has primary responsibility or not. The Phase I Review Team, therefore, strongly recommends that the IFHP senior management and staff (as well as USAID/Ethiopia) be prepared for its involvement, similar to the Implanon roll out, as noted below.

At the national level:

- **Assure technical quality** of the strategy, system, approach, and/or intervention by being involved with the relevant Technical Working Groups.
- **Assure feasibility (and technical quality)** of roll out plans by participating in the micro-planning processes and offering IFHP woredas for implementation learning phases.

At the operational level:

- **Support roll out implementation** by offering and supporting roll out in woredas where IFHP is providing support.
- **Phase implementation and structure evaluative research to assess quality and effectiveness.** IFHP should help to build in evaluative research to high priority initiatives, such as maternal health and newborn care, and into BCC activities.
- **Support complementary technical inputs.** If USAID arranges for complementary technical support for areas such as maternal health (see Recommendations for USAID below), IFHP should collaborate by facilitating the work of the other technical assistance provider(s) through its regional and cluster structures and counterpart relationships at regional, zonal and woreda levels.

Programmatic Initiatives:

Both IFHP and the GOE have lists of new health initiatives and/or additions to those already underway. The Review Team also identified some specific issues that should be addressed by IFHP in Phase II. For all intervention areas, there are major challenges ahead for training providers and assuring adequate drugs and consumable supplies.

Family planning

- Ensure that all IFHP staff and providers in IFHP-supported woredas are familiar with USAID FP compliance requirements; monitor and document voluntarism and choice at all levels of service delivery. Ensure that all facilities including all health posts have the Tiaht posters on the walls, preferably in local languages (at least Amharic).
- Distinguish USAID/IFHP support for PAC from other abortion services. Ensure that all PAC services offer FP counseling and the provision of the method of choice or referral.
- Continue to support the FMOH's roll out of Implanon, ensuring the quality of counseling and clinical skills during the training, and that it is incorporated in the ISS tools. The roll out should be closely coordinated with the M&E process supported by FHI/PROGRESS.

- With the FMOH, and regional, zonal and woreda health managers, ensure availability of trained providers for implant removal. Develop and implement a plan to increase access to implant removals at health posts and health centers.
- Develop plan to roll out training and provision of permanent methods of FP, tubal ligation and vasectomy, in as many sites as is feasible, with adequate support for informed choice, infection prevention, commodity and consumable supplies, etc.
- Ensure inclusion of FP counseling and the provision of methods in post-partum care, PMTCT, and other HIV/AIDS services.

Child Health

- Focus on quality of services and actual practices in CH interventions for ORT and EPI.
- Participate in planning for roll out of CCM for pneumonia and assure that plan emphasizes high quality and is feasible.
- Build in evaluation to CCM roll out and follow up on findings.
- Continue active participation in Child Health Technical Advisory Committees to harmonize CH message, strategies and activities.

Nutrition

- Participate in the Nutrition-related TACs to evaluate effectiveness of and harmonize the many different nutrition interventions (TCN, ENA, CBN, SAM).
- Build in evaluation to IFHP nutrition interventions to assess effectiveness and impact.
- Based on evaluative results, plan for substantially increased CSGH nutrition funding in FY 2011.

Maternal Health

- Once approved by the GOE, start to implement the learning phase of the MNH strategy already proposed in the PHCUs of selected woredas, preferably the same woredas as the GOE may propose for its “learning centers.” Broaden the strategy to include some areas distant from the health centers; this would ensure that some under-served communities would have access to a package of community-based MNH services: clean and safe delivery, misoprostol, information on birth preparedness and complication readiness, community transport for emergencies, essential newborn care, and newborn resuscitation.
- In the post-learning phase, expand the PHCU model. Institute GOE-approved quality improvement approach. Pay special attention to prevention of post-partum hemorrhage with AMTSL, management of pre-eclampsia and eclampsia, and use of the partograph. Expand community MNH program.

Newborn Care

- Clarify content and timing of postnatal and essential newborn care. Expand PNC with a focus on the first week after birth.
- Strengthen the “N” in IMNCI in health centers, with special attention to newborn infection management. Expand kangaroo mother care for low birth weight babies in facilities and communities.
- Support GOE to roll out newborn resuscitation in collaboration with UNICEF and USAID’s Global Development Alliance with Laerdal and the American Academy of Pediatrics.
- Strengthen the integration of PMTCT and maternal and newborn care services.
- Harmonize MNH strategies developed by various development partners (UNICEF, H4).

Youth, Gender and Harmful Traditional Practices

- Interventions for youth (including youth center and youth-friendly services) should be evaluated for cost-effectiveness.
- Interventions for gender and HTPs should also be evaluated and the most effective approaches identified and scaled up.
- Approaches for changing HTPs should include not only those related to reproductive health, but also those related to feeding practices, maternal care during pregnancy and delivery, newborn care, and management of fever and other diseases.
- Approaches to HTPs should be integrated into on-going BCC and community mobilization activities under the HEP.

Systems Strengthening Initiatives:

These will include those already familiar, but not yet rolled out:

- New HMIS; LMIS; new logistics distribution system.

In addition, likely to come up in Phase II are: implementation of community health insurance and financing; quality assurance approaches.

The Review team also strongly recommends that IFHP consider training as a system by:

- Identifying the appropriate focal points for training organization and management at the national level and regional and zonal levels;
- Developing their capacity to do what IFHP now does in planning, organizing and managing training programming at the operational level.

Recommendation 4: Increase and systematize program research and learning.

As IFHP supports the roll out of GOE health intervention and systems initiatives, it should consistently build in evaluation approaches that allow IFHP to assess their progress and impact. This will require more strategic program research and documentation than is taking place now.

The Review Team proposes these key steps:

- Use a collaborative process with the FMOH, regional, and peripheral levels to identify priority areas for program or evaluative research.
- Provide professional capacity to help build in (and advocate for) evaluative research design, implementation, and analysis for program activities; fill the Operations Research Officer position in the Country Office.
- Contract with local expertise (universities, schools of public health) to support the design, implementation and analysis of program-based research.
- Support operational levels of the IFHP and counterparts in research/evaluation design, implementation and analysis.
- Go “beyond baselines and endlines,” that is, use other methods (cluster surveys, LQAs) to collect data on outcomes (e.g., practices, such as hand washing, as well as service utilization).
- Document and disseminate qualitative and quantitative findings; share widely lessons learned and best practices from technical programs and systems strengthening interventions.

Recommendation 5: Support operational level counterparts in problem solving, resource mobilization, and leveraging to address key issues.

In the de-centralized health care delivery system in Ethiopia, health system managers, such as woreda health officers, must play multiple roles: leaders, planners, supervisors, and accountants. They must also be problem solvers and advocates for their programs and needs with local authorities to whom they are directly responsible and from whom they may receive financing from the local government's budget. IFHP, through its roles in supporting planning, the quarterly reviews, ISS data, and the like, can play an important role in assisting these managers to identify key problems and ways to address them that do not rely on direct IFHP support. IFHP can:

- Assist GOE health managers at all levels in identifying and anticipating problems. Among the recurring problems are: lack of water at health posts; transport for HEW supervisors; reliable sources of consumables; and, support for ISS and woreda meetings.
- Assist GOE health managers in identifying possible solutions to the problems and possible sources of funding, such as the local woreda council, other development partners, local businesses, PHCU income.
- Offer support in pursuing the solutions and following up.

Recommendation 6: Reconsider the IFHP staffing numbers and composition: right size for the tasks ahead.

Given the success of IFHP to date, the needs for IFHP attention in the HEP program, and the large agenda of initiatives of which the team is aware, the Phase I Review Team strongly recommends that IFHP add more staff to the Cluster level of its organization. The team is aware that IFHP is already thinking along these lines and strongly endorses these plans. When IFHP makes these changes, the team also suggests that IFHP revise its organigram to better reflect actual positions and practice and eliminate organization designations. Specifically, the team proposes that IFHP:

- Add a limited number of clusters in each region and staff (1 or 2) to each cluster.
- As a high priority, strengthen staffing in the Country Office for BCC and Community Mobilization; one position is vacant and the other is soon to be. Both need to be filled immediately with topnotch candidates who can meet IFHP's skill needs. Use AED to bring in more short-term expertise.
- Strengthen staffing in the Country Office for program research and evaluation and documentation. This is a growing need as new initiatives are designed and roll out.
- Continue to use "outside" partners' capabilities in selected technical areas, for example, the IPOs for community mobilization at the operational levels; Alive and Thrive for nutrition expertise; UNICEF for IMNCI.
- For MNH, consider including a Jhpiego staff member resident in the Country Office as part of the sub-agreement now under negotiation.

B. Recommendations for USAID/Ethiopia and USAID/W: Actions to support Phase II.

Although the recommendations below are aimed primarily at USAID/Ethiopia, USAID/W also has an important role in advocacy and information dissemination in the organization; the IFHP experience should inform policy-making as the Global Health Initiative (GHI) gets underway.

Recommendation 1: Support the efforts of IFHP.

Phase II of IFHP represents an enormous agenda for and effort from the IFHP staff. The senior leadership and staff will need active support from USAID to accomplish its goals and succeed. In particular, USAID should:

- **Increase funding levels for IFHP.** Staffing increases at the Cluster Offices and possibly in the Country Office as well as investments in more programmatic and evaluative research require funding. The Phase I Review Team believes that these investments will have highly relevant and useful benefits.
- **Participate actively in Technical Working Groups.** While participation from IFHP advisors and experts will be very beneficial, participation from USAID provides a direct and stronger endorsement from USAID and indicates the value USAID places on key policy issues.
- **Stay as involved as possible with the planning for HSDP IV.** HSDP IV will affect greatly Phase II of IFHP. USAID needs to influence the agenda to be encompassed by HSDP IV; the implications of HSDP IV need to be fully understood and communicated with the senior management of IFHP and considered in planning for Phase II.
- **Facilitate linkages with other USAID programs and sectors.** IFHP and health programs cannot accomplish development changes at the community level on their own; moreover, many programs, such as education, agricultural development, and the like can be mutually reinforcing of the programming is synchronized and coordinated.
- **Leverage PEPFAR to support the GOE PHC platform.** By using more readily available PEPFAR funds to ensure access to key HIV/AIDS-related services such as PMTCT in peri-urban areas, through strengthening systems for commodity distribution, and construction of health centers, the platform for PHC services is also extended.
- **Visit IFHP sites regularly.** Visits from USAID not only are very encouraging and welcomed by IFHP staff and their counterparts, the visits signal USAID's interest and concern with the program and build USAID staff's ability to promote and speak knowledgeably about IFHP to the GOE, other donors, and stakeholders.

Recommendation 2: Promote the successes of IFHP.

Too little is known in Addis and Washington about the successes to date of IFHP; even less is known about the IFHP implementation modality and of its capacity building and health improvement effects. IFHP is a program exceptionally well-aligned with the principles of the Paris Declaration and approaches now being promoted under the GHI and should be recognized for this. More specifically, USAID should:

- Develop (with IFHP) success stories, its “embedded” implementation approaches, and “best practices” from IFHP experience, document them, and disseminate them widely.
- Raise the profile of IFHP (in part by using the success stories and best practices) with the GOE, other donors, and in all appropriate fora.
- Use IFHP as a vehicle for providing complementary technical (and systems strengthening) support to the health sector in Ethiopia. For example, if USAID/Ethiopia decides to provide additional technical support for maternal health to the FMOH, the team strongly recommends that this support be provided “through” IFHP, using IFHP's infrastructure and working relationships with the health system at all levels rather than creating any parallel delivery mechanism.

Recommendation 3: Encourage other programs and activities to adopt IFHP-type (“Paris-friendly”) implementation modalities.

While the long-term success of IFHP is yet to be proven, the Phase I Review Team was impressed by its progress to date. IFHP appears well on its way to building GOE management

and service delivery capacity for assuring access to PHC services at the community level. Granted this is in the context of an activist FMOH taking a strong leadership role. Nonetheless, IFHP's approach to collaboration is not only much appreciated by counterparts, it seems highly effective.

Recommendation 4: Take other actions to facilitate IFHP's activities.

USAID/W and USAID/Ethiopia also should:

- Under the GHI, revise the standard indicators. The present indicators are not helpful to any potential uses.
- If requested by the FMOH, consider secondment of policy and/or technical advisors at the Central level. Under the BPR, some of the technical expertise has been dissipated across the FMOH, presenting a challenge as new technical initiatives are being planned. USAID should be as responsive as possible to any requests for help so as to assure sound planning for roll out of the important initiatives being considered.
- With IFHP, plan for increased CSGH nutrition funding.