Sustainability of Management Approaches Supported by the Integrated Family Health Program in Ethiopia

Assessment report covering management
approaches applied at the woreda health care level
of Ethiopia's health system

September 2014

About E2A

The Evidence to Action Project (E2A) is USAID's global flagship for strengthening family planning and reproductive health service delivery. The project aims to address the reproductive healthcare needs of girls, women, and underserved communities around the world by increasing support, building evidence, and leading the scale-up of best practices that improve family planning services. A five-year Cooperative Agreement awarded in September 2011, E2A is led by Pathfinder International in partnership with the African Population and Health Research Center, ExpandNet, Intrahealth International, Management Sciences for Health, and PATH.

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Acknowledgements

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Acronyms

E2A	Evidence to Action for Strengthened Family Planning and Reproductive Health Services for Women and Girls
GHI	Global Health Initiative
HC	Health Center
HEP	Health Extension Program
HEW	Health Extension Worker
HMIS	Health Management Information System
HSDP	Health Sector Development Program
IDI	Individual Depth Interview (in-depth interviews)
IFHP	Integrated Family Health Program
ISS	Integrated Supportive Supervision
MNCH	Maternal, Newborn and Child Health
MOH	Ministry of Health
NGO	Nongovernmental Organization
PHCU	Primary Health Care Unit
PRM	Performance Review Meeting
SNNP	Southern Nations, Nationalities and Peoples Region (Ethiopia)
SPSS	Statistical Packages for Social Sciences
UDDM	Use of Data for Decision Making
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WAC	Woreda Advisory Committee
WBP	Woreda Based Planning
WHO	World Health Organization
WorHO	Woreda Health Office

Executive Summary

With more than 80 million people, Ethiopia has the second largest population in sub-Saharan Africa. About 44% of the population is under the age of 15 and 82% live in rural areas. Recognizing that there needs to be a healthy, educated workforce to achieve and sustain economic development, the Government of Ethiopia is leading an ambitious Health Sector Development Program (HSDP), which is conducted in a phased approach. The Health Extension Program (HEP), introduced in HSDP III, provides key preventive health education and an essential package of services in areas such as water and sanitation, immunization, family planning, and nutrition interventions at the household and community levels. The USAID-funded Integrated Family Health Program (IFHP) has fully supported HEP and HSDP III.

For the past six years, IFHP has been working jointly with its government counterparts at the regional, zonal, *woreda* (district)[1], and primary health care unit (PHCU) levels[2] to support implementation of government policies and procedures for effective management, oversight, and performance of HEP. At the time of this assessment, IFHP had worked in 292 woredas—in Amhara, Oromia, SNNP, Tigray, Beneshangul, and Somali regions— to assure broader service coverage and higher service quality in PHCUs, effective mobilization and behavior change at the community level, and effective referrals to the health center. To improve performance of health systems at the health center and health post service delivery levels, IFHP has focused on building capacity and institutionalizing the following management approaches, which are described in this report:
- Woreda Based Planning (WBP);
- Integrated Supportive Supervision (ISS);
- Use of HMIS data for decision making (UDDM) at all levels; and
- Performance Review Meetings (PRM) at woreda and kebele levels.

This report comes at the request of USAID/Ethiopia, which asked that IFHP, with technical assistance from the USAID-funded Evidence to Action for Strengthened Family Planning and Reproductive Health Services for Women and Girls (E2A) project, conduct a sustainability analysis of the health management approaches applied across woredas supported by IFHP. At the time of the assessment, IFHP had been supporting the implementation of the management interventions in Ethiopia for over four years, and hence provided an appropriate opportunity to assess the likelihood of the sustainability of the interventions. The report provides evidence which can be used to *gauge the potential* of Woreda Health Offices (WorHOs) to sustain the management approaches after IFHP comes to end. The report also provides data that can be applied to discern the conditions under which the WorHOs could sustain the approaches.

Methodology
The study team collected data from service statistics, structured interviews, random follow-up visits, and in-depth interviews (IDIs); a review of project documents supplemented the primary data sources. They collected primary data by working closely with WorHO heads or representatives and health center staff in 33 woredas in Amhara, Tigray, SNNP, and Oromia regions, where IFHP implements family planning, reproductive health, and maternal, newborn, and child health programs. The data collection instruments included:

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[1] Ethiopia is divided into 8 regions which are subdivided into 68 zones and about 770 woreda (districts). The regions are the first-level administrative divisions, followed by the zones and the woreda. The woredas are composed of a number of *kebele* (wards) or neighborhood associations, which are the smallest unit of local government in Ethiopia.
[2] The PHCU consists of the health center and its surrounding health posts.

- A semi-structured questionnaire for WorHO heads or representatives to obtain information on how the management approaches were implemented;
- A semi-structured questionnaire for health center manager/staff to obtain information on how the management approaches were implemented at the health center;
- A costing tool (integrated into the questionnaire) to obtain information on recurrent costs of the management approaches to IFHP;
- An IDI guide for discussions with zonal health office staff on the implementation of management approaches in non-IFHP supported woredas; and
- A service delivery form to obtain service data that can be analyzed to examine trends in service delivery performance during the implementation of the management approaches (pre-study selected indicators were used).

The study team measured the potential of management approaches to be sustained by the ability of the WorHOs to partially or totally take over the technical, logistic, and financial support that IFHP has been providing for ISS, PRM, HMIS/UDDM, and WBP. The indicators used to measure the sustainability of the management approaches in this study were:

- The capacity of WorHOs to retain staff trained in the management approaches.
- Inclusion of management approaches in WorHO plan and allocation of separate budget line for their implementation.
- WorHO leaders' perceptions of their ability to continue implementing the management approaches.

Study Limitations
Since IFHP support for the standards had not ended at the time of the assessment, the data collected relate more to the *potential* to sustain and not *actual* sustainability of the standards. To assess actual sustainability of the standards, the assessment would have been conducted at some point after IFHP had ended. By doing the assessment while support was still ongoing, it was impossible to capture what the actual situation would have been had support ended. Study limitations also related to the inadequacy of financial data, which hindered the study team from determining the relative financial contributions of IFHP and the WorHOs to implementing each management approach, and a lack of clearly defined financial and technical criteria that prevented the study team from fully determining which woredas were ready for graduation from USAID/IFHP support. The study team was also hindered in its ability to determine the effects of implementing the management approaches on system strengthening and service delivery, and instead looked at the trend in some health outcomes in the IFHP-supported woredas. Additionally, it was difficult to determine with precision the strength of the staff trained in each woreda.

Study Results
Capacity has been built in the different management approaches. A large number of WorHO staff have been trained on the different management approaches and the majority of these trained staff were still employed by the WorHOs at the time of the assessment. This finding implies that some level of capacity has been built among the WorHOs to implement the management approaches.

IFHP support to WorHOs varied slightly by management approach and type of support. The data show that not all WorHOs received IFHP technical and/or financial support to implement all four management approaches, although all WorHOs received IFHP support in at least one or more management approach. More WorHOs reported to have received technical than financial support.

The financial contribution of WorHOs increased over time. The WorHOs that provided financial support to the implementation of the management approaches reported that their financial contribution

increased over time, which suggests the increased commitment of WorHOs to the implementation of the management approaches.

WorHOs' perception of their ability to sustain the management approaches at the IFHP-supported scale varied by management approach. Only three WorHOs reported an ability to continue the implementation of all four management approaches with their own staff and resources should IFHP support end. Except for HMIS/data use for decision making, most WorHOs would "reduce scale of implementation and continue implementation with only staff/resources" as a response to graduation in order to sustain the implementation of the approaches. Given that only a few WorHOs considered discontinuing implementation as the only response to discontinued IFHP support, however, this suggests a level of commitment on the part of the WorHO managers to seek ways of sustaining the implementation of the approaches beyond IFHP.

Recommendations

Develop criteria for determining readiness of WorHOs to graduate from direct financial and technical support. In consultation with USAID, the Government of Ethiopia, and the WorHOs, implementing partners should develop criteria for determining the readiness of a WorHO to graduate from direct financial and technical support. The criteria could be used to directly assess the capacity of WorHOs to sustain the management approaches and to inform decisions about the minimum financial allocation each WorHO would need for sustainability.

Engage stakeholders in early discussions about the scale of programs to be implemented and provide guidance on what they can do to make programs sustainable. The results from this assessment highlight the need to engage stakeholders at different levels in discussions about the scale of programs to be implemented and be guided on what they could do to sustain such programs. Several WorHO staff perceived the scale of the management approaches to be above their ability to implement without external support.

Develop a timetable for graduation, where possible. For the implementation of the management approaches, there appeared to be no timetable for this graduation process. Consequently, the WorHOs appear to be operating under the assumption that support from IFHP will continue for a few more years. Expectations regarding the role of district or community-level stakeholders in sustaining programs should be communicated to them early in the program by government, funding agencies, or implementing partners. If possible, a timetable for graduation of the WorHO should be developed and shared with affected WorHOs.

Ensure implementation standards for the management approaches are adequately defined and communicated to the WorHOs. A situation where the breadth of activities becomes limited in order to continue implementing the management approach might compromise quality and positive impact on health outcomes.

1. Introduction

One of the core principles of the Global Health Initiative (GHI) is sustainability through health system strengthening. The GHI outlines the US Government's commitment to strengthen countries' existing health systems through partnerships with host governments, nongovernmental organizations (NGOs), and implementing partners to enable efficient, effective, and sustained provision of health care services and public health programs. Inherent in the GHI is the expectation that appropriate metrics be adopted to assess the robustness of health systems and promote both improved access to and utilization of quality health services, particularly for marginalized and disadvantaged populations, with a view to improving key health outcomes. In line with the GHI principle focused on health systems strengthening, the Integrated Family Health Program (IFHP), currently in its sixth[3] program year, has been supporting the Government of Ethiopia's rural Health Extension Program (HEP) by providing technical, logistic, and financial support in four major regions to strengthen the management, clinical, and service standards of the health system at the Primary Health Care Unit (PHCU) and woreda (district) levels. IFHP also supports the oversight and management roles of the Regional Health Bureaus and Zonal Health Departments.

To make decisions regarding IFHP's support to the implementation of health management standards and to assess the potential of Woreda Health Offices (WorHOs) to sustain the implementation of the standards beyond the IFHP program period, USAID/Ethiopia requested IFHP, with technical assistance from the Evidence to Action for Strengthened Family Planning and Reproductive Health Services for Women and Girls (E2A) project to conduct a woreda sustainability analysis. It was expected that the data collected for this analysis would also help to confirm that the management approaches contribute to effective and sustained implementation of primary health care at the PHCUs (health center and health post) and the community. At the time of the assessment, IFHP had been supporting the implementation of the management interventions in Ethiopia for over four years, and hence provided an appropriate opportunity to assess the likelihood of the sustainability of the interventions. However, we would like to emphasize at the onset that since IFHP support for the standards had not ended at the time of the assessment, our data relate more to the *potential* to sustain and not <u>actual</u> sustainability of the standards. To assess actual sustainability of the standards, the assessment would have been conducted at some point after IFHP has ended. By doing the assessment while support was still ongoing, it was impossible to capture what the actual situation would have been had support ended.

For this evaluation, sustainability is defined as the potential of the woredas to continue implementation of the standard management approaches without technical, financial and logistic support from IFHP. That is, in the absence of IFHP support, sustaining the implementation of the standards will require that a woreda has adequate internally generated resources and/or has the capacity to mobilize resources from other donors. Consequently, part of the assessment was to find out how the woredas plan to obtain the technical and financial resources needed to implement the standard management approaches.[4]

1.1 Background: Health Situation in Ethiopia, Health Extension Program, and Integrated Family Health Program

With more than 80 million people, Ethiopia has the second largest population in sub-Saharan Africa. About 44% of the population is under the age of 15 and 82% live in rural areas. Recognizing that there needs to be a healthy, educated workforce to achieve and sustain economic development, the Government of Ethiopia is leading an ambitious Health Sector Development Program (HSDP), which is conducted in a phased approach, now reflected in its latest and current phase, HSDP IV.

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[3] IFHP was in the fourth program year when the assessment was conducted.
[4] The management approaches are discussed in the next section.

Ethiopia has made significant gains in the areas of child survival and family planning use. The total fertility rate declined from 5.4 in 2005 to 4.8 in 2011; modern contraceptive prevalence increased from 13% to 27%. Deaths of children under five declined by 28% and corresponding improvements were seen in measures of nutritional status, immunization, and treatment-seeking behavior for children under the age of five. Results from the 2011 Ethiopian Demographic and Health Survey show less progress in the areas of maternal and newborn health. Although there have been steady reductions since 1990, Ethiopia has one of the world's highest maternal mortality ratios in the world at 676 deaths for every 100,000 live births (DHS 2011). While child mortality dropped by a quarter, neonatal mortality remained virtually unchanged at 39 in 2005, and 37 in 2011.

To address the critical health issues in the country, the Ministry of Health (MOH) introduced a 20-year HSDP implemented in four phases, each lasting for five years. Phase III-HSDP introduced the HEP, which provides key preventive health education and limited services in areas such as water and sanitation, immunization, family planning, and nutrition interventions at the household and community levels. Significant proportions of the health achievements reflected in the 2011 DHS can be associated with the HEP objectives of expanded immunization and family planning coverage, nutrition education, and safe water initiatives. HSDP IV continues support to the HEP and continues the government's expansion of curative health services throughout the country, with a special focus on reducing maternal and neonatal mortality.

For the past twelve years, USAID/Ethiopia has supported interventions in community-based family planning and child survival. USAID's support has evolved along with the government's priorities and plans. The latest incarnation of this work is IFHP, which fully supports the Government's HEP and HSDP III. As the government transitions from HSDP III to HSDP IV, USAID realized the need to reconfigure its support to best address government priorities and plans, while maintaining the gains made in the core areas of family planning and child survival. IFHP is a five-year, USAID-funded health program implemented by Pathfinder International and John Snow, Inc., in partnership with the Consortium of Reproductive Health Associations and other local partners. It follows an earlier family planning/reproductive health program implemented by Pathfinder and the Essential Services for Health in Ethiopia (ESHE) Program implemented by JSI. The program is currently in its sixth year and is currently implemented under the umbrella of the E2A Project.[5]

IFHP has been working jointly with its government counterparts at the regional, zonal, woreda, and PHCU levels to support implementation of the government policies and procedures for effective management, oversight, and performance of the HEP. At the time of the assessment, IFHP had worked with the PHCUs in 292 woredas across six regions of Ethiopia—Amhara, Oromia, SNNP, Tigray, Beneshangul, and Somali. The ultimate objective of IFHP's support to the woredas is to assure broader service coverage and higher quality in PHCUs, effective mobilization and behavior change at the community level, and effective referrals to the health center. To attain this objective and improve systems performance, IFHP's management standards support has focused on building capacity and institutionalizing the following management approaches (policies and procedures) at the woreda and PHCU levels:
- Woreda Based Planning (WBP);
- Integrated Supportive Supervision (ISS);
- Use of HMIS data for decision making (UDDM) at all levels; and
- Performance Review Meetings (PRM) at woreda and kebele levels.

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[5] The assessment was conducted at the beginning of IFHP's Year 5.

Woreda Based Planning

WBP is a process of engaging the WorHOs in broad integrated health sector planning. It is conducted by all zones once a year at their zonal headquarters to develop annual work plans. The actual planning meeting is usually preceded by the training of zonal level staff at the regional health bureaus. The trained zonal staff/managers then train others at woreda and health center (HC) levels on how to prepare an annual work plan. The WBP meeting attendees include heads of WorHOs and HCs, finance officers, and administrative officers.

As with other areas of management, IFHP has provided some logistical and financial support to the implementation of WBP. IFHP mainly provides three types of support to the implementation of the management standards/approaches:

- Technical support, which includes training, post training follow up and mentoring;
- Logistic support, which includes provision of vehicles for transport during ISS, stationery materials, manuals and guidelines; and
- Financial support, which includes per diem and transportation allowances during program review meetings, ISS, and WBP, among others.

Integrated Supportive Supervision

ISS is an important component of the government's strategy to ensure efficiency in the health sector and improve quality and performance of the health care system. It can be defined as a process of guiding, helping, training, and encouraging staff to improve their performance in order to provide high-quality health services through the use of integrated tools for all priority programs and motivating health service providers at all levels. Supervision is approached as a helping process and not as an inspection.[i] Supportive supervision applies a practical system of objective measures to foster improvements in the procedures, personal interactions, and management of primary health care facilities. While many approaches have been proposed to improve the quality of health services (for example, quality assurance, continuous quality improvement, client-centered services, district team problem-solving, fully functional service delivery points), the supportive supervision approach improves services by focusing on meeting staff needs for management support, logistics, and training and continuing education. Using short checklists enables supervisors to provide guidance on the *technical* aspects of services, which, combined with a client-centered outlook, results in high-quality primary health care (Management Sciences for Health, 2006).[ii] Supportive supervision promotes quality health service provision at all levels of the health system by strengthening relationships within the system, focusing on the identification and resolution of problems, and helping health care providers improve performance (IFHP, 2011).[iii] IFHP provides technical, logistic, and to some extent, financial support to periodic supportive supervision conducted by health bureaus at different levels (regional, zonal, and woreda). Integrated checklists are used during such visits.

Reformed HMIS Rollout

HMIS is a tool for collecting routine health data, and, when used effectively, the data can inform decision making to strengthen health systems.[iv] To use data for decision making, users must be adequately trained to analyze and interpret data. Under the guidance of the MOH, the regional health bureaus have been rolling out the reformed HMIS at various levels of the health sector. IFHP is one of the key organizations supporting the rollout. IFHP activities include the following:

- Training on the rollout of the reformed HMIS. Training participants include health care providers, administrative/support staff, HC heads, HEP supervisors, IT professionals, and HMIS focal persons who have a major role in the implementation of the reformed HMIS.
- Printing and distribution of HMIS tools/formats and financial support.

Based on expressed needs during initial visits, IFHP has supported the HMIS/data for decision making program by donating stationery (registers, graph paper, file racks, markers, etc.) to WorHOs, HCs, and/or health posts during follow-up visits. This support has enabled many WorHOs and health facilities to prepare and display wall charts needed for performance monitoring, an essential component of data use for decision making. During follow-up visits to the health facilities, IFHP staff have also provided onsite technical support/training on performance monitoring, including how to make and maximize use of information in the wall charts.

Program Review Meetings

A major component of the Government of Ethiopia's strategy is to improve health sector performance review. Internal performance reviews of the health sector are conducted on a quarterly or semi-annual basis to assess performance, identify gaps, and discuss mechanisms for improvement. During such periodic PRMs, a participatory approach is used to engage stakeholders in discussions around challenges and opportunities for improvement; a review of progress is also conducted towards targets and compliance with health policies. The ideal scheduling of the PRMs includes: once per month (health post and HC); once per quarter (hospital, woreda health office, and zonal health department); and once every six months (regional health bureau).[v] The meetings are attended by all key stakeholders—zonal administrators, woreda administrators, political party leaders, women's affairs representatives, heads of HCs, and representatives of partner organizations. At the kebele level, the meetings are usually held to address some specific health issues and are attended by all residents of the kebele.

The PRM has four key benefits:[v]
1. Enables organizations to track progress and understand challenges and opportunities for improvement;
2. Shares experiences and identifies best practices;
3. Enables stakeholders to coordinate efforts; and
4. Encourages positive competition and increases motivation.

IFHP has provided technical, logistical, and sometimes financial support to the WorHO, zonal health departments, and regional health bureaus to organize review meetings. All the regional health bureaus and a significant number of zonal health departments and WorHOs have received some support from IFHP to coordinate the meetings.

1.2 Purpose and Objectives of the Assessment

The primary goal of this assessment is to determine the current levels of capacity and readiness of WorHOs to implement and support activities without project support in the four areas of management.

Assessment Objectives

- Identify the type of support received by WorHOs from IFHP on the four management approaches.

- Assess the extent of IFHP's assistance in IFHP-supported WorHOs and HCs over time, in terms of technical support (person-days of visits, etc.), and funding provided; also, the recurrent cost to IFHP, WorHOs, and health centers implementing the management approaches.*

- Assess the four management approaches/interventions in IFHP-supported woredas that can be continued with or without technical, logistical, and/or financial support from other donors or implementing partners, and how the woredas plan to support these interventions in the absence of external assistance.

- Suggest some management approaches/interventions that require some re-thinking, revision, adjustment, or other changes to enhance the likelihood that they will be sustained; and

- Track and analyze changes in selected family planning/reproductive health and maternal, newborn and child health program performance indicators/outcomes during the implementation of the management approaches.**

The analysis for recurrent costs will take into account variations in the size of woredas and PHCU catchment areas, staffing available, and access to vehicles, among others;

***Examining changes in selected FP/RH and MNCH outcomes was done to determine the direction of changes in health outcomes during the implementation of the management approaches. It also directs attention to one of the ways in which the effects of management approaches could be assessed in the long run.**

In order to determine the potential to continue implementation of a management standard after IFHP support ends, the woredas were also asked to indicate the conditions under which they would continue implementation. They were asked to indicate whether:

- Implementation of standards will continue with only internally generated resources, in which case they would not require any support from other donors or implementing partner;
- Implementation of standards will continue only if **some[6] funding** was made available by other donors or implementing partners; or
- Implementation of standards will continue **only if substantial[7] support** is made available by other donors or implementing partners.

It is important to note that the final design of this assessment did not permit the determination of the effects of the management approaches on service delivery performance or health outcomes (see the section on limitations of the assessment). To determine effects, a more robust design that permitted a comparison of appropriate indicators between areas where management approaches were implemented

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[6] "Some" refers to small to medium size financial support received by a district for the implementation of an approach (that is, less than half of total resources needed to implement the approach).
[7] "Substantial" refers to large size financial support received by a district for the implementation of an approach (that is, more than half of total resources needed to implement the approach). Respondents chose between these categories based on their understanding and this explanation of the terms.

and those in which they were not implemented would have been executed. Such a design would have also permitted an assessment of the role of other factors that could contribute to improved service delivery performance or health outcomes, since changes in service delivery performance/health outcomes result from the interplay of several factors that include but are not limited to an improved management system.

In the short term (as is the case with the IFHP activities), the management approaches may contribute to increased ownership of health programs and quality of services, which in the long term could facilitate significant increase in service utilization and improved health outcomes. It is in this context that we examine changes that are taking place in service delivery performance/health outcomes during the implementation of the management approaches. Neither the Government of Ethiopia nor IFHP established a direct linkage between the management approaches and health outcomes; thus, our assessment does not attempt to make that linkage.

1.3 Operational Definitions

The potential for the sustainability of management standards/approaches was measured in terms of the ability of the WorHOs to partially or totally replace the technical, logistical, and financial support that IFHP has been providing for ISS, PRM, HMIS/UDDM, and WBP. Indicators used to measure the sustainability of the management approaches in this study included:

- **The capacity of WorHOs to retain staff trained in the management approaches.** Retaining staff trained in management approaches for considerable lengths of time is an indicator of the availability of some staff who could train and provide post training follow-up and mentoring to other staff in the WorHO. And, depending on the ratio of actual to expected/desired number of trained staff, availability of trained staff suggests some capacity to totally or partially replace the technical support that is being provided by IFHP.

- **Inclusion of management approaches in WorHO plans and allocation of separate budget lines for their implementation.** This is an indicator of commitment to the implementation of the management approaches. It also shows a sense of ownership or a desire to own the approaches. Ownership and commitment to implementation are essential ingredients of sustainability. The allocation of separate budget by the WorHO for the management approaches shows a commitment to totally or partially cover per diem, training, logistic, and transportation costs.

- **The availability of other partners/donors that can support the implementation of management approaches signifies diversity in sources of funding and/or technical support.** Diversity in sources of technical, logistic, and financial resources are essential ingredients of sustainability as the future of a program becomes less dependent on a single donor/partner's program implementation plans and cycles.

- **WorHO leaders' perception of their ability to continue implementing the management approaches.** This is an indicator of potential commitment to continue implementation and the conditions under which implementation might be continued.

1.4 Methodology

Data for this assessment were obtained from multiple sources: service statistics, structured interviews, random follow-up visits, and in-depth interviews (IDIs). A review of project documents supplemented the primary data sources. Primary data were collected from 33 woredas selected from Amhara, Tigray, SNNP, and Oromia regions where IFHP implements family planning, reproductive health, and MNCH programs. Several steps were taken to select the woredas. First, within each of the four regions, we

selected study zones depending on the size of the regions. For example, one zone each in SNNPR and Tigray, and two each in Amhara and Oromia, were selected. In order to avoid traveling over long distances in Amhara and Oromia, where we selected two zones each, we selected contiguous zones. Secondly, within each zone, we selected woredas that are supported by IFHP. The number of woredas selected in each region is almost proportional to the relative size of the region. In SNNPR,[8] eight woredas were selected; in Tigray, five woredas were selected; eight woredas were selected in Amhara; and 12 woredas were selected in Oromia. Thirdly, a health center was randomly selected in each of the woredas.

Primary data were collected from WorHO heads or representatives and HC staff. The data collection instruments included:

- **A semi-structured questionnaire for WorHO heads or representatives** to obtain information on how the management approaches were implemented, including the technical, logistic, and financial support of IFHP, the WorHOs, and other organizations. Also included were questions on the implementation of the management approaches and the perceived readiness of the WorHOs to continue implementation of the approaches should funding and technical support of IFHP cease;
- **A semi-structured questionnaire for HC managers/staff** to obtain information on how the management approaches were implemented at the HC;
- **A costing tool** (integrated into the questionnaire) to obtain information on recurrent costs of the management approaches to IFHP. The tool/form, organized around key management approaches, was meant to obtain information on how much was spent by IFHP to support the implementation of each approach;
- **An IDI guide** for discussions with zonal health office staff on the implementation of management approaches in non-IFHP supported woredas; and
- A **form used to obtain service data to examine trends in service delivery performance** during the implementation of the management approaches (pre-study selected indicators were used).

The data collection instruments were pre-tested, revised to incorporate observations from the pretest exercise, and translated into two local languages—Amharic (for interviews in Amhara, Oromia[9], and SNPPR) and Tigrigna (for interviews in Tigray). All fieldworkers/research assistants were trained for three days to gain a clear understanding of the objectives of the assessment, the structure of data collection instruments, their roles in the assessment, the need for good-quality data, and interview techniques, particularly on building rapport with the respondent. Training was conducted through formal presentations, small group discussions, and role plays. Recruitment of research assistants was based upon academic qualification, past experience in data collection, and ability to relate to respondents. IFHP staff and an IFHP-recruited consultant trained the field workers and participated in the supervision of field activities to ensure high quality data.

Field workers consisted of six teams of three people (two teams in each of Amhara and Oromia regions, and one team in each of SNNP and Tigray regions). One member of the team served as supervisor and ensured the accuracy and internal consistency of data collected. Also, each team had a member with the skills to conduct IDIs and transcribe the information collected.

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[8] The initial plan was to select 5 woredas from SNNPR. However, on the advice of the IFHP Cluster Officers, three more woredas were selected.

[9] Initially, the plan was to conduct the interviews in Oromia in Oromifa language. However, during the training the Research Assistants expressed concerns that there are different versions of the Oromifa dialect and that the version we had might not be well accepted in all parts of the region. Since the people speak Amharic language in the areas selected for the study, they advised that the interviews be conducted in Amharic.

The management assessment data were entered into a SPSS database system using a data-entry screen with built-in checks to minimize data entry errors. IDIs were translated into English and checked for accuracy.

1.5 Study Limitations

There are four major study limitations related to the methods and approach used in this study.

1. The first limitation was the inadequacy of financial data to assess the relative financial contributions of IFHP and the WorHOs towards the implementation of each management approach. One of the original objectives of this assessment was to determine which of the management approaches is most cost effective and which is least cost effective. However, WorHO and IFHP budget and financial report structures and categories did not allow for later disaggregation or classification of financial data by management approach. Related to this structural challenge, some of the IFHP and WorHO activities that supported the management approaches cut across project activities and could not easily be disaggregated to determine, for example, how much of the cost associated with onsite follow-up visit supported ISS, PRM, UDDM, WBP or other technical areas. As a result, this objective of the study was not met[10].

2. The second limitation has to do with the study's inability to determine the effects of implementing the management approaches on system strengthening and service delivery performance. Determining the effects would have shown the significance/relevance of implementing the management approaches and the motivation to continue implementing them. Unfortunately, due to sensitivities around what non-IFHP partners might think about the assessment were their catchment areas used as comparison areas, the idea was dropped. Instead it was decided to look at trends in some health outcomes in the IFHP-supported woredas. While this design yields data on changes in selected health outcomes during the implementation of the management approaches, it does not yield data to make judgment on attribution; similar changes could have taken place in areas without the IFHP-supported management approaches.

3. The third limitation relates to the lack of clear-cut predefined financial and technical criteria to determine which woreda is ready for graduation from USAID/IFHP support. For instance, the availability of a pre-defined ideal number of trained staff for the implementation of the management approaches would have given the evaluation team a benchmark against which to compare the observed number of trained staff, thus permitting a determination of gaps between expected and actual number and consequently, adequacy, of already trained staff. In the absence of pre-defined criteria, the assessment was able only to provide a description of the situation on ground at the time of the assessment with the hope that it would inform what should be put in place to better monitor readiness for graduation. It is difficult to take decisions on graduation based on perceptions rather than well-defined measures that are communicated to the program implementers at the start of the program.

4. The fourth limitation relates to the depth of the information obtained through IDIs. Although the IDIs provided useful qualitative information on the implementation of the management

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[10] The evaluation team was made to understand that since IFHP is an integrated program, most of the activities are implemented simultaneously and as such has been difficult to determine the exact amount invested in every single activity. Except for specific training activities related to individual management approach, the support to the public sector is usually technical and is provided during follow up visits. The financial system was not set up to track the cost of technical support to every single activity. The same is true of the WorHOs which also operate a financial system that was not set up to track every individual activity.

approaches in non-IFHP supported areas, they did not provide enough details on staff trained on different management approaches and the partners that trained them. Poor record-keeping contributed to the difficulties in determining with precision the numbers of staff trained and types of training received in each woreda. Thus comparisons between IFHP supported woredas and non-IFHP woredas were not possible with respect to training and capacity building in different management approaches.

2. Health Facilities and Training in Management Approaches in the Assessment Woredas

The health system of Ethiopia consists of different groups of facilities that are linked to each other in a hierarchical manner. This assessment focused on the PHCU and woreda levels of the health care system. The HCs are under the management of each WorHO; under each HC are five health posts, which are managed at the *kebele* (village) level. In this section, we provide an overview of health facilities and health staff in the woredas where the assessment was implemented.

As earlier discussed, examining the number and category of staff helps to determine the availability of some staff that could train and provide follow-up visits and mentoring to others when IFHP support ends. Constant training and mentoring of program staff promote program sustainability by ensuring a pool of providers with the capacity to provide high-quality services now and in the future. Refresher training offers program staff the opportunity to learn new methods and approaches required to cope with current and emerging challenges. When adequately implemented, training and mentoring programs help to reduce dependence on external technical assistance by ensuring a cadre of staff that can address technical issues, as well as train others to do so. Realizing the role of training and mentoring in ensuring successful implementation of programs, IFHP has provided training in different management approaches and program areas to health service providers in the four program regions. Over the years, IFHP has assisted in building a pool of trained staff with the ability to provide high-quality services to community members and training to other staff. WorHO and HC staff stated that the training they received has increased quality of health services, improved access to health services, improved demand for health services, and increased evidence for decision-making. While this assessment does not investigate the details of the training provided in the different program areas, it does provide information on training provided in the management approaches as this has direct bearing on continued implementation of the approaches.

2.1 Types of Health Facilities and Staff

Health Facilities by Type
As indicated in the beginning of this report, a total of 33 woredas were selected for this assessment. Three categories of health facilities were identified in the study areas: government (public), NGO, and private. In the study woredas, the government health facilities were made up of one hospital, 164 HCs (translating to an average of 5 HCs per woreda), and 827 rural health posts (an average of 25 health posts per woreda). The NGO facilities were made up of one hospital, one HC, and three clinics. The private facilities were made up of 115 clinics (an average of 4 clinics per woreda).

Staff Education Levels and Job Positions
A major condition for sustainability is the availability of adequately qualified staff that could carry on program implementation when external support ceases. Therefore, the educational profiles of the staff of the 33 assessment WorHOs were compiled to examine how well their qualifications align with required qualifications for the positions they hold, with a view to assessing their technical capacity to sustain the implementation of the management approaches. The profile (see Table 2.1) shows that most

of the senior staff had adequate education and training for their job positions and, with adequate support, should be good technical resources for continued implementation of the management approaches.

Table 2.1 Government Technical Staff in the Woreda (WorHO, Hospitals, Health Centers) by Sex and Qualification

Staff type	Degree		Diploma		Certificate		Total
	M	F	M	F	M	F	
# of Health Officers	151	46	-	-	-	-	**197**
# of Midwives	5	7	47	176	-	-	**235**
# of Comprehensive Nurses	28	13	7	5	-	-	**53**
# of Clinical Nurses	33	25	753	538	9	10	**1,368**
# of Public Health Nurses	-	-	79	57	-	-	**136**
# of Pharmacy Technicians	25	4	191	80	-	-	**300**
# of Lab Technicians	35	7	134	101	-	-	**277**
# of Environmental Health Workers	58	3	27	14	-	-	**102**
# of Health Extension Workers	-	-	-	-	-	1,723	**1,723**

Training in Management Approaches

During the survey, information was collected from the WorHO and HCs on the number of staff trained between 2009 and 2012 in each management approach. Data on the number of staff trained were obtained from training registers/logbooks and are shown for the four management approaches in Table 2.2.[11] The table shows that the number trained is highest for Health Management Information Systems (HMIS/UDDM; 2,215), followed by ISS (340), WBP (294), and PRM (157).[12] Of the 2,215 staff trained in HMIS, 64% were HC staff, 20% were Health Extension Workers (HEWs) and 16% were WorHO staff[13]. More HC workers were trained to conduct ISS (59%) and PRM (73%) than WorHO staff. For WBP, the number of WorHO staff trained was significantly higher than that of the HC (60% of WorHO staff vs. 40% of HC staff). HEWs were not trained in ISS, PRM, or WBP.

The relative sizes of WorHO and HC staff trained in each management approach reflect expectations regarding their roles in health system management in Ethiopia. For HMIS, health service providers, particularly those at the HCs, are expected to use data they collect to make decisions regarding the

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[11] It should be noted that the individuals trained in the different management approaches are not mutually exclusive of one another. It is possible for an individual to have undergone multiple trainings in different management approaches.

[12] Since 33 WorHOs were surveyed, these numbers represent an average of 67, 10, 9, and 5 individuals trained per Woreda in HMIS, ISS, WBP and PRM, respectively. These numbers vary by region.

[13] With 33 WorHOs surveyed, this number represents an average of 67 trained individuals per WorHO – 11 WorHO staff, 43 HC staff and 13 HEW. These numbers vary by region.

services they provide. With several HCs and health posts under the management of each WorHO, it should be expected that the number of staff trained across the HCs and health posts would be higher than the number of WorHO staff trained. HC staffs are expected to conduct ISS among health posts and engage in performance reviews. As indicated earlier, without knowledge of the pre-defined number of trained staff needed to sustain the implementation of the management approaches beyond the end of IFHP, it is difficult to determine the adequacy of the current number of trained staff for program sustainability. The information presented here is meant to help program coordinators determine the gap between what they perceive as the ideal/sufficient number of trained staff (which was not pre-defined) and existing number of trained staff with a view to redressing gaps.

Table 2.2 Number of WorHO, HC and HP Staff Trained in Management Approaches: January 2009 to June 2012

Training Conducted	Number of staff trained January 2009-June 2012, by type of staff			Number of staff trained January 2009-June 2012, by partner		Number of staff trained currently working in the woreda, by partner		*Staff retention (%)
	WorHO staff	HC staff	HEWs	IFHP	Other Partners	IFHP	Other Partners	
Integrated Supportive Supervision (ISS)	138	202	N/A	334	6	262	6	79%
Health Management Information System /Use of Data for Decision Making	364	1413	438	1029	1186	939	1109	92%
Woreda Based Planning	176	118	N/A	151	143	142	131	93%
Performance Review Meeting	43	114	N/A	134	23	121	22	91%

Estimated as the total number of trained staff working at the time of the study divided by the total number recruited between 2009 and 2012.

Role of IFHP and Other Partners in the Training of WorHO and HC Staff

All organizations involved in the training of WorHO staff, HC staff, and HEWs were classified into two groups: IFHP and others (including other organizations/partners/MOH staff). Table 2.2 above shows that IFHP trained more staff in three management approaches (ISS, WBP and PRM) than all other organizations combined. Of the staff reported to have been trained to conduct ISS, WBP, and PRM, IFHP was reported to have trained 98.2%, 51.4% and 85.4%, respectively. Of the staff trained UDDM, 46.5% were trained by IFHP and 53.5% by other organizations. These figures show the dominant role of IFHP in training WorHO and HC staff in management approaches. The data also show the existence of other organization(s) that might be relied upon to provide training, particularly in WBP and HMIS/UDDM, when support from IFHP ends. Across all IFHP-supported woredas, IFHP reported to have trained 617 on ISS in Year 3 and 358 in Year 4 of the program, and 6,246 people on the rollout of the reformed HMIS in Year 3 and 51 people in Year 4. Training participants consisted of health care providers, administrative/support staff, HC heads, HEP supervisors, and IT professionals.

Retention of Trained Staff

One of the major markers of sustainability is the ability to retain trained staff with the skills to manage service delivery programs over a long period of time. Consequently, in order to gauge the ability of the WorHOs, HCs, and health posts to retain staff, we obtained information on the number and percent of health workers trained between 2009 and 2012 who were still employed by WorHOs, HCs, and health posts at the time of the survey. The data are presented in the last three columns of Table 2.2 by partners. Overall, the data show good staff retention (79% for ISS and above 90% for the other three) That is, for HMIS/UDDM, WBP, and PRM, over 90% of health workers trained between 2009 and 2012 were still working with the WorHO, HC, or health post. Staff retention was lowest among those trained to conduct ISS. It is important to note that all the WorHO heads or representatives reported that the trainings had helped to improve capacity to implement these approaches, particularly their ability to use data for decision-making.

The preceding discussion shows clearly that some capacity, essential for the implementation of the management approaches, has been built among WorHOs through support from IFHP. Several WorHO workers have been trained in the management approaches and high percentages of the trained staff were still with the WorHOs at the time of the survey. However, a major question that the evaluators could not answer by simply looking at the training data is: "do WorHOs already have enough trained officers to take on the technical roles of IFHP in strengthening management approaches should support from IFHP end?" In the absence of pre-defined ideal numbers of trained staff against which actual numbers of trained staff could be compared to identify gaps, the evaluators relied heavily on WorHO leaders' judgment of the adequacy of the existing number of trained staff to continue the implementation of the management approaches.

In the next section, a description of the management approaches as they were being implemented at the time of the survey with IFHP support is presented to highlight the scope of activities that the WorHOs would have to take on should they decide to continue implementation of the management approaches beyond IFHP end date. Having information on the range of activities undertaken with IFHP support will also help donors and partners to better appreciate the amount of additional technical and financial responsibilities that the WorHOs will have to assume, should they no longer receive IFHP support. Having this information will also help donors understand the responses given by the WorHO respondents regarding the condition under which they thought they could continue the implementation of the management approaches.

3. Management Practices in IFHP-Focused Areas: Implementation and Support for Implementation

IFHP has always considered systems strengthening an integral component of its work to ensure the health sector provides high-quality services to families and communities. In partnership with the MOH and regional health bureaus, IFHP works to build the capacity of government health service system through targeted training of staff, technical support to district heath management and health service delivery points, and by providing materials (guidelines, manuals, etc.) to aid service provision. IFHP has facilitated the supportive supervision program and has participated in the review of programs at all levels; in addition, IFHP has facilitated post-training follow-up and mentoring, worked to ensure adherence to the principles and procedures of decentralization which facilitate and enhance ownership, ensured planned and need-based logistics support for services, and operated on the principles of partnership and collaboration with multiple actors in the area.

As we review the activities implemented with IFHP support, the pertinent questions being addressed are: "would the WorHOs be able to continue implementing these activities as they were being implemented at the time of the survey once IFHP technical, financial, and logistical support ends?" And if they could not implement them as they were being implemented with IFHP support, what adjustments would they make in the implementation of the approaches in order for them to continue implementation?

3.1 Implementation of Integrated Supportive Supervision (ISS), including IFHP and WorHO Support

A few essential implementation elements were examined during the study. The data are presented in table 3.1 and key findings are summarized below.

Existence of ISS Plan
The WorHO head or representative/officers were asked to show evidence of an existing ISS plan, or a document that highlights ISS objectives and process, including frequency of implementing ISS, guidelines on recruitment and training of supervisors, and mobilization of financial resources to support ISS activities. Of the 33 WorHOs surveyed, 24 (73%) were able to show the interviewers their written plans; eight (24%) reported having ISS plans but could not show them to the interviewers and one reported not having an ISS plan. The existence of a plan is indicative of the WorHO's recognition of the importance of implementing ISS and represents a conscious effort on their part to ensure continuity and consistency in the implementation of the ISS activities even when administrations change.

Training of Staff on ISS
Related to the issue of sustainability is the availability of competent staff at WorHOs who can provide supervision at lower level structures (i.e. HCs and health posts) now and in the future. Of the 32 WorHOs that responded to the question on the number of staff trained to conduct ISS, only five (16%) reported to have not trained any staff who could conduct ISS; these five will have to depend on external assistance to train individuals on ISS. Although the number of staff trained varies widely among the remaining 27 WorHOs, this finding shows that some internal capacity to conduct ISS and train others who could conduct ISS has been built among the WorHOs. In the absence of a pre-defined expected number, it was not possible to determine whether the number already trained was adequate to meet the ISS needs of the WorHOs. It is worth noting that across all IFHP-supported Woredas, IFHP reported training 617 on ISS in Year 3 and 358 in Year 4 of the program.

Frequency of Conducting ISS in Health Centers and Health Posts

The frequency of conducting ISS is an indicator of how much time and financial resources the WorHOs will have to expend on improving quality of services through supportive supervision when IFHP support ends; the higher the frequency of conducting ISS, the greater the staff time and financial resource needs. Table 3.1 shows some variations among WorHOs in the frequency of conducting ISS. About 70% of WorHOs reported to conduct ISS at HCs quarterly, and approximately 76% reported to conduct ISS at health posts at least once a quarter. Ten (30%) WorHOs reported to conduct ISS at HCs once or twice a year, and eight (24%) reported to conduct ISS at health posts once or twice a year.

Type of Support WorHOs have received from IFHP and their Perceptions of the Trend in IFHP Support Over Time

All 32 WorHOs that reported receiving any form of support[14] from IFHP reported to have received technical support in ISS in the form of training. Of these WorHOs, 27 (84%) reported receiving financial assistance toward travel and per-diems of supervisors, and 28 (88%) reported to have received administrative support. The administrative support covers assistance in organizing and coordinating supervision visits. Additionally, 13 (41%), five (16%) and 14 (44%) WorHOs reported that the technical contribution of IFHP to the implementation of ISS has decreased, remained the same, and increased, respectively, over time.

Budget Line for ISS

Having a separate budget line for ISS could be an indicator of the importance WorHOs attached to the implementation of ISS. It could also indicate their desire to continue implementation should external support end. Of the 33 WorHOs, 12 (36%) reported to have a separate budget or budget line for ISS; the remaining 21 (64%) reported to have no separate budget line for ISS, implying they support ISS from a WorHO budget that covers all the management approaches or rely on donor support.

WorHOs' Perceptions of Their Contributions to ISS Over Time

Another element of ISS implementation that was considered an indicator of WorHOs' preparation to sustain the implementation of ISS is the WorHO's technical and financial contributions to the implementation of the approach before and at the time of the survey. The WorHO administrators/officers were asked to provide information on the financial and technical contributions of their WorHOs to ISS activities in the years 2009-2012. As stated above, we were not able to obtain adequate data on the financial contributions to the implementation of ISS. However, the WorHO administrators/staff were able to provide qualitative information regarding the trend in their technical and financial contributions.

Of the 32 WorHOs that reported to have provided technical support to ISS, most (23; or 72%) reported that their technical support to the implementation of ISS has increased over the years. Likewise, of the 22 WorHOs that reported to have provided financial support, over half (14; or 64%) reported that their financial support to the implementation of ISS has increased over the years. Seven out of ten WorHOs that reported an increase in their *technical* contributions over time, and the six in ten that reported an increase in *financial* contributions suggest increased interest and commitment of WorHOs to the implementation of ISS. Because of lack of data on actual financial/technical support, it could not be determined whether the increase in technical and/or financial support was big enough to sustain the implementation of ISS when external support ends.

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[14] One WorHO reported to have never received any form of support from IFHP.

WorHO's Perceptions of their Ability to Sustain Implementation of ISS

In addition to the indirect measures of the potential to sustain the implementation of ISS, another way we assessed the potential of the WorHOs to sustain the implementation of ISS activities was to ask a direct question on what would happen to ISS activities should technical support from IFHP end. Only one-quarter of WorHOs (24%) expressed confidence in their ability to continue implementing ISS at the current frequency/scale with only their trained staff (that is, without support from IFHP or other agencies). Sixteen (49%) WorHOs reported that they would continue to implement ISS with only their staff, but will reduce the frequency of conducting ISS. Nine (27%) reported that they would be able to continue the implementation of ISS activities only if they obtain training and technical support from other agencies. That no WorHO thought of stopping the implementation of ISS altogether when support from IFHP ends is an indication of the WorHOs' resolve to find a way to sustain the implementation of ISS; this they planned to do, either at the current or reduced scale, with only their internally generated resources, or, by combining internal resources with support from other organizations.

To validate perceptions regarding the ability to continue with ISS activities, WorHO Administrators were asked to state whether they would be able to provide all the technical, financial and logistical resources needed to implement ISS activities should support from IFHP end. **The response confirms the perceptions and shows that majority of the WorHOs are not yet in a position to bear all the costs of implementing ISS alone.** While 23 (70%) WorHOs said they would be able to provide technical resources, only 13 (39%) said they would be able to bear the financial responsibilities alone. It is, however, important to note that the majority of WorHOs that reported an inability to implement ISS without IFHP support would need only minimal support.

Table 3.1 Implementation of Integrated Supportive Supervision, including IFHP Support and WorHOs' Potential to Sustain Implementation

Existence of ISS Plan	N=33
Yes, plan seen	(72.7%) 24
Yes, plan not seen	(24.2%) 8
No	(3%) 1

Number of Trained Staff on ISS	Valid N=32
0	(15.6%) 5
1	(6.3%) 2
2	(12.5%) 4
3	(12.5%) 4
4	(15.6%) 5
5	(9.4%) 3
6-10	(12.5) 4
11 and above	(15.6) 5

Frequency of conducting ISS in Health Centers	HC (N=33)	Health Post (HP) (N=33)
Quarterly	(69.7%) 23	(75.8%) 25
Bi-annually	(21.2%) 7	(15.2%) 5
Annually	(9.1%) 3	(9.1%) 3

Type of support received from IFHP	Any Support (N=33)	Technical (N=33)	Financial (N=33)	Administrative (N=33)
Yes	(97%) 32	(97.0%) 32	(81.8%) 27	(84.8%) 28
No	(3%) 1	(3.0%) 1	(18.2%) 6	(15.2%) 5

Trend in IFHP technical support for ISS, compared to 2+ years ago	Valid N=32
Reduced	(40.6%) 13
Remained the same	(15.6%) 5
Increased	(43.8%) 14

Separate budget for ISS	N=33
Yes, separate budget	(9.1%) 3
Yes, separate budget line	(27.3%) 9
No	(63.6%) 21

Trend in WorHO contribution to ISS implementation	Technical Support (N=32)	Financial Support (N=24)
Reduced	(12.5%) 4	(3.8%) 3
Remained the same	(15.6%) 5	(19.2%) 5
Increased	(71.9%) 23	(53.8%) 14
No Response		(8.3%) 2

What will happen to ISS activities if training and onsite technical support from IFHP comes to an end	N=33
WorHO will continue using only WorHO staff	(24.2%) 8
WorHO will try to continue by seeking support from other partners	(15.2%) 5
WorHO will continue using own staff but with reduced frequency	(48.5%) 16
WorHO will try to continue by seeking support from other partners and with reduced frequency	(12.1%) 4

Stop implementation of ISS activity altogether	(0%) 0		
Capability to conduct ISS with no Support from IFHP	**Technically N=33**	**Financially N=33**	**Logistically N=33**
Yes	(69.7%) 23	(39.4%) 13	(42.4%) 14
No	(30.3%) 10	(60.6%) 20	(57.6%) 19
Of those who said No above, percent requiring minimal support	**N=10**	**N=30**	**N=19**
Yes	(70.0%) 7	(60.0%) 12	(63.2%) 12
No	(30.0%) 3	(40.0%) 8	(36.8%) 8

3.2 Use of HMIS Data to Inform Decision Making

Over the years, IFHP has supported training of WorHO staff in use of data for decision-making; IFHP has also provided onsite technical support in data use as well as financial support in the form of stationery to make graphs, tables, and charts.[15,16] The implementation elements described below were used to assess the potential of the WorHOs to sustain the roll-out of HMIS and the use of data for decision making. The data are presented in table 3.2.

Existence of HMIS Committee at the WorHO

The HMIS committees are expected to coordinate use of data activities and monitor utilization of data for decision making. Twenty-eight (nearly 85%) WorHOs reported having an active HMIS committee. This finding shows that a high majority of WorHOs have put in place some structures to ensure adequate roll-out of HMIS and use of data for decision making.

Type of Technical Support Received from IFHP

As indicated earlier, IFHP supports use of data for decision-making in several ways: technical (which includes classroom-type training and on the job technical support); administrative, which involves assisting in planning training; and logistics, which covers supplies of HMIS forms and stationery to prepare tables, graphs, and charts. Twenty-two (67%) WorHOs reported to have received training support; 27 (82%) reported to have received onsite technical assistance, and 20 (61%) reported to have received general administrative assistance. The majority of WorHOs reported to have received supplies from IFHP, with 27 (82%) reporting to have received stationery for preparing tables, graphs, and charts, and 21 (64%) reported to have received HMIS forms. These percentages suggest a high dependence on IFHP for both technical and financial/administrative support.

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[15] WorHO staff are expected to train HC staff on the use of data for decision making.
[16] IFHP support includes trainings on HMIS, transport, and purchase of computers.

Table 3.2 Implementation of Data Use for Decision Making, including IFHP Support and the Potential of WorHOs to Sustain Implementation Beyond IFHP End-date

Existence of HMIS committee at the WorHO	N=33
Yes	(84.8%) 28
No	(15.2%) 5

Type of support received from IFHP	Training (N=33)	On-site Technical (N=33)	Administrative (N=33)	Logistics – Stationery (N=33)	Logistics – HMIS Forms (N=33)
Yes	(66.7) 22	(81.8%) 27	(60.6%) 20	(81.8%) 27	(63.6%) 21
No	(33.3%) 11	(18.2%) 6	(39.4%) 13	(18.2%) 6	(36.4%) 12

Trend in IFHP technical support for HMIS, compared to 2 or more years ago	Valid N=32
Reduced	(46.9%) 15
Remained the same	(25%) 8
Increased	(28.1%) 9

Ever supported HMIS/UDDM from WorHO Budget	N=33
Yes	(78.8%) 26
No	(21.2%) 7

Trend in WorHO contribution to HMIS	Technical Contribution (N=32)	Financial Contribution (N=26)
Reduced	(9.1%) 3	(3.8%) 1
Remained the same	(18.2%) 6	(9.2%) 5
Increased	(72.7%) 24	(53.8%) 14
No response		(23.1%) 6

What will happen to HMIS/UDDM if training and on-site technical support from IFHP comes to an end	Valid N=33
WorHO will continue using only WorHO staff	(36.4%) 12
WorHO will try to continue by seeking support from other partners	(12.1%) 4
WorHO will continue using own staff but with reduced frequency	(30.3%) 10
WorHO will try to continue by seeking support from other partners and with reduced scope/frequency	(3.0%) 1
Stop implementation altogether	(15.2%) 5
Other	(3.0%) 1

Capability to conduct HMIS with:	Technically	Financially	Logistically
No Support from IFHP	**N=33**	**N=33**	**N=33**
Yes	(36.4%) 12	(33.3%) 11	(27.3%) 9
No	(63.6%) 21	(66.7%) 22	(72.7%) 24

Of those who said "No" above, percent requiring minimal support	N=21	N=22	N=24
Yes	(52.4%) 11	(40.9%) 9	(45.8%) 11
No	(47.6%) 10	(59.1%) 13	(54.2%) 13

Trend in IFHP Technical Support for HMIS/Use of Data for Decision Making

Although technical assistance is necessary for HMIS implementation, a high percentage of the WorHO administrators perceived that the support from IFHP has decreased over time. This perception aligns with program data reported by IFHP in the annual reports for Years 3 and 4. Although it was part of IFHP's plan and strategy to train fewer people in Year 4 than in Year 3 (since some of the persons trained in Year 3 were expected to train others in Year 4 and beyond), the Woreda Health Officers appeared to not have understood IFHP's rationale; they reported on **what** happened and not *why* it happened. Thus, 15 (47%) WorHOs reported reduced levels of IFHP technical support over time, and eight (25%) reported that the level of technical support had remained constant. The trend in IFHP support is in line with the strategy to enable WorHOs own and implement these activities when external sources of support end.

Trend in WorHO Contribution to HMIS/Use of Data for Decision Making (Technical and Financial)

Twenty-four (73%) WorHOs reported that their contribution to use of data for decision-making activities has increased over time. Regarding financial contributions, 14 (70%) reported an increase in financial support. As with the trend in technical contributions, the increased financial support from the WorHOs indicates greater independence from IFHP.

Support for HMIS/UDDM from WorHO Budget

One of the implementation elements used to assess the potential of WorHOs to sustain the roll-out of HMIS and use of data for decision making was the availability of WorHO's financial resources for HMIS/UDDM activities. Supporting the implementation of HMIS/UDDM activities from WorHO budget reflects some commitment and desire to own the management approach. Of the 33 WorHOs, 26 (79%) reported to have provided some financial support to the implementation of HMIS/UDDM.

WorHOs' Perceptions of their Ability to Sustain Implementation of HMIS/Use of Data Activities

Since it was difficult to decide whether the reported increase in technical and financial contributions have put the WorHOs in a position to sustain the implementation of the data use for decision making related activities, the WorHOs officials were asked to state whether they could continue to implement all the HMIS/use of data for decision-making activities that IFHP had been supporting should the support end. Only 12 (36%) WorHOs reported that they would be able to continue with HMIS activities at the current scale with only their staff; another 10 (30%) reported that the scale of implementation would have to be reduced for them to continue with only their staff. Four (12%) WorHOs reported that they would have to seek support from other sources in order to continue with the implementation of HMIS/use of data-related activities. Five (15%) reported that they would stop implementation altogether. On whether they would be able to provide all the technical, financial, and logistical resources needed for implementation, a majority of the WorHOs were not yet in a position to bear the costs of implementation alone; 21 (64%), 22 (67%), and 24 (73%) WorHOs reported that they would not be able to provide the technical, financial, and logistical resources, respectively. The situation is compounded by the fact that almost half of those who reported inability to do it alone reported requiring substantial amounts of support in all these areas in order to sustain the implementation of HMIS/use of data activities.

3.3 Program Review Meetings (PRM) of Health Facility Performance

As stated in the background section, IFHP has provided technical and financial support for the implementation of PRM. And as for the other management approaches, Woreda Health Officers were asked questions regarding the potential of WorHOs to sustain the implementation of PRM, were IFHP support to end. Key findings on scope of implementation, IFHP support, and the potential of WorHOs to sustain implementation are detailed below. The data are presented in Table 3.3.

Frequency of Conducting PRM

It is recommended that WorHOs conduct PRMs on a quarterly basis. Over half (17; or 52%) reported doing so (see Table 3.3).

Type of Support Received from IFHP for PRM

Four types of support for PRM were identified: technical, financial, administrative, and logistics. Twenty-four (73%) WorHOs reported to have received technical support from IFHP. Financial support in the form of per diem was reported by 26 (79%), and transportation allowance was reported by 20 (61%). Twenty-two (67%) WorHOs reported administrative support in terms of making preparations for and organizing meetings, and 26 (79%) reported logistical support in form of helping to transport materials.

Support for PRM from WorHO Budget

One of the implementation elements used to assess the potential of WorHOs to sustain PRM was the availability of WorHO's financial resources for PRM. As for other management approaches, supporting the implementation of PRM activities from a WorHO's budget reflects some commitment and desire to own the management approach. Of the 33 WorHOs, 25 (76%) reported to have provided some financial support to the implementation of PRM.

Trend in WorHO Financial Contribution to PRM

Crucial to the issue of sustainability is the increased financial contribution of WorHOs to the implementation of PRM over time. Of the 25 WorHOs that responded to the question on financial contributions to PRM, 15 (60%) reported an increase in their financial contribution over time, and six (24%) reported that their financial contribution has remained the same.

WorHOs' Perceptions of their Ability to Sustain Implementation of PRM

The perceptions of the WorHOs regarding their ability to continue implementing PRM after IFHP end date also provide some insights into the potential of the WorHOs to sustain the implementation of PRM activities. Of the 33 WorHOs, only nine (27%) reported that they would continue PRM at the same frequency, using only WorHO staff, and 14 (42%) reported that they would continue PRM with reduced frequency. Three (9%) would continue PRM by seeking support from other partners, and two (6%) would try to continue PRM by seeking support from other partners and reducing frequency of reviews. Only four (12%) WorHOs would stop PRMs altogether.

Determining the readiness of the WorHOs to sustain the implementation of PRM activities becomes difficult in light of the response to the question about their ability to provide the technical, financial, and logistical resources required for implementation. While 27 (82%) WorHOs reported ability to assume all technical responsibilities, only 10 (30%) reported ability to bear the financial responsibilities alone. Nearly half (49%) reported having the ability to organize the meetings alone. The majority of WorHOs that reported an inability to implement PRM without IFHP support also reported that they needed only minimal support to implement the approach.

Table 3.3 Implementation of Program Review Meetings (PRM) of Health Facility Performance, including IFHP Support and WorHOs' Potential to Sustain Implementation

Frequency of conducting PRM	N=33
Twice per year	(21.2%) 7
Three times per year	(27.3%) 9
Four times per year	(51.5%) 17

Type of support received from IFHP	Technical (N=33)	Financial – Per diem (N=33)	Financial – Transportation (N=33)	Administrative-Coordination (N=33)	Logistics (N=33)
Yes	(72.7%) 24	(78.8%) 26	(60.6%) 20	(66.7%) 22	(78.8%) 26
No	(27.3%) 9	(21.2%) 7	(39.4%) 13	(33.3%) 11	(21.2%) 7

Ever supported PRM from WorHO Budget	N=33
Yes	(75.8%) 25
No	(24.2%) 8

Trend in WorHO financial contribution to PRM	Valid N=25
Reduced	(8.0%) 2
Remained the same	(24.0%) 6
Increased	(60.0%) 15
No Response	(8.0%) 2

What will happen to the PRM program if support from IFHP comes to an end	N= 33
Will continue PRM using only WorHO staff	(27.3%) 9
Will try to continue by seeking support from other partners	(9.1%) 3
Will continue with reduced scope/frequency	(42.4%) 14*
Will try to continue by seeking support from other partners & with reduced scope/frequency	(6.1%) 2
Will stop altogether	(12.1%) 4
Other	(3.0%) 1

Capability to conduct PRM with no support from IFHP	Technically N=33	Financially N=33	Logistically N=33
Yes	(81.8%) 27	(30.3%) 10	(48.5%) 16
No	(18.2%) 6	(69.7%) 23	(51.5%) 17

Of those who said No above, percent requiring minimal support:	N=6	N=23	N=17
Yes	(66.7%) 4	(65.2%) 15	(70.6%) 12
No	(33.3%) 2	(34.8%) 8	(29.4%) 5

Two woredas indicated reduced scale (not reduced frequency), but this was the most appropriate category for placement of these results.

3.4 Woreda Based Planning

In the four years preceding the assessment, IFHP provided some logistical and financial support to the implementation of the WBP. Below we highlight key features of the IFHP support to the implementation of WBP and the potential for WorHOs to sustain implementation beyond IFHP end-date. The data are presented in Table 3.4.

Type of Support Received from IFHP for WBP

Of the 33 WorHOs, 23 (69.7%) reported to have received technical assistance, 20 (60.6%) reported logistical support in terms of assistance to organize meetings, 19 (57.6%) reported financial assistance in terms of per diem to meeting participants, and 16 (48.5%) reported transportation allowances. Eighteen (54.5%) reported to have received administrative support.

Table 3.4 IFHP Support to Woreda Based Planning (WBP) and WorHO Potential to Sustain Implementation Beyond IFHP End Date

Type of support received by IFHP for WBP	Technical (N=33)	Financial – Per diem (N=33)	Financial – Transportation (N=33)	Administrative – Coordination (N=33)	Logistics (N=33)
Yes	(69.7%) 23	(57.6%) 19	(48.5%) 16	(54.5%) 18	(60.6%) 20
No	(30.3%) 10	(42.4%) 8	(51.5%) 17	(45.5%) 15	(39.4%) 13
Trend in IFHP financial support for WBP				**N=25**	
Reduced				(328.0%) 7	
Remained the same				(20.0%) 5	
Increased				(44.0%) 11	
Trend in WorHO financial contribution to WBP				**N=12**	
Reduced				(8.3%) 1	
Remained the same				(33.3%) 4	
Increased				(50.0%) 6	
No Response				(8.3%) 1	
What will happen to WBP if support from IFHP comes to an end				**N=33**	
WorHO will continue using only WorHO staff				(30.3%) 10	
WorHO will try to continue by seeking support from other partners				(9.1%) 3	
WorHO will continue using own staff but with reduced scope				(33.3%) 11	
WorHO will try to continue by seeking support from other partners and with reduced scope				(3.0%) 1	
Stop implementation altogether				(3.0%) 1	
Other				(21.2%) 7	

Trend in IFHP Financial Support for WBP

Not all WorHOs responded to the question on perceived trends in the financial contribution of IFHP to the implementation of WBP. Eleven (44%) of the 25 WorHOs that responded to the question reported an increase in the financial contribution of IFHP towards WBP; five (20%) reported that the contribution has remained the same. Although IFHP plans included scaling back some activities in some woredas over time, the WorHO responses were not systematically analyzed against these plans to gauge perception against actual provision of financial, administrative, and technical support. However, the perceptions helped to contextualize other responses.

Trend in WorHO financial contribution to WBP

Only 12 WorHOs responded to the question on perceived trends in their financial contribution to the implementation of WBP. Of these 12, six (50%) reported an increase while four (33%) reported that their financial contributions have remained the same.

WorHO's perceptions of their ability to sustain implementation of WBP

Lastly, the potential of the WorHOs to sustain the implementation of WBP was assessed through their perceptions of their ability to assume full responsibility for the implementation of WBP should support from IFHP come to an end. Ten (30%) WorHOs reported that they would be able to continue WBP with their own staff; 11 (33%) reported that the only way they could continue to implement WBP with only their staff would be to reduce the scope of activities; and three (9%) reported that continued implementation of WBP would be contingent on receiving support from other partners/organizations. Seven (21%) did not give any answer.

4. Management Practices in IFHP Non-Focus Areas: Implementation and Support for Implementation

To gain some insights into the implementation of the management approaches in woredas without IFHP support, IDIs were conducted with zonal officers overseeing program implementation in all woredas under their zones, including woredas where IFHP is implementing programs and those in which IFHP is not implementing programs. The information collected from the zonal officers regarding the implementation of the management approaches in IFHP **non-focus areas** is summarized below.

4.1 Integrated Supportive Supervision

ISS is implemented with support from several organizations, including IFHP, EngenderHealth, the United Nations Children's Fund (UNICEF), and the World Health Organization (WHO), to ensure effective monitoring and evaluation of the health-delivery systems. As indicated in the background section, ISS is supposed to be conducted quarterly, but due to resource constraints, most zones reported conducting ISS three times or twice per annum. In some exceptional cases, when there are important issues to resolve, ISS is conducted more regularly.

The zonal officers reported that only a small proportion of the staff had been trained to conduct ISS. Even though some training has been conducted, the training has often involved a small proportion of the entire health workforce. The trainings have often targeted senior-level health officers who are expected to transfer knowledge to lower-level workers. Due to lack of resources, the few health workers trained often fail to train other people, especially at the HC level. The other problem is high turnover among trained health staff.

Regarding use of standard ISS checklist (as per the government's guidelines), it was noted that not all woredas are using them. An officer from West Hararge Zone remarked:

Yes, the ISS is being implemented, but I do not think that all woredas are implementing as per government guidelines due to different problems. These problems are lack of capacity, high turnover of trained staff due to different reasons and other related factors.

A similar view was expressed by an informant from Gamo Gofa Zone:

Yes, the implementation of ISS should follow government guidelines. According to the guideline, ISS should be conducted quarterly. Although every woreda is conducting the ISS, there are differences in quality and frequency of implementation. There are strong woredas that conduct ISS strictly according to the guideline and some others that conduct ISS two or three times in a year. So, there are some variations among the woredas.

According to an informant from Sidama Zone, although there are no data to assess differences among woredas in terms of how ISS is implemented, it is "common knowledge" that woredas with support from IFHP are performing well in this area. For example, it was observed that in woredas supported by IFHP, the staff have good skill levels, and there are adequate medical supplies. It was also observed that IFHP-supported woredas conduct self-assessments before the zonal assessments. IFHP supports training for ISS, as well as providing transport, skilled staff, and materials to conduct ISS.

According to the informants/zonal officers, the sustainability of ISS is threatened by lack of budget support from core government funds. More than 90% of the Woreda Health Office budget goes to staff remuneration and very little, if any, is left for ISS. ISS has not been internalized as a core woreda activity in terms of budgeting, as most funding is provided by external organizations through the zonal health

department, or the MOH. Despite these logistical challenges, all zones recognize the importance of ISS in the general management of health services.

4.2 Use of HMIS Data to Inform Decision Making

It was reported that not all woredas have an HMIS committee. All zones reported that they have adopted the new HMIS (though at different levels of implementation). Some zonal officers remarked that the new HMIS is better than the old system as it does not permit staff at higher levels of the system to alter data received from lower levels of the system. Support for the new HMIS in the regions is predominantly from IFHP. Other key players are Tulane University, John Snow Inc., UNICEF, and Management Sciences for Health. Data are collected according to HMIS formats and reported monthly, quarterly, and annually. Some zonal officers noted that the new system is not working according to plan. For example, in Sidama Zone, it was noted that the plan is to have virtual access to data from lower levels but unfortunately, the internet connection is often not reliable. Consequently, respondents noted that data are not always accessed quickly enough for the decision-making process.

For IFHP-supported zones, trainings on HMIS, transport, and other essential materials are provided by IFHP. However, non-IFHP supported woredas usually experience a critical shortage, or lack of materials required to implement the HMIS. Many WorHOs have inadequate infrastructure for implementation of the HMIS and also lack trained staff to implement it due to low retention of trained staff. Some zones have embarked on the renovation or expansion of health offices to accommodate the new HMIS. Another challenge for the new HMIS is that it does not allow reporting of some indicators, that though required or essential, are not provided for in the reporting system. A parallel reporting system has to be created to capture these indicators, particularly those related to HIV and AIDS programs. According to one informant from East Shewa Zone:

A major challenge is that provisions are not made to report some essential indicators through the new HMIS…. For example, the new system does not have the information to know what type of family planning is used in the zone, thus limiting the ability to make decisions regarding FP methods. The old system had information on family planning by type of method; the current one does not.

Some zonal officers noted that HMIS is more likely than other management approaches to be sustained because it is less costly to implement once the relevant package has been installed. However, some zones expressed opinions that government may still require external support to fully operationalize and sustain the HMIS. For example, the informant from Sidama Zone expressed the following view when asked whether the zone was able to implement HMIS/use of data related activities without external support:

No, it is impossible for a zone to implement HMIS without external support. Imagine all the tools, training and other things required to implement it. The budget allocated to the WorHO is inadequate to meet the needs. In a given woreda there are about 11 health centers and within these health centers there are so many professionals. There are about 42 kebeles in each Woreda. In these kebeles, there are about 90 health extension workers. The budget is about 100,000 birr... How could it be possible to handle training for health extension workers and health professionals, distributing HMIS tools with only 100,000 birr[17] It is impossible.

4.3 Program Review Meetings

PRMs are implemented in all zones. The frequency of conducting PRM varies across zones, but most zones conduct their PRMs quarterly. However, owing to limited resources, some zones are unable to have quarterly meetings.. HEWs are poorly represented in these meetings in some zones, but there are plans to increase their participation.

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[17] 100,000 birr is about US $4,950.

IFHP and other partners support PRMs in terms of providing logistics and technical expertise as required. For example, in North Gondar Zone, IFHP contributes 50% of the PRM expenses. Other donors include WHO and UNICEF. Marie Stopes International has also supported PRM in East Shewa Zone, while West Gojam Zone has received external support from UNICEF and the Global Fund. When prompted about whether they would continue with PRMs without donor support, all zones disclosed that the meetings would continue, but some noted that the number of participants would be reduced:

If IFHP ends support to PRM, we will conduct the meeting, but we will reduce the duration of the meeting and ask only key participants to attend. But we wish that IFHP will continue to work with us as it is helping us more. Without IFHP support, we might be forced to reduce the duration of meeting and the number of participants who attend review meetings.

Some zones also mentioned that they have been holding some review meetings without donor support and that little would change if the donors stopped funding PRM:

For your information (and that might surprise you), this year we conducted almost all of the review meetings without any external support to the participants.. We didn't even give them water to drink…but this has its own limitation, we can't maintain it like this…

4.4 Woreda Based Planning

The WBP is primarily supported by the government through allocations to the regional health bureau. However, externally funded programs like IFHP provide some logistical and training support; the level of support or the degree of involvement of IFHP in WBP varies across zones. For instance, an informant from Arsi zone remarked that: *…..As a zone we don't receive any financial or logistical support from IFHP…we just involve IFHP as a partner in the planning process. WBP is fully funded by the regional health bureau.*

From West Hararge Zone came this remark: *Partners, mainly IFHP, provide financial and technical support for WBP. No budget from the government is allocated so far.*

In Gondar Zone, it was remarked that the annual work plans are drawn from the five-year work plan. The process starts with the development of the five-year plan, which is reviewed annually on the basis of the situation analysis at HC and health post levels. The five-year workplans are prepared based on three scenarios: (i) assumption that there is no financial support from partners; (ii) assumption that moderate support could be obtained; and (iii) the assumption that sufficient financial and material support could be attained. However, regardless of the level of support from external organizations, all zones stressed that WBP is based on data obtained from HCs and health posts. One informant added that data generated from performance reviews inform the setting of targets to ensure that they are attainable targets. Thus, a review of performance in the previous year on specific indicators is essential to setting future targets. An informant from Shewa East Zone observed:

Planning is a dynamic activity; it is wise to examine past achievements when developing current plans. For example, if you planned to achieve 100% delivery this year, but achieved below 10%, it is unwise not to take into consideration the level of achievement this year when planning for next year. It is good to assess prevailing conditions when planning for the future. You should inquire why only 10% was achieved this year…we may need to revise our plan. All these things should be considered.

There were concerns from West Shewa Zone that variations in the base performance month for kebeles can lead to distorted judgment about the performance of the woreda. There is, therefore, a need to harmonize the base performance months for all activities at all levels.

Regarding support for WBP, IFHP-supported zones receive transport, technical assistance, allowances (or per diems), and other materials towards the planning processes. For non-IFHP supported zones, resources for WBP come only from the regional health bureaus or the federal MOH; there is no budget for WBP at either zonal or woreda levels. In some cases, owing to limited resources, the number of days set for WBP is reduced from five to three. Some zones also reported that they have at times received support from Tulane University, UNICEF, and WHO towards the WBP processes. The support received from these organizations includes logistical and technical assistance. However, some zones were not able to mention external sources of support as some organizations support WBP through regional health bureaus or the MOH.

Regarding the ability to sustain the implementation of WBP in the absence of external sources of support, non-IFHP supported zones felt that they had already been undertaking WBP with minimal donor support. They felt that it was possible to sustain WBP in the absence of donor support as long as the budgeting processes are decentralized up to the woreda level. Currently, almost the entire woreda budget is for staff salaries.

5. Family Planning, Reproductive Health and Maternal Newborn and Child Health Outcomes in IFHP Focused Areas

This section examines selected family planning, reproductive health, and other health indicators in IFHP program woredas. The outcome indicators are presented by region and for all regions combined. As indicated earlier, this analysis is not intended to determine the effects of the management approaches on family planning and health outcomes. To do that, a more robust design would have to be executed that allows a comparison of health outcome indicators between areas where management approaches were implemented and those in which they were not implemented. In addition, it would be incorrect to assume that all improvements in health outcomes are due to IFHP management interventions; however, one might assert that IFHP contributed to these improvements. Consequently, this section merely provides a snapshot of changes in family planning and health outcomes in the IFHP supported areas during the implementation of the management approaches. Examining these changes will direct attention to service delivery issues that should be addressed in subsequent visits to the health facility and Woreda Health Offices.

Data used in this section were obtained from the annual random follow-up visits conducted by IFHP in its program areas between 2009 when the implementation of the management approaches started and 2012 when the assessment was conducted. Two random follow-up visits were conducted during this period, one in 2011 and the other in 2012. As the name suggests, the random follow-up visits were implemented in randomly selected woredas, PHCUs and households to monitor outcomes of health interventions, and they yield data that are generalizable to all IFHP program areas. The specific objectives of the random follow-up visits are:[iv]
- To generate representative data that can be used for generalization of the levels of health outcomes in program areas;
- To produce periodic data for assessing changes in outcomes;
- To assess whether some key health indicators have improved in the target areas since the start of IFHP to which the program is contributing; and
- To produce strategic information for program managers for informed decision-making.

The outcome indicators are selected from family planning, antenatal care, delivery, child immunization and HIV program areas. The household sample size in 2011 was 2,560, and in 2012 it was 2,503.

5.1. Family Planning Acceptance
A measure of family planning acceptance adopted in this assessment is the percentage of women, 15-49 years, using modern methods of contraception. Table 5.1 shows that in all the regions, use of modern methods of contraception increased between the first visit in 2011 and the second one in 2012. The percentage point increase was highest in Amhara (about 17%), followed by Oromia (12%), Tigray (6%), and SNNP (4%). Because we do not have comparable data from areas where IFHP was not implementing health programs, we could not determine how much of the change in modern contraceptive use was likely attributable to IFHP interventions. However, it could be stated with confidence that IFHP interventions contributed significantly to the improvements in family planning adoption in the program areas.

Table 5.1: Percent of women aged 15-49 years who are currently using a modern family planning method

Region	2011	2012
Amhara	35.2%	51.7%
Oromia	40.0%	52.4%
SNNP	41.7%	45.9%
Tigray	50.1%	55.9%
All	41.5%	51.6%

5.2. Antenatal Care

The indicator of antenatal care selected is the percentage of mothers with children aged 0-11 months who had four or more antenatal care visits to the health facilities. Table 5.2 shows that there were significant increases in the percentages of mothers who had four or more antenatal visits in Tigray (16%), Oromia (16%), and Amhara (11%). In SNNP, there was a slight decline, from 16% in 2011 to 14% in 2012. Overall, the data suggest that IFHP interventions, including the management approaches, have led to improved utilization of antenatal care services in most regions.

Table 5.2: Percent of mothers with children 0-11 months that had four or more ANC visits at Hospital/ HC/ HP/ Home by HEW

Region	2011	2012
Amhara	9.1%	20.4%
Oromia	8.7%	24.6%
SNNP	15.9%	14.3%
Tigray	40.0%	56.1%
All	16.6%	30.8%

5.3. Delivery by Skilled Attendant

The survival chances of a newborn and mother are often influenced by the skills and actions of the delivery attendant. Consequently, IFHP has supported the availability of skilled delivery attendants through training and has promoted their engagement during delivery through health education activities. Table 5.3 shows that in all the regions, a higher percentage of infants were delivered with skilled attendants in 2012 than in 2011. The increase was largest in Amhara (50%), followed by SNNP (39%), Tigray (26%), and Oromia (19%).

Table 5.3: Percent of children 0-11 months whose delivery took place at a Hospital/HC/HP/Home by HEW)

Region	2011	2012
Amhara	17.6%	67.7%
Oromia	8.5%	27.3%
SNNP	5.9%	44.8%
Tigray	35.6%	61.2%
All	14.6%	48.5%

5.4 Child Immunization

Two indicators of child immunization were selected. The first is the percentage of children, 12-23 months, who were fully vaccinated. Between 2011 and 2012, there were moderate increases in Amhara (4%), Oromia (8%), and Tigray (1 %), and a significant decline in SNNP (-12%; see Table 5.4.1).

Table 5.4.1: Percent of Children 12-23 months fully vaccinated

Region	2011	2012
Amhara	76.8%	80.8%
Oromia	73.1%	80.9%
SNNP	69.7%	58.1%
Tigray	91.5%	92.8%
All	77.0%	78.9%

The second indicator of child immunization is the percentage of children, 0-11 months, who had not received any vaccination. The expectation is that program activities to promote child immunization would lead to a reduction in the percentages of children not immunized. Table 5.4.2 shows that between 2011 and 2012, there were slight declines in Amhara, Oromia, and Tigray. In SNPP, program activities contributed to a significant decline in the proportion of children 0-11 not immunized.

Table 5.4.2: Percent of children 0-11 months who hadn't received any vaccination

Region	2011	2012
Amhara	21.9%	18.8%
Oromia	18.6%	14.6%
SNNP	27.8%	16.2%
Tigray	10.8%	8.5%
All	19.7%	14.8%

5.5 HIV

The selected indicator for HIV is the percentage of households with a pregnant woman in the past one year who was tested for HIV during pregnancy. Table 5.5 shows that in all the regions, there were significant increases, implying that IFHP activities are having desired effects on the HIV testing during pregnancy.

Table 5.5: Percent of households with a pregnant woman in the past one year who had tested for HIV during pregnancy

Region	2011	2012
Amhara	61.7%	74.1%
Oromia	59.6%	72.2%
SNNP	67.9%	81.2%
Tigray	83.2%	94.7%
All	66.7%	78.5%

The random follow-up surveys cover several health indicators that were not examined in this report. We only examined changes in a few outcomes related to family planning, reproductive health, and MNCH, in order to provide a general picture of changes that took place during the implementation of the management approaches. Although this data is only based on change over a one year period, it could be reasonably argued that IFHP efforts to improve the ability of service providers to use data to inform program activities, strengthen planning at the woreda level, improve service provision skills through integrated supervision and on-the-job technical assistance, and identify areas of strength and weaknesses through performance reviews and appropriate feedback contributed to the changes observed in health outcomes.

6. Summary and Recommendations

The primary goal of this assessment was to determine the ability of WorHOs to sustain the implementation of each of the four IFHP-supported management approaches beyond the end date of IFHP. Efforts were made to identify the conditions under which the WorHOs could continue implementing the approaches, and to collect data that directly and indirectly measure the ability WorHOs to sustain the implementation of these health system strengthening approaches after support from IFHP ends. The results from this assessment support the following conclusions.

Some capacity has been built in the different management approaches. A large number of WorHO staff have been trained on the different management approaches and the majority of these trained staff were still in the employment of the WorHOs at the time of the assessment. This finding implies that some level of capacity has been built among the WorHOs to implement the management approaches.

IFHP support to WorHOs varied slightly by management approach and type of support. The percentages of WorHOs reporting to have received IFHP support vary by management approach and by type of support. The assessment data show that not all WorHOs have received IFHP technical and/or financial support to implement each management approach. Nineteen (58%), of WorHOs reported to have received IFHP support in all four management approaches, and the data show that there was no WorHO that did not receive IFHP support in one or more management approaches. Regarding the type of IFHP support received, the data show that more WorHOs reported to have received technical than financial support.

The financial contribution of WorHOs increased over time. The majority of WorHOs that reported to have provided financial support to the implementation of the management approaches reported an increase in their financial contributions over time. The data suggest increased commitments of the WorHOs to the implementation of the management approaches.

WorHOs' perception of their ability to sustain the management approaches at the IFHP-supported scale varied by management approach. Only three WorHOs reported an ability to continue the implementation of all four management approaches with their own staff and resources should IFHP support end. Except for HMIS/data use for decision making, most WorHOs would "reduce scale of implementation and continue implementation with only staff/resources" as a response to graduation in order to sustain the implementation of the approaches. Given that only a few WorHOs considered discontinuing implementation as the only response to discontinued IFHP support, this suggests a level of commitment on the part of the WorHO heads to seek ways of sustaining the implementation of the approaches beyond IFHP. However, caution should be taken in interpreting these results as they represent perceptions offered during a survey in response to hypothetical questions.

Recommendations

The results from this assessment suggest that in order to determine more accurately the woredas that are ready for graduation, implementing partners should **develop a set of criteria to determine the readiness of a WorHO to graduate from further financial and technical support**, in consultation with USAID, the GOE, and the WorHO. Having worked with the WorHOs for the past five years, IFHP is in a position to work with other organizations and the woredas to establish these criteria. Graduation criteria should be a combination of factors that include a reasonably high level coverage in most of the program outcomes, the presence of a pool of trainers and trained staff to continue program activities, and the allocation of internal resources or ensuring of other external resources to continue the different management approaches.

It is also important to have a creative "vision" for graduation, which is not simply a punishment for a woreda which has achieved the minimum criteria. For example, perhaps sites which have graduated can be motivated to serve as learning sites for other woredas. The criteria and this vision can then be used to assess the capacity of WorHOs to sustain the implementation of the approaches in the future. Other recommendations include the following.

Engage stakeholders in early discussions about the scale of programs to be implemented and provide guidance on what they can do to make programs sustainable. The results from this assessment highlight the need to engage stakeholders at different levels in discussions about the scale of programs to be implemented and be guided on what they could do to sustain such programs. Several WorHO staff perceived the scale of the management approaches to be above their ability to implement without external support.

Develop a timetable for graduation, where possible. For the implementation of the management approaches, there appeared to be no timetable for this graduation process. Consequently, the WorHOs appear to be operating under the assumption that support from IFHP will continue for a few more years. Expectations regarding the role of district or community-level stakeholders in sustaining programs should be communicated to them early in the program by government, funding agencies, or implementing partners. If possible, a timetable for graduation of the WorHO should be developed and shared with affected WorHOs.

Ensure implementation standards for the management approaches are adequately defined and communicated to the WorHOs. It is important to ensure that implementation standards for the management approaches are adequately defined and communicated to the WorHO. A situation where implementation activities are reduced as a result of graduation, in order to be able to continue implementing the approach, might compromise quality. Reducing the scale of implementation might reduce positive effects on health outcomes.

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