

USAID Transform: Primary Health Care
END OF PROJECT REPORT
2017 - 2022



DISCLAIMER

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MESSAGE FROM THE CHIEF OF PARTY

After nearly a six-year journey, the United States Agency for International Development (USAID) Transform Primary Health Care Activity will come to an end on September 30, 2022. It has been an exciting and fulfilling journey delivering healthcare services to millions of Ethiopians—thanks to the steadfast and relentless spirit of all those involved in the Activity. Strong coordination and partnership among the consortium partners were necessary to ensure the Activity's smooth operations.

Through our activities, we have witnessed remarkable changes in the performance levels of woredas (districts) and promising trends to maintain achievements.

With substantial improvement in service quality at the primary care level, paired with innovative approaches introduced by the Activity, it is encouraging to see some of the initiatives incorporated in the Ethiopian government's current and future strategic documents and guidelines. Our efforts have created opportunities to scale innovation and promote ownership and sustainability by the public sector.

Despite our achievements, we have faced many challenges such as frequent government restructuring, disease outbreaks, COVID-19 pandemic, natural and human-made disasters, and wide-scale conflicts resulting in the displacement of large populations— including healthcare providers. These challenges impacted some of our activities and tested our true resilience and determination to achieve expected results. We learned to adapt and strategize to ensure the continuity of healthcare service delivery while minimizing undesired negative impacts.

This Activity's success would not have been possible without the consortium's hardworking technical support team based in the home offices, the synergy from local and international partners, and the outstanding leadership from the public sector. Our staff deserve the highest recognition and continue to be the greatest asset even in times of uncertainty. Regrettably, we lost a few of our staff due to natural causes, and some were caught in life-threatening security situations. We are grateful for their dedication, service, and courage.

As Chief of Party, I have seen first-hand many of the accomplishments highlighted in this report, and the impact we've made on millions of people across Ethiopia. On behalf of the people we serve, I would like to extend my heartfelt appreciation to the American people and the United States government for their generous financial and technical support through USAID.

As the Activity ends, I sincerely hope the lessons learned from the past few years will be instrumental in sustaining accomplishments and public sector ownership. We must continue to extend our solidarity and direct our time and resources to transform healthcare services for the millions who desperately need them. No child, mother, or person—be it young or old—should be left behind from receiving the most basic healthcare services.

Mengistu Asnake Kibret (MD, MPH)
Chief of Party



MESSAGE FROM THE DEPUTY CHIEF OF PARTY

As the largest USAID Ethiopia mission-funded health project, covering close to 450 woredas, with over 40 offices in our intervention regions, this has been a unique experience for us all—one that enriched us individually in so many ways.

Our journey was challenging at times. Security threats, internal displacement, and the global COVID-19 pandemic impacted our work and lives. Through these experiences, we learned to adapt and apply our skills to help preserve the Activity's continuity.

Our work on performance and quality improvements requires iterative processes. Achieving the results we have seen is a testament to our resilience—something we should all be proud of. In the face of many challenges, we managed to scale up grant management, leadership development, and institutional strategies for equity. I hope that we will continue to reap the benefits for many years to come.

Collaborating with like-minded partner organizations enabled us to avoid duplicating efforts and focus on areas with the most urgent need. Evolving our approaches to meet our objectives was another key lesson on sustaining our achievements. As a result, we withstood and overcame significant challenges.

Perhaps, the most difficult times were when we suffered the loss of our colleagues and friends Roman, Abreham, and Hareg, who sadly passed away from chronic illnesses. These three individuals will forever be etched in our hearts. We commend them for their inspiration and bravery in serving their communities, right until the very end. Together, we powered through this as a family by being there for each other.

As I reflect on these events, I extend my gratitude to all project staff in Ethiopia and those based in the home offices. I hope that we are all proud of what we have accomplished together. Thanks to USAID for their unrelenting support that has enabled our work to be fruitful. The public sector has demonstrated trust, openness, and willingness to collaborate and share successes, allowing us to improve service delivery in local communities—especially for vulnerable women and children of our country.

Binyam Fekadu Desta (MPH, PhD)

Deputy Chief of Party

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ACRONYMS

Acronym	Full name	Acronym	Full name
AMIYCN	Adolescent Maternal Infant Young Child Nutrition	FMOH	Federal Ministry of Health
ANC	Antenatal care	FP	Family Planning
AWD	Acute Watery Diarrhea	FP/RH	Family planning and Reproductive Health
AYH	Adolescent and Youth Health	FUV	Follow Up Visit
AYHD	Adolescent and Youth Health Development	HC	Health Center
BEmONC	Basic Emergency Obstetric and Newborn Care	HCF	Health Care Financing
CBCM	Catchment Based Clinical Mentoring	HEW	Health Extension Worker
CBHI	Community Based Health Insurance	HF	Health Facility
CBMP	Capacity Building Mentorship Programs	HIS	Health Information System
CEmONC	Comprehensive Emergency Obstetric and Newborn Care	HIT	Health information Technicians
CH	Child Health	HMIS	Health Management Information System
CHD	Child Health Development	HP	Health Post
CHIS	Community Health Information System;	HPMRR	HPMRR- Health Post Monthly Report and Resupply
CPAP	Continuous Positive Airway Pressure	HSS	Health Systems Strengthening
CSC	Community Scorecards	HSTP	Health Service Transformation Plan
CSL	Clinical Skills Lab	HSTPII	Health Sector Transformation Plan II
CWS	Connected Woreda Strategy	HWs	Health Workers
CYP	Couple Years of Protection	IBEX	Integrated Budget and Expenditure
DHIS2	District Health Information System 2	ICMNCI	Integrated Community Management of Newborn and Childhood Illness
DHS	Demographic and Health Survey	IDPs	Internal Displaced Persons
ECD	Early Childhood Development	IFA	Iron and Folic Acid
EDHS	Ethiopian Demographic and Health Survey	IFRR	IFRR-Internal Facility Report and Resupply
EHA	Ethiopia Health Accounts	IGA	Income Generating Activities
EHCRIG	Ethiopian Health Center Reform Implementation Guidelines	IIP	Immunization In Practice
EHIA	Ethiopian Health Insurance Agency	IMNCI	Integrated Management of Newborn and Childhood Illness
EHIS	Ethiopian Health Insurance Service	IPOS	Integrated Periodic Outreach Strategy
EHSTG	Ethiopian Hospital Services Transformation Guidelines;	IPPPF	Immediate Post-Partum Family Planning
EHSTP	Ethiopian Health Sector Transformation Plan	IRW	Infant Radiant Warmer
EmDHS	Ethiopian mini Demographic and Health Survey	ISS	Integrated Supportive supervision
ENC	Essential Newborn Care	KPI	Key Performance Indicators
EOF	Elimination of Obstetric Fistula	LARC	Long Acting Reversible Contraceptive
EPCMD	Ending Preventable Child and Maternal Death	LMG	Leadership, Management and Governance
EPI	Expanded Program of Immunization	LQAs	Lot Quality Assurance
EVM	Effective Vaccine Management	MCC	Motivated, Competent and Compassionate

Acronym	Full name	Acronym	Full name
MH	Maternal Health	PWC	Pregnant Women Conference
MNH	Maternal and Newborn Health	QED	Quality Equity and Dignity
MOH	Ministry of Health	QI	Quality Improvement
MPDSR	Maternal and Perinatal Death Surveillance and Response	QOC	Quality of Care
MWH	Maternity Waiting Home	RaFV	Random Follow up Visit
NBC	Newborn Corner	RED/C	Reaching Every District/ Child
NH	Newborn Health	RHB	Regional Health Bureau
NHQS	National Healthcare Quality Strategy	RR	RR- Job Aid to complete the Report and Requisition
NICU	Neonatal Intensive Care Unit	SAM	Severe Acute Malnutrition
nOPV	Novel Polio Vaccine	SBA	Skilled Birth Attendance
OF	Obstetric Fistula	SCC	Safe Childbirth Checklist
OFSR	Obstetric Fistula Surveillance and Response	SDG	Sustainable Development Goal
OOP	Out-of-Pocket	SIA	Supplementary Immunization Activity
OR	Operation Room	SNNP	Southern Nations and Nationalities Peoples
ORT	Oral Rehydration Therapy	SS	Supportive Supervision
PCMD	Preventable Child and Maternal Deaths	STI	Sexually Transmitted Infections
PE	Peer Educator	TA	Technical Assistance
PFM	Public Financial Management	THE	Total Health Expenditure
PHC	Primary Health Care	TOT	Training of Trainers
PHCU	Primary Health Care Unit	TWG	Technical Working Group
PHL	Primary Hospital	UDDM	Use of Data for Decision Making
PMA	Performance Monitoring for Action	USAID	United States Agency for International Development
PMI	Performance Management and Improvement	WHO	World Health Organization.
PMT	Performance Monitoring Team	WMS	Woreda Management Standards
PMTCT	Prevention of Mother To Child Transmission	WoFED	Woreda Office for Finance and Economic Development
PNC	Postnatal Care	WorHO	Woreda Health Office
POP	Pelvic Organ Prolapse	YFS	Youth Friendly Service
PRM	Performance Review Meeting	ZHD	Zonal Health Department
PRRT	Performance Review Meeting and Refresher Training		

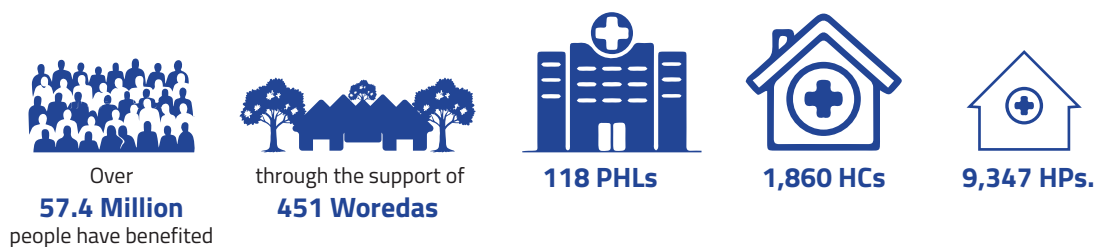
SUMMARY OF ACHIEVEMENTS

Introduction: USAID Transform: Primary Health Care (the Activity) implemented from January 2017 to September 2022 is a technical support activity implemented to enhance the capacity of health systems at the Woreda Health Office (WorHO) and Primary Health Care Unit (PHCU) levels. It is an integrated activity with more than ten thematic areas including HSS, HCF, FP, MNH, OF, CHD, AYHD, nutrition, emergency, QI/QA, gender, SBCC, and others. Core consortium members, in partnership with resource partners implemented activities in Amhara, Oromia, SNNP, Sidama, SWE, and Tigray regions, and over 57.4 million people have benefited through the support of 451 woredas, 118 PHLs, 1,860 HCs, and 9,347 HPs.

Core strategies: Key strategies followed by the Activity are phased and adaptive approaches, addressing bottlenecks, harnessing existing mechanisms and investments, collaboration, the introduction of innovations, capacity building, and sustainability.

Major interventions: Key interventions across each thematic area include Technical Assistance (TA), capacity building through training, mentorship, Integrated Supportive Supervision (ISS) and follow-up, material support, subgrant provision, knowledge and demand creations, and documentation.

Major achievements: Various process, output, and outcome level achievements were registered by the Activity at the system, facility, community, and household levels. The performance management capacity of WorHOs and PHCUs improved, which in turn improved the health service availability on the supply side. There have also been notable improvements in the health care-seeking behavior of communities and households—which increased the demand side of health services. The following are some of the key indicators used as supportive evidence for improvements made in targeted areas.



Process and output level achievements:



WorHOs and Health Facilities (HFs) in targeted areas are **capacitated** through training, mentorship, ISS/ follow-up, material support, health reform implementation, and financial support through TA and subgrant supports



111,885 Health Workers trained one or more times in 15 different technical areas.



Over **15,000 Follow-up visits** were made to WorHOs, PHLs, HCs, and HPs with on-site technical assistance.



Over **31,000 Visits** were made to communities and households and on-site sensitization/education using follow-up checklists.



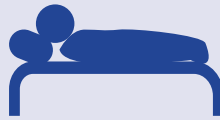
30.4 million Couple Years of Protection (CYP) was generated due to family planning activities.



1,206 Maternity Waiting Homes (MWHs) equipped with required materials.



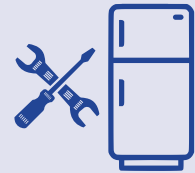
1,301 Newborn Corners (NBCs) strengthened through the supply and maintenance of medical equipment.



1,813 Confirmed Fistula Cases were referred to treatment centers.



4,983 Sets of Oral Rehydration therapy materials were purchased and distributed.



More than **1,800 Refrigerators** maintained through activity support.



15.9 Million adolescents and youth reached with health information and counseling.



5.6 Million adolescents and youth received comprehensive youth-friendly health services.



New anthropometric tools introduced in more than **380 health facilities.**



Need-based support was provided to Internal Displaced Persons (IDPs) and for disease outbreaks.



425 Quality Improvement (QI) projects designed and implemented by the Quality Improvement Teams (QITs), and 262 projects completed.



The gender thematic area's advocacy helped for the creation of **Female-Only LMG cohorts.**



1,116 HP open house events conducted.



51 Articles published in local and international peer-reviewed journals to share learnings.

Outcome level achievements:

System level improvements

- Proportion of Health Centers (HCs) with high performance ($\geq 80\%$) as measured by Ethiopian Health Center Reform Implementation Guidelines (EHCRIGs) increased from 8% in 2018 to 50% in 2021.
- Proportion of WorHOs with high performance ($\geq 80\%$) as measured by the Woreda Management standards (WMS) increased from 9% in 2018 to 62% in 2021.

- **Service quality improvements:** Service availability and utilization are two dimensions for measuring quality. A mix of available services improved quality of services while improved quality of services attracts clients for service. Both service availability and utilization showed improvement between 2017 and 2021 (Table 1), indicating quality improvement in targeted areas.

Table 1: Service availability and utilization/ coverage

Service availability (Source: RaFV)				Service utilization/coverage (Source: RaFV)			
Indicators	2017	2021	% Point change	Indicators	2017	2021	% Point change
HCs with IUCD services	68%	81%	13%	CBHI enrollment rate	51%	69%	18.2%
HCs with all BEmONC signal function services	58.1%	88.0%	30%	mCPR among women 15-49	49%	60%	11.0%
HCs capable of OF diagnosis service	56.6%	66.0%	9%	CPR-LAFP among women 15-49	15%	19%	4.0%
HCs providing IMNCI service with trained providers	79%	87%	8%	ANC 4+	63%	79%	15.8%
HPs providing ORT service	43%	54%	11%	Health facility delivery	70%	78%	8.0%
HCs with YFS services	31%	64%	33%	ARI treatment for <5 children	61%	66%	4.1%
HCs providing ferrous sulfate for PW	77.7%	92%	14%	Penta 3 vaccinations	92%	99%	6.8%
HCs with GBV services	54.2%	73.0%	19%	mCPR among women 15-24	52%	56%	4.0%
HCs with CQI	21.7%	49.0%	27%	Breastfeeding within an hour after birth	84%	97%	13.2%
				Women making decisions about their health	83%	91%	8.2%
				Model kebeles	8.2%	17.0%	8.8%

High-level achievements: An estimated number of



8.8 million
unintended pregnancies
prevented



85,600
maternal deaths



894,186
infant deaths



1.4 million
under-five deaths

were averted in targeted areas in five years.

It can be concluded that the Activity contributed to reducing preventable child and maternal deaths (PCMD).

I. INTRODUCTION

USAID Transform: Primary Health Care is a five-year and nine-month (January 2017- September 2022) Activity that aims to prevent child and maternal deaths by strengthening healthcare systems by enhancing their capacity to deliver quality care. This work supports the effective management of primary health care services at the woreda level, in primary hospitals, health centers, and health posts. The Activity is implemented by a diverse group of partners bringing unparalleled on-the-ground knowledge and the ability to respond to challenges to build a foundation of trust that ensures success. The core consortium members include Pathfinder International, JSI Research & Training Institute, Inc., Abt Associates, EnCompass LLC, and the Ethiopian Midwives Association. Malaria Consortium was part of the core consortium from 2017 until 2020. Additionally, General Electric (GE), Massachusetts General Hospital (MGH), and We Care Solar participated in activity implementation as resource partners. Since its inception, the Activity has strived to achieve the following high-level results:

1. improved management and performance of the health system;
2. increased sustainability of quality service delivery across the primary health care unit (PHCU) continuum of care;
3. improved household and community health practices and health-seeking behaviors; and
4. enhanced program learning to impact policy and program learning related to preventing child and maternal deaths.

The Activity was implemented in the Amhara, Oromia, SNNP, Sidama, SWE, and Tigray regions, benefitting over 57.4 million people. This report is organized under each expected result, followed by the thematic areas.

CORE STRATEGIES

- **Phased and adaptive technical assistance (TA):** The Activity targeted 300 woredas for the first year and added more in the following years. Support was focused on low-performing

woredas, while also helping high-performing woredas to address challenges, sustain performance, and share successful strategies with lower-performing woredas. The learning by doing approach was deployed to improve activity implementation. Learnings have been drawn and used to improve the TA approaches throughout the period.

- **Addressing bottlenecks to close the equity gap:** An annual strength and gap analysis followed by Theory of Change (TOC) helped identify focus areas for preparing an annual work plan.
- **Harnessing existing mechanisms and investments:** The Activity built on existing public sector investments and public sector priorities by avoiding a parallel approach. Most of the Activity's offices were set up within the health systems so that the Activity's staff at the lower level could co-implement activities with the public sector staff to promote sustainability.
- **Collaboration:** A landscape analysis of key partners and government initiatives within target regions and woredas was conducted at central and regional levels. This work included desk reviews and consultations with the public sector and partners. Knowing what other implementers are doing in target regions ensured the Activity harnessed and leveraged existing mechanisms and investments and minimized duplication of efforts.
- **Innovation:** Identifying new ways to achieve results and scale successful existing innovations was a strategy. Our process began with small-scale interventions, follow-up, evaluation and documentation, sharing lessons using different forums such as technical working groups, and scaling up fruitful innovations.
- **Capacity building and sustainability:** Instilling government ownership and sustainability were core principles of the Activity's design. Across all interventions, strengthening the public sector staff's skills and knowledge to manage, source, or provide technical assistance was a priority. Joint implementation of training and follow-up activities enhanced public sector capacity and ensured sustainability.

II. RESULT I: IMPROVED MANAGEMENT AND PERFORMANCE OF HEALTH SYSTEM

2.1 PERFORMANCE MANAGEMENT AND IMPROVEMENT (PMI)

Background: The performance of health systems depends on the capacity of leaders, managers, and systems for continued improvements to meet standards of excellence. The Ministry of Health (MOH) promotes sector-wide strategic alignment through minimum standards for primary health care entities in Ethiopia. According to the Health Sector Transformation Plan (HSTP I & II), performance standards are developed and recommended for Woreda Health Offices (WorHOs), Primary Hospitals (PHLs), Health Centers (HCs), Health Posts (HPs), communities, and households. The endorsed standards consist of Woreda Management Standards (WMS), Ethiopian Hospital Services Transformation Guidelines (EHSTG), Ethiopian Health Center Reform Implementation Guidelines (EHCRIG), and Key Performance Indicators (KPIs).

PMI: Major Interventions

Training: The Activity supported team-based training of health workers on minimum national standards, use of data for decision making, and strategic problem-solving tools.

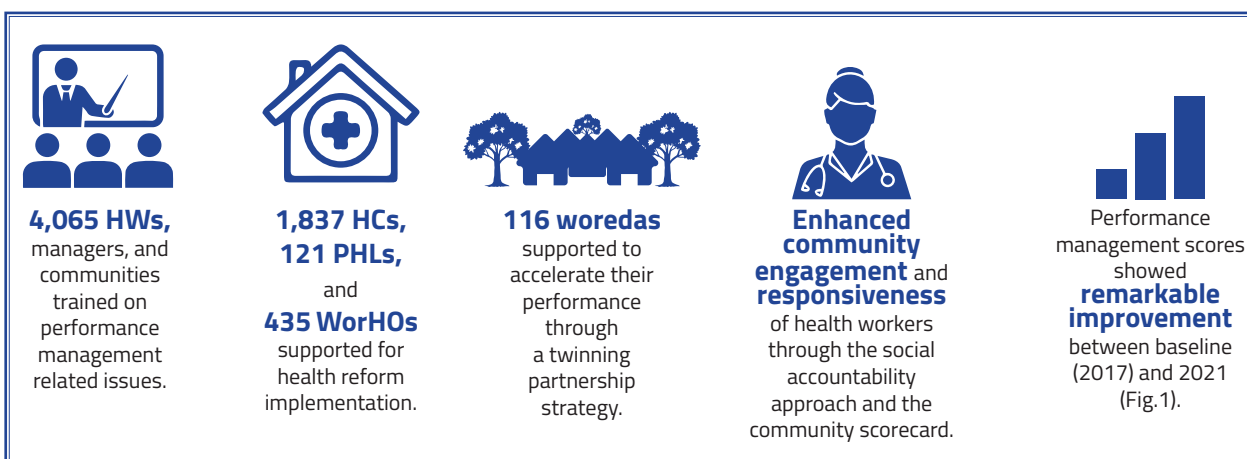
Technical assistance: The Activity assigned and collaborated with health system strengthening experts at the three levels, MOH, RHB, and ZHDs – who are mandated to provide technical support on continuous performance measurements, development of achievable projects, and organization of experience sharing events and performance review meetings.

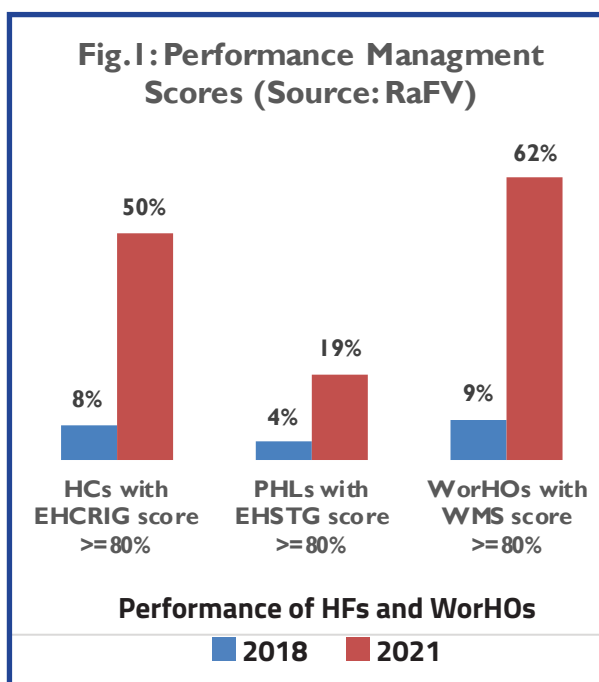
Continuous performance measurement: The Activity used information at the point of data collection for individual and organizational performance management, and enhanced a culture of teamwork, dialogue, and cooperative work practices in learning organizations.

Twinning partnership: Foster formal, substantive, and collaborative partnerships established between high- and medium- or low performing institutions.

Technical support of the Ministry of Health and Regional Health Bureaus: Developed strategic documents and guidelines, strengthened capacity of health workers to validate self-measurements, and monitor performance.

PMI: Major Achievements





PMI: Lessons Learned

- Institutionalized performance management innovations assisted the health system in building organizational culture and helped health leaders provide comprehensive induction to new staff. The Activity-supported primary healthcare units had higher organizational culture and excellence scores than their counterpart non-supported facilities.¹
- The implementation of community scorecards (CSCs) enhanced accountability and transparency in contributing to the health system's performance in maternal and child health services. In addition, the responsiveness of health workers and utilization of basic health services by community members were found to significantly differ and increase as a result.²

1. Heyi WK, et al. (2022) An Evaluation of Excellence in Primary Healthcare Units After Introduction of a Performance Management Innovation in Two Regional States of Ethiopia: A Facility Based Comparative Study. BMC Health Services Research.

2. Argaw MD, et al. (2021) Implementing a Social Accountability Approach for Maternal, Neonatal, and Child Health Service Performances in Ethiopia: A Pre-Post Study Design. Global Health: Science and Practice. 9(1):123-35.



In 2017, the USAID Transform: Primary Health Care Activity and the Government of Ethiopia piloted the “twinning partnership strategy”— a formal and substantive collaboration between two districts or health facilities to improve its ability to provide primary healthcare services.

For Hobichaka Health Center, twinning with neighboring and higher-performing Angacha Health Center was instrumental in improving its performance scores—which was an ongoing challenge. Since then, Hobichaka has improved from a medium to high ranking. In August 2018, six of the facility’s staff attended the woreda-level training on the “twinning partnership strategy,” organized by the Activity. Those staff members returned and provided mentoring and trained other colleagues on what they had learned. The Activity continued to support supervision, organize visits, and coaching sessions to evaluate performance gaps, raise awareness, and devise action plans to overcome shortcomings. Stakeholder coordination and staff commitment were identified as major bottlenecks. As a result, the facility met with all five catchment kebeles to provide on-the-job training and share lessons on improving performance. These actions improved community perceptions, as demonstrated by the rise in community scorecard scores from 65% to 87%, above the targeted goal. *“After the training and sharing [insights] with Angacha HC, we realized that the correct application of resources has a lot to do with the success of our interventions. Ways to improve performance should be the focus rather than pointing at budget shortages for ineptitude,”* says Getachew Abebe, head of the facility.

Participants of the twinning strategy from Hobichaka Health Center, SNNP. Photo: The Activity

HOW TWINNING TRANSFORMS

2.2 LEADERSHIP, MANAGEMENT AND GOVERNANCE

Background: Lack of leadership, management, and governance (LMG) capacity at all levels of the health systems was identified as a major constraint to scaling proven high-impact and affordable services in low- and middle-income countries. The USAID Transform: Primary Health Care LMG interventions are designed to strengthen the health system by building the competencies of health workers at all levels. Priorities during leadership project development, implementation, and monitoring include child health, immunization, family planning, maternal and neonatal health services, disease prevention (e.g., malaria, tuberculosis, and HIV) activities, and health sector reforms. Health workers developed skills to identify the root causes of prioritized challenges in their health facilities and woreda health offices and developed solutions.

LMG: Major Interventions

The Activity implemented LMG training and intervention using nationally endorsed documents.

- **Block course:** A six-day classroom LMG training paired with a six-to-nine month-long leadership project, organized for maternal health program champions from primary healthcare facilities. During the project period, the trainees receive coaching from staff of in-service training institutes every 30–45 days for a maximum of nine months.
- **Segmented course:** Two workshops of three-day classroom LMG training, and a six-to-nine months-long leadership project.
 - **Segment I:** Two or three health systems managers recruited from primary health care facilities (e.g., woreda health office, health centers, primary hospital) attended two rounds of workshops with a one-month gap and implemented 6-month-long leadership projects. These include capacity enhancement training, innovations/ initiatives introduced, technical support, and material support. The training was held at the district level, with coaching provided by zonal (regional) health departments (ZHDs) every 30–45 days.

- **Segment II:** Two to three health systems managers from primary health care facilities (including the woreda health office, health centers, and primary hospital) attended two rounds of training with a 1–2-month gap and implemented 6–9 month-long leadership projects. Every 30–45 days, coaching was provided by USAID Transform: PHC Activity field staff.

LMG: Major Achievements



897 Projects were designed, of which 90% achieved their objectives. The remaining 10% are in progress.



50% of the LMG projects were on MNH, 20% on HSS, 20% on FP, and 10% on other cross-cutting issues like tuberculosis case detection, and malaria prevention.



3,373 People were trained on LMG, of which 19% were women.

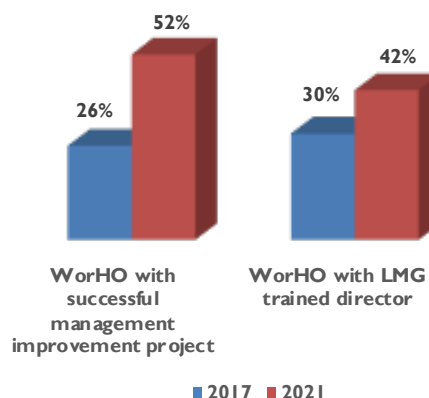


Of trained women leaders, 19% are in senior public health leadership positions.



LMG indicators showed improvement between 2017 and 2022 (Fig.2).

Fig.2: LMG indicators (Source: RaFV)



LMG: Lessons Learned

- Performance of districts was scored using four parameters: capacity, structure, management practices, and quality of care. LMG intervention woredas scored an average of 5% higher than non-intervention woredas.³
- LMG intervention health facilities scored 6.8 percentage points higher than average for contraceptive acceptance rate, antenatal care, skilled birth attendance, postnatal care, full immunization, and growth monitoring services.⁴



Dr. Mishame Adane received training from the Activity, SNNP.
Photo: The Activity

A YOUNG PHYSICIAN'S JOURNEY TO LEADERSHIP

Dr. Mishame Adane, 25, dreamed of something great since she was a little girl. After completing her studies in medicine and graduating as a general practitioner from Mekelle University's College of Health Sciences in February 2019, Dr. Mishame was assigned to Lisane Health Center within the Hadiya Zone of the SNNP Region, where she was employed as a case team coordinator. Just two months into her new job, she was selected to attend a training provided by the USAID Transform: Primary Health Care Activity on leadership, management, and governance (LMG). *"The training has enhanced my skills,"* says Dr. Mishame. *"It has taught me about what it takes to become a good leader, how to form and carry out projects that improve the quality of my work, and how to be a better communicator,"* she adds. Two months after the training, Dr. Mishame was transferred to Homecho Primary Hospital in the Gibe Woreda of Hadiya Zone as a clinician and head of the quality and clinical governance department. As the only female senior manager and governing board member from a staff of about 200 people, she applied many of the teachings she learned in the LMG training, particularly creating an inclusive work environment for women. During her eleven-month post in the role, she led the implementation of seven projects and ensured women had active roles in trainings, managed projects and were involved in all decision-making processes.

3 Desta BF, et al. (2020) Does frequency of supportive supervisory visits influence health service delivery?—Dose and response study. PLOS ONE 15(6): e0234819. <https://doi.org/10.1371/journal.pone.0234819>

4 Argaw MD, et al. (2021) Implementing a Social Accountability Approach for Maternal, Neonatal, and Child Health Service Performances in Ethiopia: A Pre-Post Study Design. Global Health: Science and Practice. 9(1):123-35.

2.3 HEALTH INFORMATION SYSTEM

Background: Health information system (HIS) manages data generation, compilation, verification, analysis, synthesis, communication, and use. According to the 2011 HIS assessment report, among six components, four components scored low, and two scored adequate. Data management was scored as 'not functional' (13%), and three components were found present but not adequate: HIS resources (42%), dissemination and use (48%), and data sources (52%). Additionally, indicators (83%) and information products (73%) were considered adequate.⁵ The Ethiopian Health Information Revolution identified three essential components. HIS governance is a foundation for two pillars: a culture of transformation for health data use, and digitalization and scale-up of priority HIS. USAID Transform: Primary Health Care Activity adopted the connected woreda strategy as part of the health information system initiative. The connected woreda strategy facilitates the realization of information use culture and digitization of priority HIS systems at the woreda and primary health care entities. This ensures that data-use interventions target facilities and health care workers at the primary care level. The Activity worked with HMIS and M&E Scale-up on use of data for decision-making (UDDM) initiatives at all levels, HMIS and community health information system (CHIS) implementation, and capacity strengthening for health information technicians.

HIS: Major Interventions

- Facilitated the inventory of health information system resources.
- Provided technical support in the implementation of HIS at the point of care [e.g., CHIS, and mHealth and District Health Information System 2(DHIS 2)].
- Promoted the use of health information at a lower level to be successful in terms of HIS interventions in the country. Furthermore, the Activity supported and strengthened the routine data quality assurances (e.g., lot quality assurance, random data quality assurance, and identified challenges, prioritized solutions, and enhanced the practical implementation of family folders at health posts).

- Strengthened HIS governance system at lower levels by strengthening the capacity of Health Information Technicians (HIT) professionals to organize the Performance Monitoring team and performance review meeting.
- Strengthen partnership and collaboration with Capacity Building Mentorship Programs, or local Universities, and other development partners.

HIS: Major Achievements



908 People
were trained on UDDM, DHIS2, and HMIS.



WorHOs implementing the connected woreda strategy increased from 19% in 2019 to 56% in 2021.

Connected woreda implementation in progress:



303
primary health care entities were assessed



49% (149) scored
>90% (obtained model status)



43% (130) scored
between 65% to 90%
(obtained candidate status)



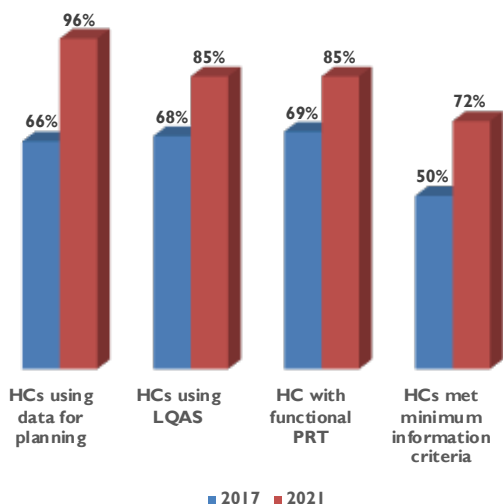
8% (24) scored
less than 65%
(obtained emerging status)



HIS indicators showed improvement (Fig.3)

⁵ Asress BM. (2014) Health Information Systems in Ethiopia. www.esglobal.org/files/wshop3/health_information_systems_in_ethiopia.pdf

Fig.3.1: Change in HIS indicators (Source: RaFV)



HIS: Lessons Learned

- Implementation of the connected woreda strategy significantly improved data quality, the culture of data use at the point of production, enhanced digitalizing facility-level health information systems, and strengthened local HIS governance.
- The effective use of data for decision-making in the management of outbreak and recovery response proved to be a smarter way of avoiding loss of life and resources.

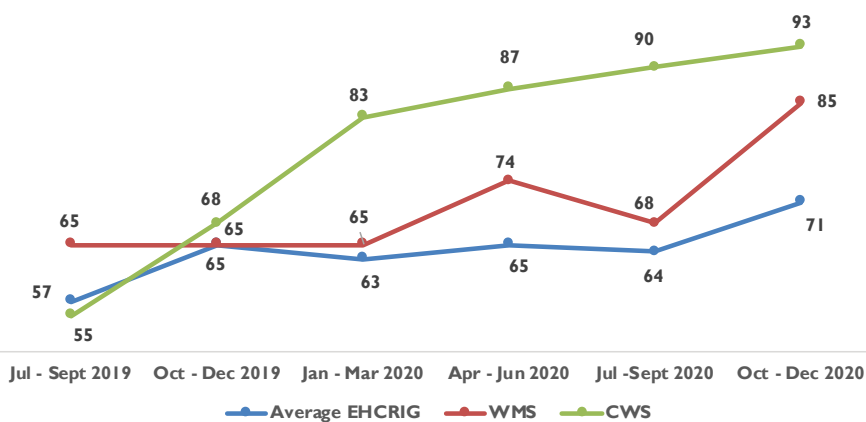


HEWs providing explanation to staff of the Activity at Wendat HP, Amhara region. Photo: The Activity

HOW DATA QUALITY REVITALIZES PERFORMANCE

Debay Tilat Gin Woreda, located in the East Gojam Zone of the Amhara Region, aspires to serve its community of 153,255 people with quality health services and see them prosper. However, it was challenging to carry out this aspiration. The woreda and its facilities of six health centers could not efficiently manage and use their data—a crucial element of providing health services. In 2016, Ethiopia introduced a five-year information revolution strategy as part of its health sector transformation plan, a ‘connected woreda’ approach to improve data quality and information use for primary health care entities. The process uses a health management information system for digital reporting assessment and connected facility criteria which sends and accesses data digitally. To support these efforts, the USAID Transform: Primary Health Care Activity developed a connected woreda strategy dashboard mentorship and coaching tool and connected woreda approach tracking dashboard to track the implementation of the initiative at the primary health care level. Trainings were provided to 771 public sector health information technicians. The Activity supported Debay Tilat Gin Woreda in identifying its major problems and developed an agreed action plan to improve the data quality of its facilities. To improve the performance of the woreda, USAID Transform: Primary Health Care Activity provided tailored support through performance based subgrant provision and training for both woreda and health center staff. Regular mentorship and coaching using the connected woreda strategy to strengthen the use of data for decision-making to improve the overall woreda performance followed. As a result of these efforts, the woreda noted improvements in health reform agendas including growth in Connected Woreda Strategy (CWS) from 55% (Emerging) to 93% (Model), and woreda management standard and EHCRIG scores from 65% to 85% and 57% to 71%, respectively.

Fig 3.2: Improvement in data quality at Debaytilatgin Woreda(%)



2.4 HEALTH CARE FINANCING (HCF)

Background: According to the Ethiopia Health Accounts (EHA) 2016/2017 study, out-of-pocket (OOP) spending on health remains high at 31% of Total Health Expenditure (THE), with 4.2% of households facing catastrophic health expenses. The GOE has taken significant steps in mobilizing health resources to protect people from financial hardship. This includes the implementation of Community Based Health Insurance (CBHI) and measures to strengthen efficiencies in the utilization of resources. The increase in government health financing and its share of overall health spending is encouraging, but yet to reach the anticipated level to alleviate high rates of Out of Pocket (OOP) spending and enable access to health services to citizens, without financial hardship. The public sector has been focused on accelerating progress towards universal health insurance coverage, ensuring health insurance financial sustainability, improving equitable utilization of quality health services, and strengthening health insurance system capacity⁶. The other focus areas are increasing government budget allocation for health, enhancing efficiency and effectiveness of resource mobilization and utilization, enhancing PFM capacity for HFs, introducing the use of technologies for registering HF revenue, and managing expenses⁷.

HCF: Major Interventions

Integrated Interventions: The activity integrated a range of reinforcing interventions to strengthen public finance management capacities and systems of health facilities at primary health care; manage public funds; and expand CBHI across project geographic reach.

Capacity Enhancement Training: Developed and provided targeted in-person training to PFM and CBHI implementers, managers, and supervisors to increase knowledge, skills, and performance.

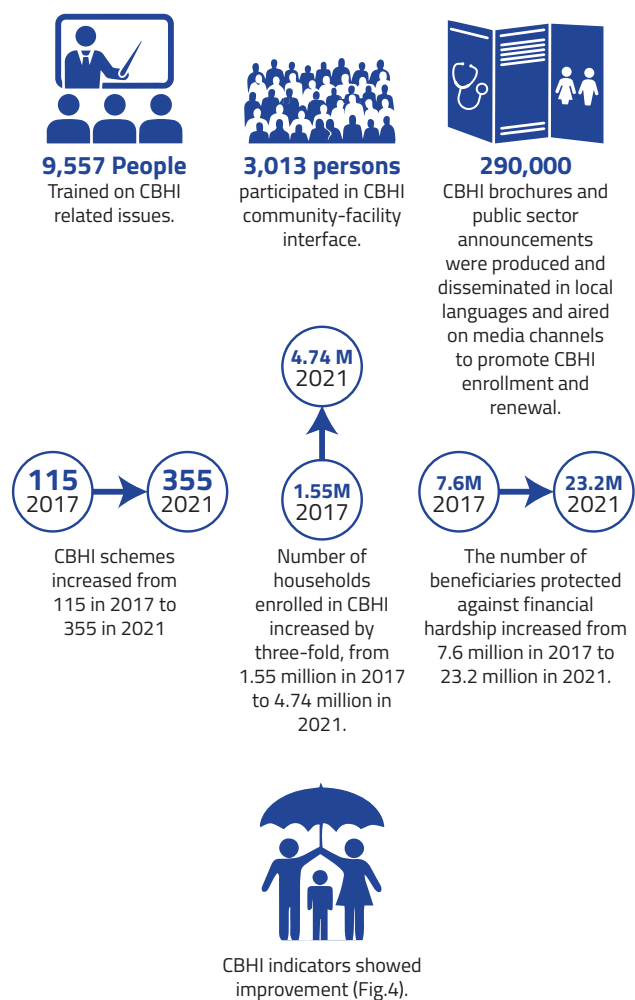
Technical Assistance: Provided demand-driven technical assistance to reinforce skills and knowledge on CBHI and PFM mentorship, on-the-job training, and ISS.

Material Support: Supported the development of PFM guidelines and training materials/brochures. Also supported public service announcements in local languages, aired on media channels to encourage CBHI enrollment and renewal.

Organizational Development to Institutionalize HCF in Government Structures: Supported HCF staffing arrangements to redesign the health organizational structure. Technical Assistance (TA) provided government counterparts a more effective way to manage HCF programming and implementation, including advocacy to integrate HCF indicators in health SS and ISS checklists, and other prominent manuals and guidelines.

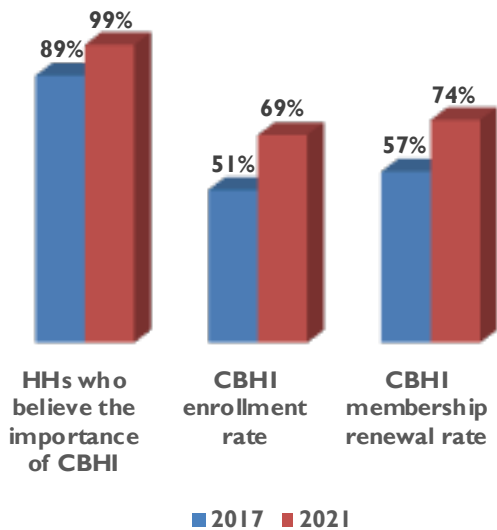
HCF: Major Achievements

Substantial increase in the number of schemes and households enrolled in CBHI:



⁶ (EHIA strategic plan 2020/21-2024/25)
⁷ (FMoH HCF Strategy 2020/21-2029/30)

Fig.4: Change in CBHI indicators
(Source: RaFV)



Improved Woreda Level Health Budget Allocation and Utilization:



Proportion of budget appropriated to health as a percentage of total woreda government budget increased from **12%** in **2017** to **14%** in **2021**.

Utilization rate of woreda health budgets improved from **92%** to **94%** between **2017** and **2021**.

Strengthened PFM practices

Increased Resource Retention and Utilization Practices at Health Facilities:



Revenue collected by PHCUs increased by **89%** between 2017 and 2021.



Retained revenue utilized increased from **ETB 450 Million** to **ETB 900 Million** between 2017 and 2021.



75% of retained funds are used by PHCUs to purchase drugs and medical supplies to ensure a consistent supply of materials. HFs also used retained revenue to construct maternity waiting rooms, believed to increase the uptake of institutional delivery.



3,553 persons trained on PFM



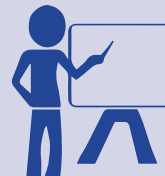
PFM guidelines developed and approved by the public sector with project support and distributed



PFM Mentoring Guide developed and distributed



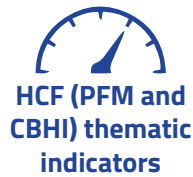
Comprehensive PFM training package (facilitator guide, participant module & PowerPoint presentation) developed for PHC and distributed



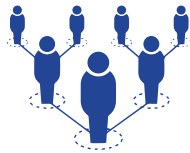
Established a pool of **150 PFM master trainers** and **180 mentors**



CBHI directive and **operational manuals** distributed



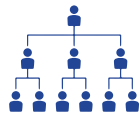
HCF (PFM and CBHI) thematic indicators
included/integrated into the health supportive supervision (SS) and integrated SS checklists



Established networking
between the finance and health sector



Pilot the Integrated Budget and Expenditure system in **117 HFs** to digitize the PFM practice at PHC level.



Aligned HCF staffing arrangement
within the revised and redesigned health organizational structure.

Increased access to and use of health services



- Number of visits made by CBHI members to public health facilities increased more than five-fold from the baseline of 1.7 million health service visits in 2017 to 9.2 million in 2021.

Innovations

PFM mentoring at PHC level using a standard mentoring guide and supporting finance personnel to use the IBEX system at the PHC level are the two innovations introduced with the project support.

Post conflict support

- TA provided through training: a refresher training on CBHI was provided for 152 (30 women) persons drawn from seven woreda CBHI schemes in war-affected areas of Amhara. Those trained included CBHI scheme executive staff, key CBHI board members, general assembly members, and CBHI kebele section representatives.
- Material support provided: one desktop computer, copies of CBHI membership application form, CBHI directive, CBHI financial management manual, and CBHI data

management manual were provided to the eight schemes.

HCF: Lessons Learned

- Encouraged local ownership of activities was an advantage during guidelines and materials development, capacity enhancement, mentoring, and supervision.
- The use of multiple interventions, targeted at various levels of the system, such as distinct personnel (managers, supervisors, and practitioners) is essential to ensure that PFM staff practice good financial practices and are supported by supervisors and managers who themselves are conversant and knowledgeable of the systems, processes, and requirements.



HW presenting the performance of Jarso HC, Oromia region. Photo: The Activity

FACILITATING INCLUSION THROUGH INSURANCE

Mira, 37, and mother of seven is a community-based health insurance member sits at the Jaro Woreda in Oromia Region in Ethiopia. Photo: The Activity.



The Government of Ethiopia promotes universal health care through the community-based health insurance (CBHI) scheme. CBHI is also one of the criteria by which kebeles (villages) achieve a 'model' rating per national standards. Malia Yusuf and Mahlet Wubishet are health extension workers stationed at Ifajalala Health Post in Jarso Woreda. Together, they achieved a 100 percent rate of CBHI enrollment and renewal of 4,139 community members in their kebele. In 2018, the health post's performance on CBHI was 65 percent. After training, Jarso Woreda gathered staff from kebele administration offices, Women Development Army members, religious leaders, elders, and other influential community members to discuss increasing CBHI enrollment. Malia and Mahlet led discussions on CBHI and explained the scheme's benefits. Following these campaigns, community members began using health services through CBHI and became advocates by persuading neighbors and friends to join.

The CBHI covers ten members of Mira's family. Living a five-minute walk away from Ifajalala Health Post, the 37-year-old mother of seven joined the scheme in 2018. "Before joining, we had no information on CBHI, so when we would fall ill, we would wait until we saved up enough money to seek medical care," she recounts. "This was agonizing, especially when I would see my children's health deteriorate."

Everything changed when Malia and Mahlet visited Mira's household and informed the family about CBHI. Mira is happy to pay the 250 Ethiopian Birr (ETB) (5 USD) annual fee, as she previously would spend, on average, 600–700 ETB (12 -14 USD) for medical services. "It was a huge relief to realize that ten family members are covered, and we can visit the health center whenever we feel unwell," said Mira.

2.5 SUBGRANT MANAGEMENT

Background: Over the last few decades, Ethiopia has made significant improvements in reducing maternal and child-related deaths. This improvement was a result of well-coordinated, extensive efforts and intensive investment in primary care by Ethiopia's government, partners, and community through its primary health care units. USAID Transform: Primary Health Care Activity's subgrant to government entities promoted ownership and contributed to the improvement of health system. The subgrant objectives were to:

- Enhance the health system's capacity in addressing PCMD related critical gaps within the HSTP, strengthening resource diversification;
- Enhance grant management experience; and
- Encourage the health system to find local solutions for local problems to sustain the health system's performance during shocks and ensure resilience.

Subgrant: Major Interventions

Performance Improvement Fund Support: USAID Transform Primary Health Care Activity provided subgrants on round bases to improve the performance of Ethiopia's public sector, at the woreda level. A pre-award assessment was conducted for applicants using a checklist to assess whether they are eligible for the subgrant. A term of reference was developed and endorsed by the committee for the subgrant management process.

Rapid Response/Crisis Modifier Fund: This fund was provided to government entities to help minimize the effect of emergencies on regular health service delivery and to maintain health service performance at all levels. This subgrant was provided when the regional public emergency management team submitted acceptable proposals and has USAID concurrence. Among others, acute watery diarrhea, cholera, scabies, yellow fever, pertussis outbreaks, COVID-19 pandemic, and internal displacement of persons arising from conflicts, landslides, and floods were some of the crises supported by this fund.

National Grant Management Committee: Subgrant management committee had been chaired by a delegate from the Federal Ministry of Health Resource Mobilization Directorate and Co-Chaired by

a delegate from the MCH Directorate. USAID Transform: Primary Health Care Activity Deputy Chief of Party and National Program Support Advisor act as members and the activity Grant manager served as a secretary.

Regional Grant Management Committee: The committee was chaired by the vice head of the regional health bureau with other members from the RHB and regional Activity program office.

Subgrant Priority Setting: This is one of the key steps for grant management. Based on the input from the regional grant management committee, the National grant management committee identified priority PCMD activities for each round of subgrants.

Subgrant Management Training: Capacity strengthening through training was provided to the grant management team on objectives of the grant, eligibility criteria for each type of grant, roles of the Activity staff, problem identification, proposal development, implementation, and tracking results. Additionally, an orientation on the nature of fixed amount awards was combined with a training on Public Financial Management (PFM) for the public sector finance team.

Technical support: Support was provided in the areas of planning and activity implementation, report preparation, and documentation at the grantee level during supportive supervision visits.

Supportive Supervision (SS): Supportive supervisory visits were conducted using the grant management field visit checklist to assess grantee project design capacity, implementation readiness, level of transparency, knowledge on compliance, activities implementation status, and quality of activities implementation and documentation.

Subgrant: Major Achievements



National and regional grant management committees were established and capacitated through training, TA, and supervision.



\$21,642,513 performance improvement fund was disbursed to support **1,209** projects.



In addition to direct financial support for projects, **20** v-scan ultrasound machines and **150** solar suitcases were procured and distributed, and **563** maternity waiting homes at HFs were furnished.



\$7,814,330 of rapid response /crisis modifier funding was approved to respond to emergencies such as acute watery diarrhea, cholera, scabies, yellow fever, pertussis outbreaks, COVID-19 pandemic response, COVAX, post-conflict facility restoration, and internal displacement of persons arising from conflicts, landslides, and floods.



Grant management committees were actively involved in priority setting and monitoring of funds.

Subgrant: Lessons Learned

- Subgrant mechanism improved public sector staff's ability to formulate problem statements and set SMART objectives in proposal development.
- Subgrant strategy enhanced public sector skills to critically evaluate, prioritize, and address gaps with limited resources and improved technical and administrative capacity of subgrantee staff; and improved skills to secure more resources from other donors.
- Subgrant increased opportunities for health sector staff to exercise transparency, teamwork, and integration



*A laboratory technician on duty at Dinkara HC, Amahra region.
Photo: The Activity*

III. RESULT II: INCREASED SUSTAINABILITY OF QUALITY SERVICE DELIVERY ACROSS THE PRIMARY HEALTH CARE UNIT (PHCU) CONTINUUM OF CARE

3.1 FAMILY PLANNING AND REPRODUCTIVE HEALTH (FP/RH)

Background: Modern contraceptive use by current married Ethiopian women increased from 6% in 2000 to 35% in 2016, to 41% in 2019, but the percentage for unmet need remains high, 25% in 2011 and 22% in 2016 (DHS 2011,2016, PMA 2019). The HSTP has identified top health sector transformation areas as quality and equity, information revolution, motivated, competent and compassionate health workforce, and health financing and leadership. To achieve the government's vision, USAID: Transform Primary Health Care Activity invested in FP/RH interventions that address the six WHO health system building blocks of HIS, service delivery, medical products, and technologies, including: logistics and supply management, health systems financing, health workforce development, and leadership and governance. The Activity supported the implementation of existing and new initiatives to strengthen the health system in an integrated manner.

FP/RH: Major Interventions

- **ISS, follow-up visits, and TA:** Mentorship, integrated supportive supervision, follow-up technical assistance, and monitoring of program implementation, including flagship programs, were done to ensure the quality of services.
- **Innovative system strengthening interventions:**
 - Planning exercise on FP/RH using routine health service data (data for decision-making) for health managers, FP service providers, and logistic officers.
 - Exercise on how to organize the package of activities implemented at an HF level.
 - Capacitate/support PHCUs to conduct on-site (workplace) Implanon insertion training on their own.
 - FP-service integration into other health service outlets in HCs and PHLs
 - Support HCs to initiate integrated back-up-LARC services support from HCs to rural communities.
 - Peer-to-peer education/learning on IPPFP skills and fulfillment training. First, trained providers in a delivery room will educate the practice of non-trained providers. After completing the skill exercise, the non-trained providers receive the theoretical and simulated model practice training at an offsite training approach.
 - Orient HPs and HCs on how to complete and send supply requests and reporting forms to Ethiopian pharmaceutical and supply agencies for resupply.
- **Capacity building including training/orientations:** This intervention strengthened the quality of existing FP/RH services and initiated flagship capacity enhancing programs (IPPPF, level IV HEWs program).
- **Post-training and gap-filling supply provisions:** Facilities were provided supplies immediately after skills training to initiate FP/RH services and ensure skills were not lost, and during ISS to ensure continuity of the initiated services.

FP/RH: Major achievements

HIS, procurement and supply chain and health financing:



Training of Trainers (TOT) on planning exercises for FP/RH was provided to **1,432** participants drawn from **134** WorHOs, **564** PHCUs, and **30** PHL. Some of the topics discussed during the training include, how to use routine health service data to generate health information, financial planning, and supply chains.

TOT participants rolled out the planning exercise for FP/RH to **2,054** FP service providers and facility management staff drawn from **243** PHCUs and **28** PHLs by coordinating workshops

Service delivery:



10,497 persons were trained on Implanon NXT, comprehensive LARC, PAC, PM &/or IPPFP service provision, and **8,634** HF's were reached.

Close to **2000** PHCUs conducted **15,529** visits to HPs and provided integrated backup LARC service support.

10,497 providers were oriented on FP/RH service and **8,634** facilities were covered by the orientation.

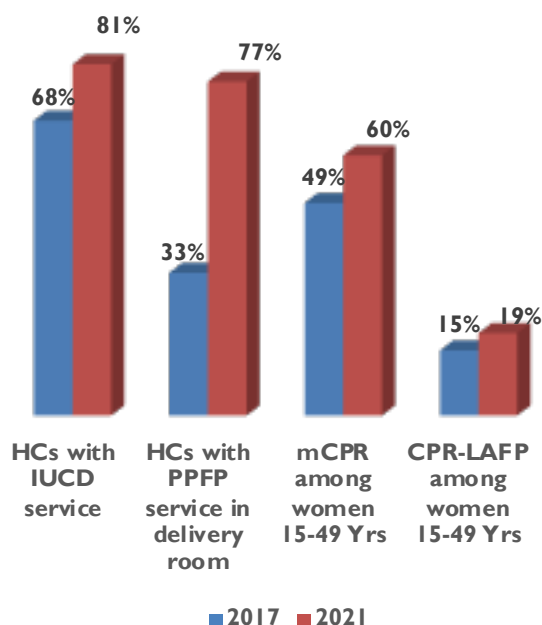
FP service was integrated with PAC service at **108** HCs & **18** PHLs, and with ART service at **31** HCs & **21** PHLs, and with immunization service at **61** HCs.

6,408 facilities

received post-training support to address supply gaps such as implant removal kits.

FP service availability and coverage improved (Fig.5)

Fig.5: FP service coverages (Source: RaFV)



Human resource for health:

766 HEWs received on-site Implanon insertion training, and **179 PHCUs** have independently conducted this onsite.

Implanon insertion training provided to HEW within their catchment areas.

130 teams of FP/RH trainers were formed in **52 WorHOs** for woredas to conduct FP/RH trainings on their own.

Facility management:

3,486 health managers, FP service providers, and logistic officers were trained on facility management and organization, and trainees from **134** WorHOs, **564** PHCUs, and **30** PHLs.

Innovations made under FP/RH:

3,486 health managers, FP service providers, and logistic officers were trained on facility management and organization, and trainees from **134** WorHOs, **564** PHCUs, and **30** PHLs.

Back-up LARC service support from HCs to the rural communities (similar to mobile outreach) intervention was practiced by nearly **2,000** PHCU in more than **400** woredas.

IPPPF service increased from zero in 2017 to **more than 800 HCs** in 2022.

FP/RH: Lessons learned

- Investing in a package of FP/RH activities across the woreda care system with public sector support resulted in health systems strengthening by addressing all six building blocks.
- Capacity building on data-driven planning and services management can ensure efficient integration of additional services into the existing care system, and enhance quality, equity, continuity, and ownership of FP/RH services.
- Investment in FP/RH at a systems level and the introduction of innovative interventions will improve the local capacity and self-reliance of the public sector.





UNINTENDED PREGNANCY COMPELLED A WOMAN TO USE CONTRACEPTIVE AFTER DELIVERY

Tegegnesh Habte is 34 years old and resides in Yeabtar kebele in Debat wore-da—70 kilometers from Gonder town, Amhara region. She has four children including twins who are aged ten, a seven-year-old, and a five-year-old. Tegegnesh is a family planning (FP) user. She used short-acting FP methods before switching to a long-acting reversible contraceptive (LARC). The decision was made when Tegegnesh experienced headaches and burning sensations with short-acting FP. She said, “After quitting the method, I got pregnant for the third time— the pregnancy was not planned.” Tegegnesh felt like she had learned a lesson from not using family planning. Immediately after the delivery, she visited the Yeabtar health post to receive counseling on FP services. She informed the health extension workers (HEWs) about her experience with the short-acting FP method. She opted for an Implanon insertion by one of the HEWs. She reiterated, “I didn’t want to repeat any mistakes, so I decided to use Implanon.” After using Implanon for three years, she returned to the HP for a replacement— which she continues to use.

*Tegegnesh Habte, 34, seeks family planning service in Amhara region in Ethiopia.
Photo: The Activity*

3.2 MATERNAL HEALTH (MH)

Background: The maternal health service coverage showed improvement over time. From 2016 to 2019, ANC improved from 62% to 74%; SBA from 26% to 50%; and early PNC for the mother from 17% to 34%.⁸ Despite these improvements, these coverage rates continue to hinder the prevention of maternal mortality from the major issues such as hemorrhage (37%), anemia (16%), hypertensive disorders of pregnancy (11%), and infection/sepsis (6%) [MPDSR 2012 EFY]. In response to these problems, the Ministry of Health (MOH) has planned to use data to inform how to improve quality and equitable ANC, labor, delivery, and PNC services. Interventions include introducing at least one ultrasound for all pregnant women before 24-weeks of gestation; expanding maternity waiting homes (MWHs) to more facilities; mandating a 24-hour facility stay after delivery; improving community engagement for transportation solutions; and improving access to comprehensive emergency obstetric and newborn care (CEmONC) through the expansion of operation room blocks. Additional interventions by the MOH include equipping and staffing of HFs; improving referral networks for women during complications; ensuring comprehensive services are accessible within a 30-minute distance; and strengthening the maternal and perinatal death surveillance and response (MPDSR) system.

MH: Major Interventions

- **Capacity enhancement:** gap-filling on-and off-site trainings for health care providers and health managers supplemented with catchment based clinical mentoring (CBCM), clinical skills practices at clinical skills labs (CSL), supportive supervision (SS), and review meetings.
- **Improving readiness of facilities:** service delivery setups were improved at HFs through technical support to rearrange service delivery units, supply and maintenance of medical equipment, and supply of MWH materials.
- **Innovations:** introduction of modified WHO safe childbirth checklist (SCC), ultrasound service at HCs, uterine balloon tamponade (UBT) at PHLs, establishment of CSLs, installation of solar suitcases, revised BEmONC training integrated with respectful maternity care and preventive medical equipment maintenance.

- **Technical support:** phased and adaptive technical support during routine and random follow-up visits (FUV).
- **Demand creation:** different demand creation endeavors were put in place including pregnant women conferences (PWC) in communities and the use of family recognition certificates.

MH: Major achievements

9,166

HWs, health managers, and health extension workers (HEWs) were trained

306 mentees

graduated from CBCM after six months of mentoring

35 CSLs

were established and utilized by 9,352 mentees

1,206 MWHs and **460 HFs**

were equipped with MWH materials and medical equipment and 129,794 women stayed in MWHs

Solar suitcases were installed at **250 HCs**

Limited obstetric ultrasound service was availed at 138 HCs and 88,290 pregnant women received ultrasound scanning service

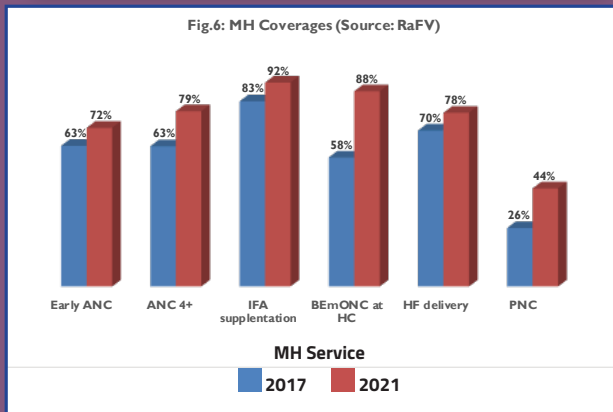
Uterine Balloon Tamponade (UBT) service was availed at **119 PHLs**

⁸ Central Statistical Agency (CSA) [Ethiopia] and ICF. (2016 & 2019) Ethiopia Demographic and Health Survey: Key Indicators Report. Addis Ababa, Ethiopia, and Rockville, Maryland, USA. CSA and ICF.

Modified WHO Safe Childbirth Checklist is being utilized at all HCs in target areas

Support provided to MOH in the development of national MH guidelines and training materials

MH indicators showed improvement (Fig.6)



MH: Lessons learned

The use of modified WHO Safe Childbirth Checklist in HFs improves the availability of essential birth supplies and adherence of providers to essential birth practices.⁹

Establishment and use of clinical skill labs help the retention of skills which might have been lost from failure to routinely use them.

Catchment based clinical mentoring is an effective way of capacity enhancement to fill gaps from health workforce turnover.

Introduction of ultrasound services in health centers improves the confidence of providers,¹⁰ and the prevention of maternal morbidities and mortalities.¹¹

Successful use of uterine balloon tamponade service at the primary health care level reduces the need for surgery, transfusion, and referral of postpartum hemorrhage cases.

Installation of solar suitcases in health facilities reduces power outages and helps to avail services 24/7 and reduce unnecessary referrals.



9 <https://doi.org/10.1186/s12884-021-03565-3>

10 <https://doi.org/10.1186/s12884-022-04523-3>

11 <https://doi.org/10.1186/s12884-022-04703-1>

Dingete Tamiru, a midwife trained by the USAID Transform: Primary Health Care Activity in Jarso Woreda, Oromia region, performs an ultrasound on Aynie, a 28-year-old mother. Photo: The Activity



USING TECHNOLOGY TO MAKE ACCURATE, INFORMED CLINICAL DECISIONS

Detection of fetal abnormalities via ultrasound can mean the difference between life and death for mothers and newborns. Before USAID Transform: Primary Health Care Activity, in Ethiopia ultrasound services, were available only in hospitals and private facilities. To get an ultrasound test, women usually need a referral from their local facility and travel long distances, which can be costly.

During her first two pregnancies, Aynie, 28, was unaware of the ANC she needed. When she was seven months into her third pregnancy, Dingete Tamiru, a midwife working at Ejersa Goro health center in Oromia Region explained the importance of ANC to her. Dingete was trained by the USAID Transform: Primary Care Activity to perform ultrasounds to check the health of mothers and their babies. Within five months of receiving the ultrasound provided by USAID Transform: Primary Care Activity, Dingete scanned 171 women, identified 24 abnormalities, and referred women to nearby hospitals for confirmation of the findings and treatment. "We are seeing increasing numbers of women coming to us for ANC as more and more hear about our ultrasound services. They all experience a sense of relief after attending these check-ups," says Dingete.

3.3 NEWBORN HEALTH (NH)

Background: The main causes of newborn mortality are preterm birth complications, birth asphyxia, and severe infections. Unskilled delivery is a major contributor to mortality, in addition to limited newborn care in health facilities and inadequate newborn care-seeking behaviors of caretakers. The USAID Transform: Primary Health Care Activity has been supporting the Ministry of Health (MOH) to meet its priorities by scaling up essential newborn care (ENC) in communities and HFs and neonatal intensive care (NIC) in PHLs. These services are important for averting neonatal mortalities. MOH has planned to improve newborn health by improving the comprehensive package of services impacting NH: access to CEmONC, equipping and staffing of HFs; improving referral networks for newborns during complications; strengthening the MPDSR system; expanding advanced neonatal care, NICU, ENC services, and services for low birth weight and preterm babies; PMTCT; contextualized integrated community case management of new-born and childhood illness; and quality integrated management of newborn and childhood illnesses services.

NH: Major Interventions

- **Capacity enhancement:** gap-filling trainings were offered to health care providers supplemented with CBCM, clinical practices at CSLs, SS, and review meetings.
- **Setup improvement:** service delivery setups were improved at HFs through technical support to rearrange service delivery units, supply, and maintenance of medical equipment.
- **Technical support:** both general and thematic, phased, and adaptive technical support was provided during routine and random FUVs.
- **Innovations:** introduction of modified WHO SCC, Ultrasound service at HCs, the establishment of CSLs, integrated revised BEmONC training, and the installation of solar suitcases.

NH: Major Achievements

1,310 newborn corners (NBCs)

strengthened through supply and maintenance of medical equipment.

830 HWs

were trained on ENC.

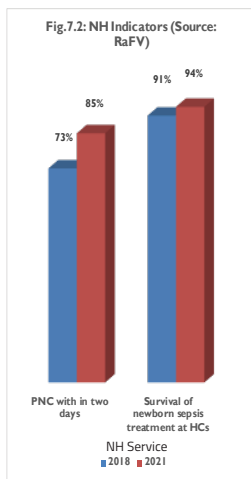
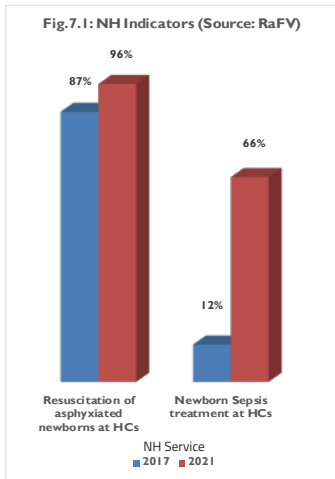
119 NICUs were strengthened (including establishing **19** new NICUs) through training of **393** NICU nurses and orientation of **119** general practitioner physicians in NICU, and supply of medical equipment such as infant radiant warmers/IRW, continuous positive airway pressure/CPAP, oxygen concentrator, pulse oximeter and maintenance of faulty medical equipment.

43,837 sick newborns were treated in the NICUs, **80%** improved and sent home, **11%** referred, **6%** died, **2%** on treatment at the time of the report, and **1%** left against medical advice.

Research on NH was published.¹²

NH indicators showed improvement (Fig.7.1 and 7.2).






NH: Lessons Learned

- The use of ultrasound scanning in health centers contributes to the prevention of neonatal morbidities and mortalities.
- Informing mothers of what has been done for their babies immediately after birth (Essential Newborn Care) needs to be part of the information provided at time of discharge after 24 hours stay in facilities.



*A newborn at Dinkara HC, Amhara region.
Photo: The Activity*



A newborn receives care in the newborn intensive care unit at Shinshicho Primary Hospital, in Kacha Bira Woreda. Photo: The Activity

ATTENTIVE CARE FOR FRAGILE INFANTS

Twenty-eight-year-old Selamnesh experienced fear and uncertainty when she prematurely gave birth. She delivered at Shinshicho Primary Hospital in SNNP Region and saw her newborn rushed off to the newborn intensive care unit (NICU) that was newly established on site.

“It wasn’t easy to see my baby in that state, but I received wonderful care at the hospital. I can see that my baby is making progress,” she said. The USAID Transform: Primary Health Care Activity establishes NICUs in primary hospitals, supports existing NICUs, trains nurses and general practitioners, provides medical equipment, and training on equipment maintenance. Before 2018, Shinshicho Hospital did not offer NICU services and referred patients elsewhere.

“Some of our patients would die or suffer severe health consequences while being transported to other facilities,” says Kassahun W., CEO of Shinshicho Primary Hospital. In addition to lack of equipment, there were gaps in health worker maternal and newborn health skills, according to Kassahun. Within a year of the Activity establishing a NICU and training three providers, the number of admitted newborns increased from 173 in 2018 to 407 in 2019.

3.4 OBSTETRIC FISTULA-PELVIC ORGAN PROLAPSE (POP)

Background:

Women with obstetric fistula (OF) suffer multifaceted health, psychological, and socio-economic consequences. A USAID commissioned survey for Ethiopia in 2014, estimated a prevalence of 36,000 to 39,000 untreated OF cases with an incidence of 3,300 to 3,750 new cases per year. In line with the Health Sector Transformation Plan (HSTP I (2014/15 - 2019/20)), the Ethiopian Ministry of Health (MOH) committed to accelerating the elimination of obstetric fistula by 2020 through a comprehensive, two-pronged approach which is now being further reviewed for a five-year extension (2021-2025) in alignment with HSTP II. USAID Transform: Primary Health Care Activity is committed to preventing new cases and providing treatment for accrued cases of fistula to achieve the national goal of ending obstetric fistula in Ethiopia. This approach embarks on intensifying identification, diagnosis, referral, repair, and rehabilitation. Additionally, as one of the chronic maternal morbidities with overwhelming prevalence in Ethiopia, pelvic organ prolapse (POP) was identified as a public health priority by MOH.¹³ The Activity also facilitated case treatment of POP to support the government's efforts in reducing the burden in Ethiopia.

OF: Major Interventions:

- **Capacity enhancement:** OF and POP case management capacity enhancement was conducted through task-sharing and shifting of clinical roles between senior professionals (gynecologists) and mid-level health workers (midwives).
- **OF case identification and referrals for treatment:** HEWs and communities were sensitized on fistula case identification and referral to health facilities for diagnosis and treatment using the continuum of care approach.
- **Innovations scaled up:** supported the expansion of innovative implementation strategies proposed by the public sector such as the use of 'Fistula Hot Spot Districts' for resource prioritization, the continuum of care approach in

survivors tracing and management, and the scale-up of clinical skill training of mid-level health providers.

- **Technical and financial support:** provided support for the development, printing, and distribution of guidelines, training materials, job aids, algorithms, brochures, and leaflets; in the finalization, and implementation of the two sequential national strategic plan documents, and the finalization of the 'OF Surveillance and Response Guideline'.
- **Partnership, networking, and collaboration:** As a member of the OF-TWG, the Activity regularly engaged with pertinent actors in joint planning, performance review meetings, resource mapping, and mobilization towards the national effort to end obstetric fistula in Ethiopia.

OF: Major achievements

Capacity enhancement:

901 PHCUs

capacitated on OF and POP case management through task-sharing and shifting and clinical training of 1,048 (49% women) mid-level health care providers.

Enabled and sensitized **over 7,550** HEWs and **14,500** community leaders for OF case identification and referral from community to facilities for diagnosis and treatment.

2,718 suspected fistula cases identified.

2,080 cases referred for confirmation.

1,813 confirmed cases referred to treatment centers.

¹³ Ethiopian MOH. (2015 & 2020) Health Sector Transformation Plan I and II.

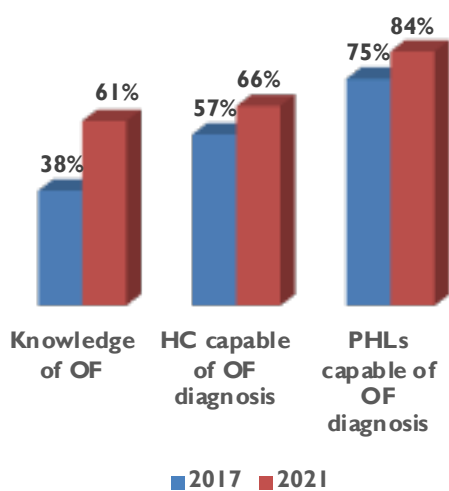
1,567 fistula cases
treated at treatment centers

1,110 fistula survivors
were rehabilitated and reintegrated in
partnership with other actors

3,698 mothers with POP identified (**93 %**
confirmed), **2,143** of them referred for
treatment and **1,987** received treatment.

OF indicators showed improvement (Fig.8)

Fig. 8: Change in OF indicators
(Source: RaFV)



Innovations:

- ✓ Expanded implementation of the 'two-pronged approach' of the national strategic plan towards Elimination of Obstetric Fistula in Ethiopia
- ✓ Pioneered and implemented the idea of 'Fistula hot spot woredas' for resource prioritization.

Technical Support:

- ✓ Provided profound technical and financial support in the development, finalization, and implementation of the two sequential national strategic plan documents.
- ✓ Proactively engaged in the finalization of the 'OF- Surveillance and Response Guideline'.
- ✓ Provided technical and financial support to initiate the development guidelines, job aids, algorithms, brochures, and leaflets

Material Support:

- ✓ Procured and distributed hygiene materials, sanitary pads, and dressings for thousands of fistula survivors.
- ✓ Provided tens of thousands of training materials, guidelines, strategic plan documents, and IE-BCC materials for the public health facilities

OF: Lessons Learned:

- ✓ Task- shifting of fistula clinical skill transfer helped to implement fistula prevention and care activities at the lower level of the health system
- ✓ Partnership, networking, collaboration, and integration among key partners is helping in mobilizing resources and tackling the long-standing public health burden of Fistula in Ethiopia.
- ✓ Integration of POP case identification with OF related activities helped facilitate identification of suspected POP cases, referrals, and treatment.



*Fistula Survivor on Farming,
Ugaz Lencha Kebele,
Photo: The Activity*

LIFE TRANSFORMED AFTER OBSTETRIC FISTULA TREATMENT

Nuriya Usman is 47 years old residing in Ugaz Lencha Kebele, Haromaya, East Hararghe, Oromia regional state. She was married to a local farmer 30 years ago; they lived a decent life until she became pregnant for her 4th child in 2008. She developed a prolonged obstructed labor that lasted over 72 hours and was taken to a zonal public hospital 70 kilometers from her village. She gave birth through a cesarean section operation. Sadly, the fetus came out dead due to the obstruction and prolonged labor. Nuriya started leaking urine continuously for ten years; Nuria's life has taken a different turn since then; she spent most of her time in her backyard, locked up, afraid of public exposure. She became embarrassed, dealing with psychosocial strain, and avoided social and economic events, mosques, markets and funeral places, and festivities. After years of health issues, a Health Extension Worker, examined her and suspected she had Obstetric Fistula. The HEW referred her to Away Health Center, where a trained midwife confirmed the diagnosis. Nuria was counseled and referred to Harar Hamlin Fistula (HHF) Center for treatment and care.

In 2018, Nuriya had a successful surgical procedure at HHF Center. She was then rehabilitated and given 10,000 Ethiopian Birr in seed money by the Hamlin Fistula Ethiopia to assist in her IGA endeavors. Following her treatment and recovery, Nuria said, "I was once called unpleasant names by my relatives and loved ones due to my condition, Alhamdulillah, I am now relieved of my suffering, resuming life and thankful for the care and support I received from Hamlin." Nuria asserted that the availability of trained Health Workers near the community helped her access and facilitate referral and transportation services. "Life has now started anew, to show me its smiley face following the treatment, my fast recovery, rehabilitation, and the economic support from Hamlin partners," she said.

3.5 CHILD HEALTH DEVELOPMENT

Background: EDHS 2019 showed that the under-five mortality and the neonatal mortality were 55 and 33 per 1000 live births, respectively.¹⁴ The HSTP II target is to reduce under-five mortality from 55 to 44 and neonatal mortality from 33 to 21 per 1000 livebirths by 2024/2025. Globally, 43% of children are at risk of sub-optimal development, while in Ethiopia 60% of children are at risk. This means more efforts are needed in Ethiopia to nurture children to reach to their full potential. Early Child Development (ECD) encompasses a young child's needs for good health, optimal nutrition, security and safety, opportunities for early learning, and responsive care giving. The USAID Transform: Primary Health Care Activity aimed at improving child health through the various interventions.

CH: Major Interventions:

Capacity building through training: The Activity provided a range of child health training to health facility workers on topics such as IMNCI, ICMNCI and ECD.

Material support: The Activity printed and distributed registration books, chart booklets, and training materials, as well as ORT supplies.

TA in the preparation of policies and guidelines: The Activity provided technical support at FMOH and RHB level through the Technical Working Groups (TWGs) in the preparation of policies, strategies, and training materials.

Supportive supervision: The Activity provided support conducting SS and PRM, during supportive supervision cases are observed from health center and health post registration and assessed how correctly children were treated and technical support provided on gaps identified, including availability of drugs and trained manpower.

Review meetings/Performance review and refresher training (PRRT): It was woreda level review of child health activities including EPI and nutrition, where health workers and health extension workers presented their activities under and health service utilization and quality evaluated, suggestions given to improve service. They were updated on and standard developments by the ministry.

¹⁴ Central Statistical Agency (CSA) [Ethiopia] and ICF. (2019) Ethiopia Demographic and Health Mini Survey: Key Indicators Report. Addis Ababa, Ethiopia, and Rockville, Maryland, USA. CSA and ICF

CH: Major achievements

8,328 HWs and **HEWs** trained on IMNCI, ICMNCI, and/or ECD.

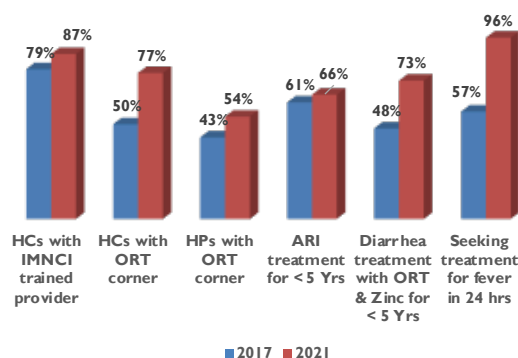
61 sessions of PRRT conducted, and **1,914 HW** and **HEWs** attended it.

2,000 IMNCI chart booklets distributed with **867** sets of modules (1-6), **2,000** IMNCI registration books, **745** ICMNCI chart booklets and exercise booklets, **2,000** ECD counseling cards, and **172,000** key message cards.

4,983 sets of Oral Rehydration Therapy (ORT) materials purchased and distributed.

Child health indicators showed improvement between **2017** and **2021** (Fig.9).

Fig. 9: Change in child health indicators (Source: RaFV)



Child Health: Lessons learned

- ✓ Onsite IMNCI trainings helped build capacity of woredas to continue capacity enhancement activities by themselves without interruption of routine service at low cost.
- ✓ Integration of child health capacity enhancement activities helped health workers support multiple thematic areas at the same time, reducing costs and time spent.

REVOLUTIONIZING CARE FOR CHILDREN



On-site training on integrated management of childhood illnesses, Amhara.

Photo: The Activity

To improve child survival rates in Ethiopia, the USAID Transform: Primary Health Care Activity works with primary healthcare units to strengthen the skills and knowledge of health workers. The Activity developed an innovative on-site training for health workers (provided without the interruption of routine health services), creating a pool of facilitators who will pass on newly acquired skills to respective woredas—ensuring sustainability. Forty-six health workers from six health centers within the Wadla woreda in the Amhara Region received training from the Activity over two consecutive weekends. The practical sessions were within the health centers and integrated with routine services. Within just six weeks of this intervention, the correct classification of sick children improved from 58% to 86.4%, and correct treatment provided improved from 28% to 84.3%. Molla Kassaw, Child Health Officer at Wadla Woreda Health Office, is excited to see improvements. “Previously, due to the high rate of staff turnover and internal staff rotation, clients experienced poor quality of care. The onsite training greatly impacted our quality of care, since we now have all of our health workers trained on management of childhood illnesses,” he says.

3.6 EXPANDED PROGRAM OF IMMUNIZATION (EPI)

Background: EDHS 2019 showed that infant and under-five mortality will be 43 and 55 per 1,000 live births by 2024/2025. In Ethiopia, the vaccination program accounted for 23% of child deaths averted, contributing up to a 29% decrease in child mortality if coverage and quality are improved. EDHS 2019 also showed that Pentavalent I coverage was 76%, Pentavalent III was 61%, and 43% of children were fully vaccinated. HSTP II aims to increase Pentavalent III coverage from 61% to 85%, and fully vaccinated children from 43% to 75% by 2025. The USAID Transform: Primary Health Care Activity aimed to improve vaccination coverage through various interventions.

EPI: Major interventions

Capacity building through training and orientations: Trainings and orientations were provided in the following areas: Immunization in Practice (IIP), effective vaccine management, reaching every district/community (RED/REC), cold chain and preventive maintenance, community-based surveillance, measles management, and Integrated Periodic Outreach Services (IPOS).

Technical, financial, and logistics support: Support was provided for vaccination campaigns such as COVID-19, and outbreaks of measles, pertussis cholera, and yellow fever. Similar support was also provided during campaigns for novel Oral Polio Vaccine (nOPV), Supplementation Immunization Activity (SIA), and COVAX. Technical assistance was provided to learn about the Reaching Every District/Child (RED/C) database to improve vaccination services.

Material support: EPI training materials, job aids, foam pads, and maintenance kits were printed and distributed.

Installation and maintenance: Different kinds of medical equipment and refrigerators were installed and maintained, with support from project and public sector staff.

EPI: Major achievements

3,876 HW were trained on IIP, effective vaccination management, RED/REC, and/or measles management.

663 HWs and HEWs trained or oriented on community-based surveillance.

110 HW and HEWs oriented on IPOS.

541 public and project staff were trained on cold chain maintenance.

624 EPI training materials and **2,500** EPI job aids were printed and distributed, during trainings, supervision, and review meetings. **20,000** foam pads for bedding were purchased and distributed.

663 public sector staff were oriented on preventive maintenance by the Activity.

100 sets of refrigerator maintenance kits were purchased and distributed to project staff to learn about maintenance.

More than 1,800 refrigerators were maintained by project drivers and public sector staff, saving **6.5 million ETB** in public sector money.

764 units of various medical equipment, like autoclaves, radiant warmers, OR lights, generators, and solar light materials were installed and maintained.

RED/C database is being practiced in **250** woredas and **696** HCs to improve vaccination service

58 hard-to-reach target woredas

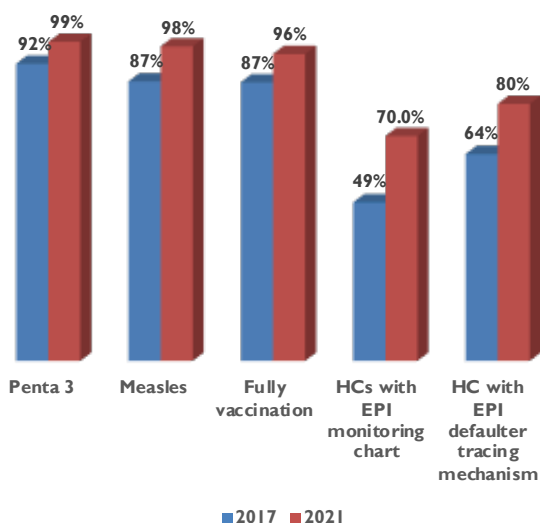
were supported through IPOS and 772,000 children and over 244,000 women received different health services.

Need-based technical, financial, and logistics support was provided during outbreaks and vaccination campaigns.

EPI indicators

showed improvement between 2017 and 2021 (Fig.10).

Fig. 10: Immunization service coverages
(Source: RaFV)



EPI: Lessons Learned

- Integration of cold chain preventive maintenance training with other EPI trainings has helped HWs preserve the quality of vaccines stored.
- IPOS has helped people living in hard-to-reach areas and those in humanitarian settings improve access to multiple health services.
- Refrigerator and medical equipment maintenance by drivers have saved millions of public sector ETB and provided more space for much needed cold storage.



ADAPTING STRATEGIES TO ADDRESS CONFLICT AFFECTED POPULATIONS



A health provider prepares to vaccinate a child during an integrated periodic outreach service in the Wolkayit Tegedie Setit Humera Zone, in Amhara Region (Photo: The Activity)

Inequities in accessing healthcare affect rural areas in developing countries and disrupt progress in healthcare advancements. Although the national immunization coverage has improved in the past few years, there are disparities between regions. To ensure that essential services reach all populations, the USAID Transform: Primary Health Care Activity identified hard-to-reach woredas and communities through consultation with regional health bureaus, woreda health offices, and local administrative kebeles. The Activity supported integrated periodic outreach services (IPOS) that provide life-saving healthcare services such as immunization, health education, and promotional messages to improve awareness of infectious diseases and behavioral practices.

The Wolkayit Tegedie Setit Humera Zone was devastated by the recent conflict. As a result, maternal, newborn, and child health services, including immunization programs, were discontinued after the conflict erupted in November 2020. To alleviate these challenges, in February and May 2021, the USAID Transform: Primary Health Care Activity provided subgrants to all woredas in the zone to conduct eight-day-long IPOS in two rounds. The Activity provided technical and logistical support to ensure the continuation of health services, which resulted in maternal and child health indicators showing significant improvement in the zone. “The Activity’s substantial support has shown us how much we can achieve in just a few days,” says Mengesha Nigusu, Head of the Zone’s Health Department. “We will use [IPOS] regularly from now on to strengthen our routine activities and target people in hard-to-reach areas,” he adds.

3.7 ADOLESCENTS AND YOUTH HEALTH AND DEVELOPMENT PROGRAM (AYHD)

Background: In Ethiopia, adolescents and youth (AY) within the age group 10-24 years account for 33 percent of the total population. This demographic is often affected by multiple challenges such as early sexual debut and early or forced marriage associated with unwanted pregnancies, sexually transmitted infections (STIs), and maternal health problems. The Government of Ethiopia has taken several measures to improve the health outcomes for AY through its youth policy, Adolescent and Youth Health Strategy 2007-2015, Adolescent and Youth Health Strategy 2016-2025, Health Sector Development Program, and Health Sector Transformation Plan. To date, encouraging outcomes have been achieved such as increased numbers of AY health facilities, improved AY healthcare-seeking behaviors, increased utilization of health services, and reduced unsafe abortions and its complications. However, there are still gaps in addressing the health service needs of adolescents and youth in country. USAID Transform: Primary Health Care Activity has been supporting the Ministry of Health to improve access to youth-friendly health services and improve the health of adolescents and youth.

AYHD: Major Interventions

Youth Friendly Service (YFS): USAID Transform: Primary Health Care Activity supported the expansion of YFS, an evidence-based one-stop-shop approach implemented through meaningful engagement of adolescents and youth to ensure access to quality, age-appropriate, and comprehensive health information, including counseling and health services.

Peer education program: The Activity empowered adolescents and youth as peer educators to meaningfully engage in YFS implementation, starting from planning, implementation, monitoring, and evaluation with strong youth-adult partnerships. Peer educators were capacitated through training and technical support and engaged in demand creation to increase healthcare-seeking behaviors and ensure referrals to YFS services. Peer educators actively participated in cleaning and planting flowers in YFS health facilities to make the area more attractive and appealing. Peer educators were also taught to be innovative in creating vegetable and fruit gardens using safe and free spaces within the grounds of the health facilities to support pregnant mothers staying in maternity waiting homes.

Reaching very young adolescent girls: The very young adolescence period (10-14 years old) is the time for laying the foundation for education, financial, and communication skills, positive health behaviors, and other important abilities for transitioning to adult life. This requires building a safe and supportive environment for adolescent girls. The “Her Space” program is a mentor-led and girl-only space that follows a skill-based and participatory methodology. Her Space girls graduate from the program after completing 40 hours of the sessions.

Strengthening multi-sectoral response for positive adolescent and youth development: Adolescents and youth need a holistic response to their personal growth and development. To facilitate this, the USAID Transform: Primary Health Care Activity, in collaboration with the RHBs, organized Woreda Advisory Committees (WAC) to assess and understand the needs of adolescents and youth and draft action plans for each sector in their respective woredas.



Peer educators receiving training at Finoteselam HC, Amhara region. Photo: The Activity

AYHD: Major Program Achievements

416 HCs started YFS with direct support from the Activity.

14,332 HWs were trained on AYHD-related issues to facilitate AYH response.

Over 10,651 peer educators were capacitated through training and QRM to create demand for YFS services and ensure referrals.

HCs with YFS increased from **31%** in October-December 2017 to **64%** in October-December 2021 in Activity intervention areas.

15.9 million adolescents and youth were reached with health information and counseling.

5.6 million adolescents and youth received comprehensive youth-friendly health services.

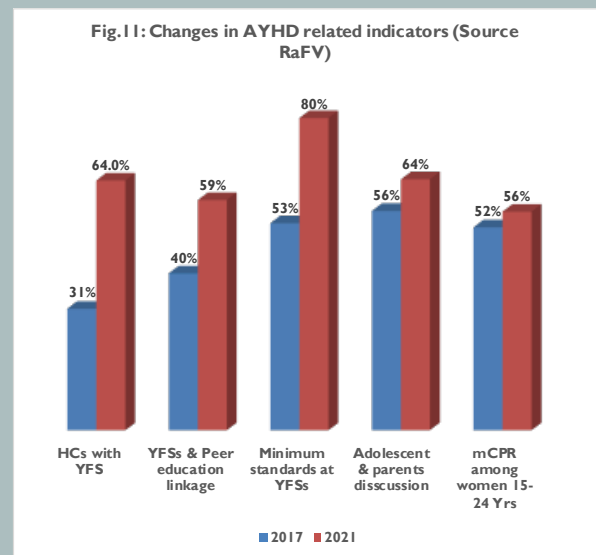
1.9 million young women accepted modern contraceptives, of which 205,756 (11%) accepted long-acting reversible contraceptives.

Over 6,000 young girls graduated from Her Space sessions after completing 40 hours of sessions.

Innovations introduced in the AYHD program are:

- Introduction of model gardening, cultivating vegetables and fruits for daily meals of pregnant women staying in maternity waiting homes.
- Introduction of phone application (Telegram) groups to facilitate quarterly YFS reporting. YFS facilities were clustered in their respective zones to form groups and the YFS facilities post their quarterly reports to share with zonal departments.

- AYHD indicators showed improvement (Fig.11).



AYHD: Lessons Learned

- Youth-Friendly Service (YFS) approaches helped increase health service access among adolescents and youth. As a result, the public sector has adopted YFS programming and scale-up in non-target areas.
- The Her Space initiative is crucial to reaching young adolescent girls. The initiative is highly appreciated and liked by the community. RHBs are implementing the Her Space program using trained staff and resources.
- The peer education program is a flagship activity that ensures the engagement of young people beyond tokenism. The Activity demonstrated the importance of engaging young people from inception to the evaluation phase of adolescents and youth-related programs.
- Through continuous advocacy, the MOH organized an Adolescent and Youth Health case team composed of eight staff under the MNCH directorate to assign AYH focal persons in RHBs. The case team strengthened adolescent and youth health services at all levels of the public health system. The MOH also made a strategic shift beyond its focus on SRH towards a full range of AYH services.



Peer educator providing health education at Durbete HC, Amahar region. Photo: The Activity.

A PATH FOR A BRIGHTER FUTURE FOR ADOLESCENT GIRLS



Lelise Melkamu, adolescent and youth and health focal person works at Oromia RHB. Photo: The Activity.

Lelise Melkamu is the adolescent and Youth and Health (AYH)-focal person at the Oromia Regional Health Bureau (RHB). She first learned about the “Her Space” program being implemented in the Oromia Region by USAID Transform: Primary Health Care Activity when she attended the graduation ceremony of girls who completed sessions at Gedo Rural Racho and Wagdi-Kortu kebeles in the Western Shoa Zone. During the ceremony, she witnessed the knowledge and skills the young girls gained from the “Her Space” sessions. “I was impressed by the ‘Her Space Girls’ after interacting with them,” she said. “Their knowledge on how to keep themselves safe, aspirations on what they want to be in the future, courage to fight gender-based violence, understanding of savings and income generation and the importance of visiting institutions like banks and the police at this young age was unexpected and so impressive.”

She goes on, “I interviewed one of the youngest girls in the group about the benefits she got from the Her Space program and about her aspirations. The girl said, ‘I would like to be employed at a bank.’ When I asked why, she replied, ‘during our practical visit session, we visited the bank and were informed on ways to save and make money and own businesses. This really interested me so I would like to be employed there. So far, I’ve saved 50 ETB. Next, I will buy chickens and work for a better income.’ It was unimaginable to hear this from a 12-year-old girl living in a rural setting.”

After seeing the effectiveness of the program, Lelise convinced decision-makers and her colleagues to implement the Her Space initiative. Consequently, the Oromia RHB decided to allocate 350, 000 ETB (6755 USD) for the 2014 Ethiopian fiscal year to print Her Space facilitator and participant manuals and scale up the initiative to 20 kebeles within 20 model woredas.

3.8 NUTRITION THEMATIC AREA

Background: Malnutrition is an important factor in maternal and child mortalities and morbidities.¹⁵ Undernutrition was cause in 45% of total child deaths in 2011 (*Lancet* 2013). Around 22% of women in Ethiopia are underweight with significant variation among regions. Twenty-four percent of women nationally are anemic which is the most frequent secondary cause of maternal deaths. Hypertensive disease in pregnancy is the second major cause of maternal deaths in Ethiopia and is associated with low calcium intake in 97% of cases. There are multiple complex determinants of malnutrition in Ethiopia, which require powerful multi-sectoral efforts. The general focus is on the first 1,000 days with a lifecycle approach through a better multi-sectoral engagement. The nutrition landscape is improving as demonstrated by the endorsement of the National Food and Nutrition Policy and Strategy and the Seqota Declaration Expansion Investment Plan. The Activity has integrated interventions to improve nutrition as one of the high-impact strategies in preventing child and maternal deaths.

Nutrition: Major Interventions

- **Coordination and collaboration:** The Activity remained an active member of coordination forums and TWGs; supporting the development and revision of policies and guidelines.
- **Capacity building:** Training and follow-up supervision and mentoring were provided to WorHOs and health facilities, including gap-filling activities for new staff, and as new areas emerged.
- **Developing and testing new initiatives:** New initiatives were developed and tested, including the introduction of adolescent nutrition, a new anthropometric tool, and nutrition task-sharing with community volunteers, with results shared with the public and other stakeholders.
- **Operational research:** Five operational studies were conducted and used to inform decisions and improve Activity implementation.
- **Multi-sectoral engagement:** To avoid duplication of effort in implementation and create opportunities for sharing lessons learned among implementing partners, sectors were involved in activity planning and execution.

¹⁵ Fetal growth restriction, stunting, wasting, micro-nutrient deficiencies, and suboptimum breastfeeding are the top contributors.

Nutrition: Major Achievements

5,507 people were trained on adolescent nutrition, AMIYCN, AWD case management, blended and integrated nutrition, SAM, and/or other nutrition-related issues.

3,315 HCs and **4,760 HPs** received mentorship support.

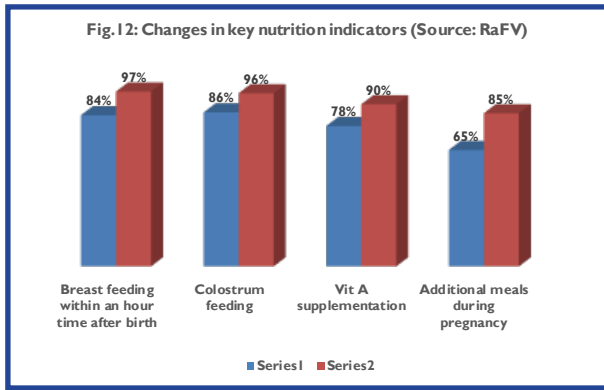
Provided support to the MOH to develop and/or review **more than 10 policy documents.**

An adolescent nutrition intervention was introduced in **252 schools.**

A new anthropometric tool was introduced in more than **380 health facilities.**

A nutrition task-sharing initiative was implemented in four kebeles of Oromia and SNNP regions.

Nutrition indicators showed improvement (Fig. 12).



- The implementation of a new anthropometric measurement to identify the malnutrition status of a child reduced the three steps to two steps. This helped improve the quality of screening services and save time. The public sector is showing a willingness to scale up this innovation.
- Multisectoral engagement was found to be a crucial method avoiding duplication of efforts and maximizing gains, particularly at the lower levels of the health sector.

Nutrition: lessons learned

- Task-sharing of some nutrition interventions with community volunteers was a key step to maintaining the regular implementation of interventions including, Growth Monitoring or Promotion (GMP), improving the quality of the services, and strengthening the relationship between the HEP and community volunteers.

Peer Educator at Durbete HC, Amhara region.
Photo: The Activity.



A SANCTUARY FOR UNDERNOURISHED CHILDREN



Eskindir Girma, works as the nutrition focal person at Ejersa Goro Health Center in Oromia Region. Photo: The Activity

Ensuring that infants receive the necessary nutrients during the first 1,000 days is critical for their development and well-being in their adult life. USAID Transform: Primary Health Care Activity improves the coverage and quality of nutrition-specific interventions in alignment with Ethiopia's national nutrition program. Children suffering from severe and moderate acute malnutrition rely on facilities like Ejersa Goro Health Center in Oromia.

Eskindir Girma, a nutrition focal person at the facility, believes that support from the Activity strengthened the health center's link with the health posts it oversees, allowing it to reach children with vital nutrition interventions much earlier. "Because we see patients a lot earlier on, the cases are a lot less severe, and many are in the out-patient therapeutic program. Before [the Activity's support] [children] would have to be admitted, and our stabilization center was overwhelmed," explains Eskindir. Misra, a 25-year-old mother of twins, is grateful for these services. "My daughters were less than five kilos at seven months, which is quite low, so I came here seeking help," she says. "The staff tried various feeding therapies, and I'm relieved to see my babies slowly gaining weight."

3.9 HEALTH EMERGENCY

Background: Ethiopia is exposed to a range of hazards associated with the country's diverse geo-climatic and socio-economic conditions. Emergencies are common challenges throughout the implementation of the Activity during which COVID-19, measles, malaria, and cholera outbreaks occurred across multiple regions. Pockets of conflict, flooding, drought, yellow fever, polio, and pertussis outbreaks were also major emergencies. With the ongoing conflict in the northern part of the country, more than 2.3 million IDPs are in desperate need of humanitarian support. Widespread damage and health service interruptions continue in the Amhara, Tigray, and Oromia regions due to ongoing conflicts. Public Health Emergency Management (PHEM) is a separate core process for the sector responsible for emergencies. Its objective is to anticipate, prevent, prepare, detect, respond, and recover from the consequences of public health threats. Despite multi-layered vulnerabilities in the implementation regions, PHEM often fails to fully execute its key functions of prevention, surveillance, response, and recovery interventions. This is mainly due to capacity limitations, resource shortages, and other system-related factors. Due to its widespread, community-level presence, the Activity provided technical, financial, and logistical support for various emergency responses. The financial support was provided through USAID's rapid response funding and later through its crises modifier fund.

Emergency: Major Interventions

The emergency responses supported by the Activity were aimed at minimizing suffering, morbidity, and deaths, and protecting development gains. The COVID-19 vaccine rollout was also one of the key areas of focus for the Activity during the last two years. The Activity provided technical, financial, and logistical support to all levels of the public sector that were responding to and minimizing the consequences of the pandemic. The following are specific interventions of the Activity in response to the COVID-19 pandemic:

- Supporting coordination and human resource development and management through the development of training and mentorship guidelines and tools.
- Providing equipment to enhance facility/response team readiness through cold chain maintenance.
- Improving community mobilization through training of media staff and community-level education using mobile vans.
- Supporting supervision, PRMs, and M&E of emergency management, and integrating emergency topics in project management practices.

A HW providing health service at Dinkara HC, Amhara region. Photo: The Activity

Achievements in Post Conflict Crisis Response in Tigray and Adjacent Areas in Amhara Region

Following the continued conflict in the Tigray and bordering areas of Amhara region, the USAID Transform: Primary Health Care Activity has been providing support to improve access to essential health services and thereby strengthen the health system's response capacity at different levels:

- **Mobile health supported:** 30 Mobile Health and Nutrition Teams (MHNTs) in 23 IDP sites supported reaching a total of 124,225 women and children with family planning, maternal and child health services at IDP/food distribution sites and in health facilities.
- **Capacity building through trainings:** 174 Health workers were provided an integrated orientation training on SAM, GBV, and Epidemic Response, and TOT was also given to 64 HWs on post crises response and psychosocial coping mechanisms.
- **Joint technical assistance:** Activity and public sector staff undertook 32 joint technical assistance visits to 32 WorHOs and 246 health facilities.
- **Material support:** The following materials were purchased and distributed:
 - 11,000 packs of sanitary pads and body soaps to women and girls in IDP sites.
 - 5,000 different furniture and medical supplies.
 - 24,000 different WASH-related materials and supplies, including 93 water tankers of 2,000 liters.
 - 150,000 sachets of plumpy'nut for treatment of malnutrition.
- **Review meetings supported:** Supported and facilitated post-crisis response review meetings with 225 review team members.
- **Health education supported:** Reached 350,050 people (184,069 female) through mobile vans and audio-mounted vehicles on key health messages.

Achievements in Response to IDPs in Amhara Region

Mobile health supported: 203,250 clients were served by mobile health and nutrition teams, on family planning, and maternal and child health service at IDP/food distribution sites and in health facilities.

Assessment support: Rapid assessment and onsite technical assistance are conducted to initiate and maintain continuity of essential health services by the mobile health and nutrition teams.

Material support: Provided more than 15,000 different basic humanitarian supplies including 'dignity kits' and WASH-related materials to IDP sites and health facilities.

Capacity building through training: 280 service providers were trained on MISP, PHEM basic training, nutrition, and GBV clinical management.

Capacity building through orientation: 1,098 (506 female) community volunteers in IDP sites orientated on hygiene and sanitation, communicable and non-communicable diseases, maternal and child health issues, family planning, nutrition, and GBV

Health education: 366,982 (189,238 females) were reached through mass awareness sessions on hygiene and sanitation, communicable/NCD and water-borne diseases, mental health (psychosocial support), nutrition, GBV, FP, ANC, SD, PNC, and others.

Achievements in Response to Epidemics and Emergencies (other than post-conflict crisis support):

Different epidemics and disasters including cholera, landslides/IDPs, malaria, yellow fever, measles, pertussis, and scabies were detected in target regions. Support was provided in response to these epidemics and emergencies, and remarkable results were registered by the Activity. A summary of activities and results is presented in the following matrix:

<p>CHOLERA, LANDSLIDES/IDPs, MALARIA SNNPR, multiple woredas</p> <p>ACTIVITIES: CM reached half a million people, case management training and deployment, and sanitary materials were provided.</p> <p>RESULTS: Cholera and malaria outbreaks were contained, and pressing needs caused by landslides were addressed.</p>	<p>YELLOW FEVER & CHOLERA SNNPR, multiple woredas</p> <p>ACTIVITIES: HWs deployed, yellow fever vaccination campaign conducted, sanitary materials provided, contact tracing done in cholera affected areas. RESULTS: Yellow fever outbreak controlled. Efforts are maintained to contain the cholera epidemic.</p>	<p>CHOLERA SIDAMA, multiple woredas</p> <p>ACTIVITIES: Case management training, different professionals were deployed, WASH and IPC interventions, community mobilization, and risk communication.</p> <p>RESULTS: Outbreak is controlled, and development gains were protected.</p>
<p>MEASLES AMHARA, OROMIA ZONE & BAHIRDAR UNIVERSITY</p> <p>ACTIVITIES: Case management, measles vaccination campaigns, professionals deployed, and EPI and PHEM linkage improved.</p> <p>RESULTS: The measles epidemic was controlled in the zone and at the university. Routine services were strengthened.</p>	<p>MEASLES, PERTUSSIS, SCABIES AMHARA, WAGHIMRA ZONE</p> <p>ACTIVITIES: Integrated case management orientation, sensitization, and integrated surveillance and outreach services were provided.</p> <p>RESULTS: Outbreaks controlled, surveillance system, community engagement, and EPI performance improved.</p>	<p>CHOLERA SNNPR, multiple woredas</p> <p>ACTIVITIES: Review meetings conducted, senior professional and field-epidemiologist supported surveillance, WASH, IPC, community mobilization, and risk communication activities.</p> <p>RESULTS: Outbreak controlled and development gains protected.</p>
<p>CHOLERA, MEASLES, IDPs OROMIA, multiple woredas</p> <p>ACTIVITIES: Case management training, sanitary materials, CM, and deployment of professionals (surveillance).</p> <p>RESULTS: Measles and cholera epidemic were controlled, cases identified through active surveillance treated, and basic services provided for IDPs.</p>	<p>MEASLES OUTBREAK TIGRAY, ASGEDE TSIMBLA WOREDA</p> <p>ACTIVITIES: Case management training, mop-up vaccination campaign, active surveillance, and supportive supervision.</p> <p>RESULTS: The outbreak was controlled, cases were managed early, the surveillance system improved with better community engagement, and routine EPI was strengthened.</p>	<p>CHOLERA SNNPR, multiple woredas</p> <p>ACTIVITIES: Aailed basic health services, supported surveillance, IPC activities, and transportation, community mobilization and risk communication activities conducted.</p> <p>RESULTS: Urgent demands addressed (basic health services). Nearly 100,000 IDPs have returned to their original locations.</p>

Emergency: Lessons Learned

- The USAID-funded 'crises modifier' modality was relevant for development projects working in Ethiopia. The Activity effectively used the approach to navigate extraordinary challenges related to health emergencies and other crises.
- The engagement of development partners in emergency responses had a synergistic effect. Coordinated and timely responses are saving lives and improving resilience.
- The ground-level presence of the Activity provided timely support during emergencies.
- A coordinated regional response plan led by the public sector improved the effectiveness and efficiency of the responses.

3.10 QUALITY IMPROVEMENT/QUALITY ASSURANCE (QI/QA)

Background: The two health sector transformation plans (HSTP-I and HSTP II) describe quality and equity in healthcare, particularly at the PHC level, as top priorities for the country. Based on these priorities, Ethiopia developed and launched a National Healthcare Quality Strategy (NHQS 2016-2020 and NHQS 2021-2025) to guide its planning and implementation of national healthcare quality and safety practices. PCMD is a focus area for the Government of Ethiopia's efforts within the HSTP. Improving the management of health service delivery and oversight of service quality is one of the sub-result areas of the Activity. The major approach for this thematic area is quality assurance and quality improvement. Quality assurance interventions improved adherence to the quality standards and protocols during service provision and regular clinical audits were conducted to measure performance and address gaps. Quality improvement efforts support the national quality effort by ensuring Activity strategies align with the NHQS by promoting a culture of continuous improvement in the health facility, fostering and sustaining change, and enhancing levels of performance through health system engagement (FMOH, RHB, ZHD, WorHO, and PHC facilities).

QI/QA: Major Interventions

- **QI team establishment:** Primary healthcare facilities were supported in QI team (QIT) establishment and for their leaders to champion QOC through a QI collaborative.
- **Capacity enhancement:** QI leaders from RHBs, ZHDs, WorHOs, and QI team members in health facilities were trained through program and subgrant budgets.
- **Clinical auditing:** The Activity introduced clinical audit tools for MNH, FP, AYH, and CH health service areas.
- **QI coaching/mentoring:** Post training, regular coaching of the initiated facilities to follow-up QI projects and activities.
- **QI project implementation:** QIT designed and implemented self-initiated QI projects in MNH, FP, AYH, and CH as part of QI collaborative.
- **Woreda level learning session:** As part of the QI collaborative, the Activity strengthened woreda level learning platforms to foster peer-to-peer learning and experience sharing on QI.
- **MNCH QOC network initiative:** Supported learning districts for MNCH QOC network initiative to draw lessons for the national level.
- **Engaging communities in QI through participant-defined quality strategy:** Brought communities and health providers together to improve RMHNCH quality of care and identify gaps in the community. Areas for improvement included: waiting time for services at HCs, construction of maternity waiting homes, pregnant women identification, and linking for early ANC.

QI/QA: Major Achievements

203 woreda, 92 PHLs, and 698 HCs received support on QI/QA.

7,257 QI leaders and HWs trained on QI/QA-related activity implementation.

QI collaborative established along the continuum of care: **331** MNH, **70** FP, **31** AYH, **37** CH, and **35** Integrated MNH-FP QI collaboratives established to improve services.

894 QI projects were designed and implemented by the QITs teams, of which 68% were completed.

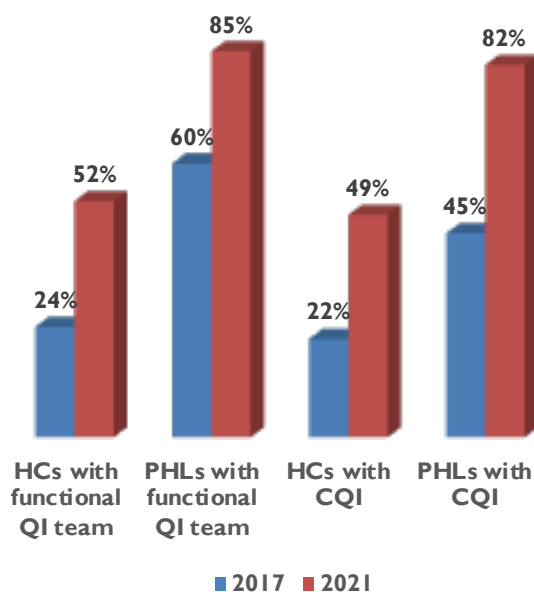
7 Woredas supported to implement Partners Defined Quality (PDQ) interventions.

The average clinical auditing score progressed from **18%** (MNH), **10%** (FP), **10%** (AYHD), and **10%** (CH) to **83%**, **74%**, **75%**, and **68%**, respectively, between **2017** to **2021**.

The Activity supported the development and implementation of the following guidelines and manuals:

- Five-year National Strategic Plan for Quality and Safety (2021-2025).
 - Revision of the National Healthcare Quality and Safety training manual.
 - Roadmap for an MNH QOC network implementation strategy.
 - Ethiopian Health Center Clinical Audit Guide and Tools.
 - Ethiopian Healthcare Quality Coaching Guide.
 - Family planning quality standards.
 - Training manual for healthcare safety.
 - Harvesting lessons from MNH QOC network implementation.
- QI/QA indicators showed improvement between 2017 and 2021 (Fig. 13)

Fig. 13: Change in QI/QA indicators
(Source: RaFV)



QI/QA: Lessons Learned

- Enhanced the capacity of leadership, management, and frontline health workers in QI/QA, and introducing quality standards are key for QI implementation.
- Collaborative learning sessions foster peer-to-peer learning and strengthen QI networks.
- Supporting the MOH's quality management system (WorHO-FMOH) and engaging the community in QI is critical for strengthening and sustaining any quality of care practice/programs.
- Quality improvement tools can be applied for any improvement activities in health facilities.

*A laboratory technician at Gimjabet HC, Amhara region.
Photo: The Activity*





IMPROVED QUALITY OF SERVICE FOR POSTPARTUM FAMILY PLANNING AT GOFCHIMA HEALTH CENTER

*Yetemare Worku, serves as maternal and child health focal person at Gofchima Health Center.
Photo: The Activity*

Gofchima Health Center (HC), in Debre Elias Woreda, Amhara Region, is supported by the USAID Transform: Primary Health Care Activity. Immediate postpartum family planning (IPPPF) services are offered at the health center. However, the quality of service was poor. Seeing this challenge, Gofchima HC and the Activity worked together to resolve the challenges. Training was organized for health workers on comprehensive FP services— including IPPFP and quality improvement (QI).

QI team members prepared an action plan to improve the quality and uptake of IPPFP services. After an action plan was put in place, service quality and coordination between the different departments at the HC improved. Additionally, the FP supply chain was prioritized, and the counseling skills of health workers improved. According to the clinical audit, the rate of FP service quality of care showed a significant increase from 5.6% in April 2019 to 78% in December 2020.

3.11 GENDER

Background: Over the past 20 years, Ethiopia has significantly improved its health system and its population health status. However, not all Ethiopians have benefitted equally, because social determinants of health affect men, women, boys, and girls differently. One in five women have an unmet need for family planning, less than one in three women complete all four recommended ANC visits, and one in four women have experienced physical or sexual violence from an intimate partner (EDHS 2016). USAID Transform: Primary Health Care Activity's gender integration approach addresses identified gender-related gaps across four result areas through several approaches such as advocacy, capacity enhancement, evidence generation, mentorship, and on-site follow-up visits. Equity is a pillar in the Health Sector Transformation Plan II (HSTP-II). The Activity aligns with HSTP II by identifying and responding to gender gaps and opportunities across each of the Activity's result areas. Priority areas focused on promoting women's leadership in the health sector, improving GBV prevention and response in PHC, better engagement of men in RMNCH, and documenting new learning and evidence to share with internal and external stakeholders.

Gender: Major Interventions

- **Advocacy:** Gender responsive work environment, elevating women to leadership positions, increased availability of post-GBV services at primary health care level were the areas of focus.
- **Technical assistance:** Capacity building through TA was a key intervention by the Activity.
- **Capacity building:** Strengthening capacity in health response to GBV, sexual violence (SV), sensitization on GBV prevention and response SOP, gender and health basic and rollout trainings, male engagement in RMNCH and GBV/ SV, and mental health awareness creation and case identification.
- **Support in policies and strategies development:** Supported the development of policy and strategy documents on GBV/SV strategic plan, workplace harassment prevention response manual, and a gender audit.
- **Integrating gender in SBCC:** Gender responsive messages were included in SBCC materials and in most of the awareness and education sessions.
- **Daycare centers support:** Supporting MOH to establish daycare centers.
- **Mentorship** on gender analysis and action planning for woreda health offices and health facilities.
- **Evidence generation and knowledge sharing:** GBV landscape analysis, formative research, and knowledge sharing at different forums.

*A mother who gave birth at Finotselam HC with her husband, Amhara region.
Photo: The Activity*



Gender: Major Achievements

2,917 People trained

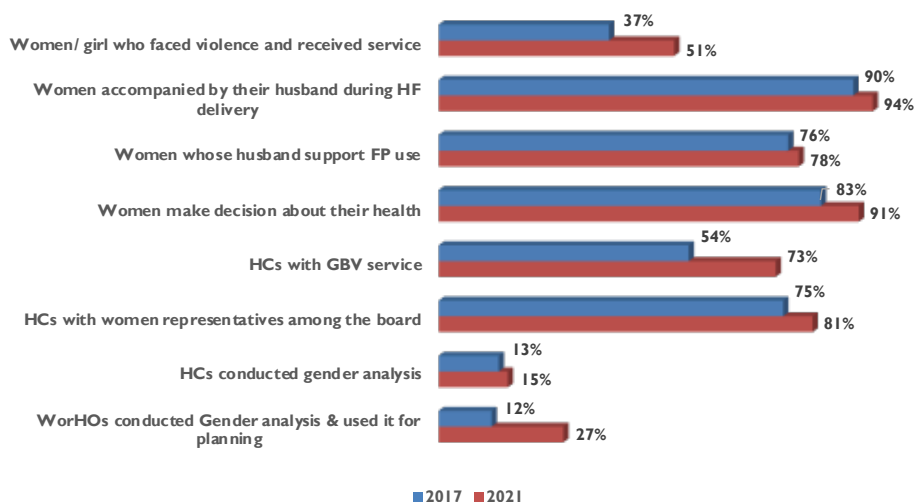
on gender-related issues (early marriage, FGM, GBV, SOP, gender and health, health response to sexual violence survivors, GBV/ SV and mental health awareness creation, and case identification in conflict-affected areas)

The gender thematic area's advocacy led to the creation of female-only LMG cohorts that were promoted to leadership positions following their training. For example, of 78 participants within a cohort, 18 (23%) were promoted to a leadership position.

Support provided for the development of a 5-year strategic plan for the MOH's Women, Children and Youth Affairs Directorate, the Health Sector Gender Audit, the Workplace Harassment Prevention and Response Manual, and the Women's Empowerment in the Health Sector Manual.

Gender indicators show improvements (Fig.14).

Fig. 14: Change in gender rated indicators (Source: RaFV)



Mr. Yonas Abebe serves as a Reproductive Health Officer and gender focal person at DebreElias Woreda Health Office.
Photo: The Activity

OPERATIONALIZING A GENDER ANALYSIS AND ACTION PLAN AT THE PRIMARY HEALTHCARE SYSTEM

At Debre Elias Woreda Health Office (WorHO) in Amhara Region, gender has been mainstreamed into the primary healthcare system. Trainings on gender and health, and gender-based violence (GBV) were organized for health workers and managers two years ago by the USAID Transform: Primary Care Activity. Mr. Yonas Abebe, a Reproductive Health Officer based at the WorHO, was trained to organize orientation sessions for health workers and other staff members at the WorHO and health centers (HCs). Mr. Yonas said, "A gender analysis at HCs was conducted based on the gender matrixes." He added that "Gender analyses were not known in the woreda previously, but now, every quarter at the HC level, a gender analysis is conducted." The findings of the analysis have been used in activity planning and action. Mr. Yonas said, "During the annual woreda-based planning, some of the gender-related activities were incorporated into the plan." At the HC level, the participation of women serving on the Board has increased. In addition, treatment services for survivors of GBV have been implemented at HCs. The WorHO is prioritizing gender issues by allocating 15,000 ETB (290 USD) for supportive supervision in the past Ethiopian fiscal year and assigned a focal person at the WorHO level.

Gender: Lessons learned

- In-depth gender analysis at the beginning of a program helps for evidence based intervention
- Policy level input is a fertile ground for addressing gender equality issues
- Technical capacity of individuals at all levels is key for effective gender integration

IV. RESULT III: IMPROVED HOUSEHOLD AND COMMUNITY HEALTH PRACTICES AND HEALTH-SEEKING BEHAVIORS

4.1. SOCIAL BEHAVIOR CHANGE COMMUNICATION

Background: Ethiopia has made significant progress in expanding primary health service coverage over the past two decades. However, there is still low health service utilization and poor health-seeking behavior resulting from lack of comprehensive knowledge, low health system literacy, the existence of deep-rooted socio-cultural beliefs, practices, and other barriers. To improve health-seeking behavior and bridge the gap in service utilization, USAID Transform: Primary Health Care Activity implemented various evidence-based and impact-driven social behavior change communication (SBCC) interventions. The interventions supported individuals, households, and communities to achieve good health by improving their knowledge, attitudes, and practices. It also systematically addressed socio-cultural and environmental barriers by engaging communities and multisectoral platforms. This is in congruence with the priorities of the Health Sector Transformation Plan and Health Extension Program Optimization Roadmap which emphasize the need to engage and empower individuals, families, and communities.

SBCC: Major Interventions

- **Community mobilization:** Strengthened community capacity to identify and address the underlying barriers to care-seeking.
- **Health post open house:** Promoted curative and preventive services available at the health post level.
- **Religious leaders' engagement:** Equipped religious and traditional leaders with the knowledge and skills required to promote appropriate health behaviors.
- **School engagement:** Equipped HEWs, WorHOs, and schools with the knowledge and skills required to plan, implement, and monitor school health interventions.
- **Strengthened Pregnant Women Conferences (PWCs):** Supported the implementation of the monthly PWCs by ensuring the availability and use of a standard facilitation guide.
- **Advocated for greater mass media involvement:** Enhanced the understanding of media houses on priority health issues and SBCC.
- **Print media:** Developed and strategically disseminated targeted IEC materials to promote appropriate health behaviors.
- **Capacity enhancement:** Augmented the SBCC capacity of regional, zonal, woreda, and kebele level health structures.
- **Mass awareness:** Health messages were broadcast using audio-mounted Activity vehicles.
- **Technical assistance:** Provided need-based SBCC support to national and regional level government health structures.

SBCC: Major Achievements

5,236 people

trained on SBCC-related topics.

1,116 HP open house events conducted.

266 experts from **31 woredas** trained on community mobilization.

828 kebeles initiated a community mobilization (CM) strategy.

168 persons

oriented on male engagement.

610 schools oriented on priority health issues and schools' engagements.

778 religious and traditional leaders oriented on priority health issues.

268 journalists oriented on priority health issues and media engagements.

657 sessions of pregnant women conferences (PWCs) supported in 70 woredas.

16,000 PWC facilitation guides developed, printed, and distributed in 3 local languages.

693,000 family health guides printed and distributed in 3 local languages.

22 types of innovative and evidence-based IEC materials produced and distributed.

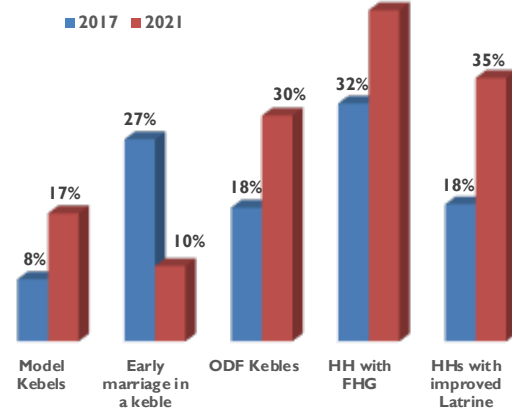
Over 35 million individuals

reached with recorded health messages using audio mounted vehicles.

184 maternity waiting home educational videos and accompanying discussion guide distributed to health centers and hospitals that have TV sets.

SBCC indicators showed improvement (Fig. 15).

Fig. 15: Change in SBCC indicators (Source: RaFV)



SBCC: Lessons Learned

- **Mixed channels:** The use of mix complementary communication tools, channels, and approaches helped to maximize effectiveness.
- **Leveraging multi-sectoral and social networks:** Harnessing existing community and traditional structures helps create ownership and accountability for health outcomes.
- **Integrating advocacy:** SBCC still receives inadequate attention from healthcare providers and government health structures. There is a need to integrate SBCC advocacy at various levels.

COMMUNITY MOBILIZATION A POWER FOR CHANGE:

Damboya, a woreda/district in Kembata Tembaro Zone of SNNP is one of the woredas that implemented the community mobilization intervention in five kebeles with support from USAID Transform: Primary Health Care Activity. The intervention enhanced community production and stewardship of health thereby ensuring meaningful community participation and sectoral collaboration. As a result, a significant increase was registered in the number of model households, improved latrine coverage, CBHI enrolment, and model schools. Currently, all five kebeles have achieved model status.

Table 2: Comparison between Baseline (BL) and Current (CU) value

Name of Kebele	Model HHs (%)		Improved latrine (%)		CBHI enrolment (%)		Model school (%)		Model kebele score (%)	
	Baseline (BL)	Current (CU)	BL	CU	BL	CU	BL	CU	BL	CU
Hamancho	67%	80%	67%	78%	30%	84%	62%	92%	75%	86%
Kota Kombola	75%	80%	75%	81%	23%	83%	46%	100%	69%	88%
Yebu	90%	92%	90%	92%	60%	85%	76%	100%	90%	95%
Hego	50%	89%	50%	89%	55%	78%	67%	100%	65%	93%
Hanja Gotmana	50.3%	92%	50.3%	92%	35%	84%	68%	100%	71%	87%

V. RESULT IV: ENHANCED PROGRAM LEARNING TO IMPACT POLICY AND PROGRAM LEARNING

Background: Evidence generated from interventions guide the development of policies and programs that are effective in reducing maternal and child death. As such, program learning has been one of the higher-level results of the Activity— to produce learnings for adaptive management and influence policies and programming. USAID Transform: Primary Health Care Activity also served as a learning ground for policy and program directions— bridging a disconnect between operation research, policy, and practice.

Program Learning: Major Interventions

Capacity building: With the support of universities, workers from the research institute (RIs) and regional health bureaus were trained in performing operations research. RIs received support in the establishment of Regional Knowledge Hubs (RKHs). Need-based support to the National Research Advisory Council was another major focus area.

Evidence generation: Knowledge generation through operations research using primary or secondary (program) data, producing numerous technical briefs, and documentation of success/case stories were some of the methods used for evidence generation.

Knowledge sharing: Dissemination of learnings using national and international conferences, journals, webinars, and websites were the key methods used since the start of the Activity.

Program Learning: Major Achievements



80 public sector staff were trained in operations research.

2 regional knowledge hubs (Amhara and Tigray) were established with the Activity's support.

51 pieces of learning evidence were published in peer-reviewed journals.

Technical assistance and financial support were provided to the National Research Advisory Council (NRAC).

A special issue on USAID Transform Primary Health Care Activity learnings was published, printed, and distributed in collaboration with Ethiopian Journal of Health Development (EJHD).¹⁴

6 knowledge-sharing webinars were conducted.

168 success stories were documented and shared.

14 thematic briefs were developed, updated, and shared on an annual basis.

¹⁴ <http://ejol.aau.edu.et/index.php/EJHD/issue/view/344>

Program Learning: Lessons Learned

- The Activity was implemented in partnership with the government at all levels, generating evidence and program learnings, and sharing them with partners through different venues/outlets to influence policies and strategies (which have now been owned by the government). For example, FP quality standards were tested at selected health facilities and found to be effective in improving the quality of service provision. These standards were incorporated into the national plan based on lessons learned from implementation at health facilities. Similarly, 'Vscan limited obstetric ultrasound' was introduced to selected health centers as a pilot by the Activity, resulting in increased service quality and utilization of services. The government later incorporated 'Vscan limited obstetric ultrasound' into the HSTP-II to scale it up.
- Establishing a research group at the project or regional level requires an end-to-end training approach. However, this requires a significant amount of time and investment and should be a continuous practice rather than a one-time event.
- The involvement of a technical advisor in programmatic research ensures the translation of findings into practice that addresses the difficulties at the junctions of research and practice. This practice also has an effect on the motivation of technical staff.

VI. MAJOR CHALLENGES

COVID-19 pandemic: The shutdown of health facilities (HFs)— following the outbreak of COVID-19 caused health workers to abandon HFs, and communities and households also stopped visiting the HFs. Demand and supply within the health sector were altered because of the pandemic, affecting the Activity's implementation. The government designed a response strategy with the involvement of USAID Transform: Primary Health Care Activity. A contingency plan to provide the support needed to maintain continuity of routine health services helped mitigate the effects of the pandemic

Insecurity: Due to conflicts, a complete shutdown of activities occurred in the Tigray Region. Similar conflicts in eastern Amhara and western Oromia also required closing program activities. Several HFs were destroyed, leading to a total shutdown of health service provision, impacting the implementation of activities. The Reprogramming and crisis modifier budget were used to respond to these challenges.

Turnover of trained public sector staff: Trained health providers often left their positions due to lack of promotion, job dissatisfaction, and safety concerns. In response, USAID Transform Primary Health Care Activity provided additional training which led to a shortage of resources. Peer-to-peer education activity at the facility level was used as an effective strategy to minimize costs incurred by additional trainings.

Weak community structures: The Activity was challenged by the absence of community structures, including dysfunctionality within the health development armies. This curtailed the implementation of SBCC interventions by the Activity.

VII. LESSONS LEARNED FROM THE ACTIVITY

Program integration addresses several health issues at a time: The integrated nature of the Activity helped with the simultaneous implementation of several thematic areas that addressed critical health issues. Staff employed at the cluster level coordinated the implementation of integrated activities in collaboration with the public sector and other partners working at the lower level. Ultimately this approach has been much appreciated by the public sector as it saves time and money. It also brings efficiencies and allows for close collaboration and skills/knowledge transfer, buy-in, ownership, and sustainability.

Peer-to-peer training at the HF level is a cost-effective way of filling gaps caused by staff turnover: Staff turnover posed challenges throughout the Activity's implementation period. As off-site re-training of staff was not a cost-effective method to address the problem, the Activity implemented a peer-to-peer onsite training at the HC level. This minimized the negative impacts of staff turnover and helped train several HWs at a time without disturbing the continuity of services.

Closely working with the public sector leads to sustainability: Sustainability was a core principle of the Activity right from the design stage and achieved by closely working with the public sector at various levels. Involving WorHO staff in annual activities, and joint-supervision and monitoring were routine practices that brought about ownership at the WorHO level. Having the Activity offices located within ZHD offices also helped foster close collaboration and partnerships with the ZHD staff daily and ultimately ensured ownership and sustainability.

Emergency response helped to maintain routine service provision: Immediate response to emergencies minimized impact on routine service provision. Several types of emergencies have occurred to date, including internal displacement due to conflict, epidemics, and the destruction of HF's. The Activity provided support for emergency response efforts in collaboration with the public sector. As a result, routine services have mostly been restored quickly.

Need-based support is valued by the public sector: Although an annual plan is prepared each year, unforeseen critical needs may arise during implementation. The public sector may be challenged by these needs as budgets may not be available. Since one of the principles of the Activity is to provide need-based support, this was a highly valued approach by the public sector.







BOLD THINKERS DRIVING REAL-WORLD IMPACT

