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EVALUATION

Final Performance Evaluation of the Strengthening Ethiopia's Urban Health Activity

February 2019

This publication was produced at the request of the United States Agency for International Development. It was prepared independently by the Ethiopia Performance Monitoring and Evaluation Service (EPMES) of Social Impact, Inc., a USAID/Ethiopia Contractor.

FINAL PERFORMANCE EVALUATION

Strengthening Ethiopia's Urban Health Activity

February 2019

Evaluation Mechanism Number: AID-663-C-16-00010-EPMES

Ethiopia Performance Monitoring and Evaluation Service for USAID/Ethiopia Activity

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ABSTRACT

The United States Agency for International Development (USAID)/Ethiopia designed the Strengthening Ethiopia's Urban Health (SEUH) Activity to support the Government of Ethiopia's (GoE) Urban Health Extension Program (UHEP) by improving the quality of urban health services, strengthening referral linkages, building the institutional and technical capacity of regional health bureaus, and promoting intersectoral collaboration on urban health challenges. Using a mixed-methods approach, this final performance evaluation examines SEUH design, implementation, effectiveness, and sustainability. The evaluation findings and recommendations can guide the U.S. government in its allocation of resources to support UHEP.

Findings show that the design of SEUH was aligned with UHEP priorities—hygiene and environmental health; family health; disease prevention and control; and injury prevention and control, first aid, and referral services—and responded to most UHEP needs. However, SEUH's design lacked a strategy for the health needs of the homeless urban poor and of youth and adolescents and did not sufficiently address interventions for noncommunicable diseases (NCDs). SEUH's main contributions to supporting UHEP included human resource capacity building, quality improvement, demand creation, and regional platforms strengthening and establishing WASH platforms. SEUH contributed extensively to improving the health system for the housed urban poor and increasing the demand and delivery of health services. Except for the integrated refresher training of health workers which has been shifted to the government, the evaluation concluded that at the time of the evaluation, most of the SEUH strategies were not sustainable by the government without donor funding.

ACKNOWLEDGMENTS

The results presented in this report come from an endline evaluation of the SEUH Activity of USAID/Ethiopia. It was conducted by Social Impact (SI)-Ethiopia staff working under the Ethiopia Performance Monitoring and Evaluation Service (EPMES) Activity and hired consultants. The evaluation team expresses their sincere appreciation to various individuals who made significant contributions to the success of this evaluation. Special thanks go to Awoke Tilahun, Mission Monitoring and Evaluation Specialist of USAID/Ethiopia and EPMES Contracting Officer's Representative (COR) and Dr. Yosef Woldegabriel, SEUH COR, for their technical contributions to the evaluation design and the report. Furthermore, special thanks go to the staff of SEUH for their unreserved support of this evaluation, without which this evaluation would not have been successful. They freely shared the Activity documentation and databases, which were essential to the design and secondary analysis of the Activity results; helped the evaluation team with scheduling of interviews; and willingly participated as key informants during the interviews. The team is extremely grateful for the support received from the SI/Headquarters staff who provided operations and technical support to this evaluation. Special thanks go to Danae Roumis/SI Technical Director, who served as the Project Director for this evaluation; Tasneem Nahar/SI Program Director, for overseeing all operational needs of this evaluation; Mike Pressl/SI Senior Program Associate, who served as the Project Manager on this evaluation; and Nora Chamma/SI Senior Program Assistant, who, in addition to providing operational support, also worked with Mike Pressl to proofread and format this report. Special thanks also go to Bettina Kimpton/SI Copyeditor for her excellent editorial support. Finally, the evaluation team thanks all individuals who served as key informant and focus group participants. This evaluation would not have been successful without their participation.

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ACRONYMS

| | |
|-------|--|
| AAU | Addis Ababa University |
| AIDS | Acquired Immunodeficiency Syndrome |
| ANC | Antenatal Care |
| AWD | Acute Watery Diarrhea |
| C/THO | City/Town Health Office |
| CD | Communicable Disease |
| CDC | Centers for Disease Control and Prevention |
| CHIS | Community Health Information Systems |
| CI | Confidence Interval |
| CMBCC | Community Mobilization Behavior Change Communication |
| CoC | Certificate of Competency |
| COP | Chief of Party |
| COR | Contracting Officer's Representative |
| CPHT | Comprehensive Public Health Training |
| CTB | Challenge Tuberculosis |
| EDA | Emmanuel Development Association |
| EDHS | Ethiopia Demographic and Health Survey |
| EPMES | Ethiopia Performance Monitoring and Evaluation Service |
| EQ | Evaluation Question |
| FGD | Focus Group Discussion |
| FMoH | Federal Ministry of Health |
| FP | Family Planning |
| FY | Fiscal Year |
| GoE | Government of Ethiopia |
| HCT | HIV Counseling and Testing |
| HEW | Health Extension Worker |
| HIV | Human Immunodeficiency Virus |
| HMIS | Health Management Information Systems |
| HRH | Human Resources for Health |
| IEC | Information, Education, and Communication |
| IGA | Income-generating Activities |
| IP | Implementing Partner |
| IR | Intermediate Result |
| IRT | Integrated Refresher Training |
| ISS | Integrated Supportive Supervision |
| JSI | John Snow Inc. |
| KII | Key Informant Interview |
| LARC | Long Acting Reversible |
| LMG | Leadership, Management, and Governance |
| MCH | Maternal and Child Health |
| MEL | Monitoring, Evaluation, and Learning |
| MNCH | Maternal, Newborn, and Child Health |
| MoU | Memorandum of Understanding |
| NA | Not Applicable |
| NCD | Noncommunicable Disease |
| NGO | Nongovernmental Organization |
| PHCR | Primary Health Care Reform |

| | |
|-------|--|
| PHCU | Primary Health Care Unit |
| PMP | Performance Monitoring Plan |
| PMTCT | Prevention of Mother to Child Transmission |
| PNC | Postnatal Care |
| PPP | Public-Private Partnership |
| QI | Quality Improvement |
| RHB | Regional Health Bureau |
| RMNCH | Reproductive, Maternal, Newborn, and Child Health |
| SAM | Short Acting Methods |
| SBCC | Strategic Behavior Change Communication |
| SDR | Service Data Recording |
| SE | Standard Error |
| SEUH | Strengthening Ethiopia's Urban Health |
| SI | Social Impact, Inc. |
| SNNP | Southern Nations, Nationalities, and Peoples |
| TB | Tuberculosis |
| TOT | Training of Trainers |
| TWG | Technical Working Group |
| UHEP | Urban Health Extension Program |
| UHE-p | Urban Health Extension Professional |
| USAID | United States Agency for International Development |
| USG | United States Government |
| WASH | Water, Sanitation, and Health |
| ZHD | Zonal Health Department |

EXECUTIVE SUMMARY

EVALUATION PURPOSE AND EVALUATION QUESTIONS

This final performance evaluation of Strengthening Ethiopia's Urban Health (SEUH), conducted from August to December 2018, documents lessons learned about SEUH design, implementation efficiency, and sustainability of results. The evaluation was guided by the following four evaluation questions (EQs):

1. How relevant and practical were the design and implementation approaches of the United States Agency for International Development (USAID)-supported SEUH Activity in relation to the Government of Ethiopia's (GoE) Urban Health Extension Program (UHEP)?
2. To what extent were the USAID-supported Urban Health Extension Activity's implementation processes and strategies efficient?
3. What are the main contributions of the Activity to the strengthening of the GoE's UHEP?
4. To what extent are the SEUH Activity strategies and interventions sustainable?

In line with the discussions with USAID, question one examined the alignment of SEUH design and planned implementation approaches with the UHEP, question two analyzed implementation modalities and their efficiency, question three investigated the Activity results, and question four assessed the sustainability of SEUH strategies and interventions.

The primary users of this evaluation are USAID/Ethiopia, the Federal Ministry of Health (FMoH) and other GoE entities, implementing partners (IPs), and other donors involved/interested in supporting health services for the urban poor and vulnerable populations. The findings will guide decisions by the United States government (USG) on the allocation of resources in support of the GoE UHEP. The findings and recommendations can inform design and implementation of future similar activities, as well as broader intersectoral learning and collaboration with other stakeholders on improving the health of urban poor populations.

ACTIVITY BACKGROUND

USAID/Ethiopia designed the SEUH Activity to support the GoE's UHEP by improving the quality of urban health services, strengthening referral linkages, building the institutional and technical capacity of regional health bureaus, and promoting intersectoral collaboration on urban health challenges. SEUH supports the GoE's UHEP to improve the quality of community-level health services, strengthen referral linkages, build the institutional and technical capacity of regional health bureaus (RHBs), and promote intersectoral collaboration to address urban health challenges. SEUH is a follow-on Activity that builds upon the achievements and lessons from the prior activity implemented by John Snow Inc. (JSI) between 2009 and 2012. JSI implements SEUH in partnership with Addis Ababa University (AAU) and Emmanuel Development Association (EDA). SEUH was designed to achieve four intermediate results (IRs):

- IR1: Improved quality of community-level urban health services.
- IR2: Increased demand for facility-level urban health services.
- IR3: Strengthened regional platforms for improved implementation of the national urban health strategy.
- IR4: Improved sectoral convergence for urban sanitation and waste management.

Five strategies drove SEUH implementation of the SEUH Activity:

- Adapting implementation approaches to the urban context needs.
- Leveraging urban advantages, prioritizing challenges, and addressing these challenges incrementally.

- Strengthening health systems and building the capacity of the FMoH, the RHB, zonal health departments (ZHDs), and the City/Town Health Office (C/THO).
- Promoting intersectoral coordination, strengthening the link between the facility and community-based health programs, addressing the determinants of urban health and well-being, and promoting public-private partnerships (PPPs).
- Capacity building civil society and capitalizing on assets already in place.

EVALUATION DESIGN, METHODS, AND LIMITATIONS

The evaluation used a mixed-methods design involving document review, secondary data analysis, direct observation, key informant interviews (KIIs), and focus group discussions (FGDs). Documents reviewed included the activity description, progress reports, and any studies conducted on SEUH. Secondary data analysis was conducted on monitoring data collected by SEUH and Ethiopia Demographic and Health Survey (DHS) data. The evaluation team conducted 79 KIIs with federal and regional government officials (including the RHB staff), USAID, SEUH staff, and urban health extension professionals (UHE- ps). The team also conducted interviews with male beneficiaries in each evaluation site. Finally, 22 FGDs were conducted with female beneficiaries of SEUH living within the catchment areas of supported health facilities and with UHE- ps working with selected health centers.

KEY FINDINGS AND CONCLUSIONS

EVALUATION QUESTION 1: HOW RELEVANT AND PRACTICAL WERE THE DESIGN AND IMPLEMENTATION APPROACHES OF THE USAID-SUPPORTED SEUH ACTIVITY IN RELATION TO THE GOVERNMENT OF ETHIOPIA’S UHEP?

The SEUH was designed by USAID with the aim of directly supporting the FMoH’s UHEP. Findings from KIIs and a review of SEUH and UHEP design and implementation established that SEUH was aligned with the four UHEP priorities: (1) hygiene and environmental health; (2) family health; (3) disease prevention and control; and (4) injury prevention and control, first aid, and referral services. SEUH implementation approaches also responded to UHEP needs and supported the system-level needs of the RHBs, C/THOs, and health centers. Some SEUH capacity-building tasks, such as the integrated refresher training (IRT), were transitioned to the GoE, which suggests the feasibility of the capacity building component of the Activity design. The SEUH design provided for technical and materials support to the joint supportive supervision tasks of the RHBs and co-located staff in some RHBs and C/THOs.

Hygiene and environmental health. The SEUH’s design addressed this component through the Water, Sanitation, and Health (WASH) initiatives. The design emphasized information, education, and communication (IEC) and strategic behavior change communication (SBCC) strategy; community mobilization; capacity building; evidence generation and use; advocacy, and PPPs for sanitation and waste management. The design specified sectoral convergence as one of its key strategies for WASH but did not take into consideration the absence of government policy for bringing sectors together to implement WASH initiatives and to allocate resources. Stakeholders perceived that SEUH did not fully define the coordination and geographic coverage requirements for the implementation of hygiene and sanitation initiatives—whereas UHEP targets national coverage, SEUH used a gradual implementation process that reached only a few towns. Within the towns reached, the nature of support varied, with the focus on mobilization and capacity building. Furthermore, the SEUH design did not include funding for the procurement of logistical needs for UHEP hygiene and environmental health interventions. Additionally, the water initiatives were implemented in only two regions (Amhara and Tigray) out of seven, due largely to the withdrawal of WaterAid from the SEUH partnership.

Family health. UHEP priorities for family health programming included maternal and child health (MCH), nutrition, family planning (FP), youth and adolescent health, and immunization. The SEUH design

addressed these priorities in its provisions for capacity building and planning, supplies, and mobilization of communities and stakeholders. Although the youth and adolescent health is a priority of UHEP, the USAID design of SEUH did not include interventions for youth and adolescents. The SEUH design also did not explicitly specify avenues for creating linkages with other USAID activities and other stakeholders involved in nutrition programming. Specifying linkages with other USAID Activities in the design would have influenced SEUH to include relevant tasks in their implementation plans. Also lacking in both SEUH and UHEP designs was a plan to reach the homeless urban poor with health services. These design gaps were cited as weaknesses during the KIIs.

Disease prevention and control. The SEUH design addressed the system-level support needs of UHEP comprehensively, including support for capacity building and planning; developing and revising guidelines, tools, and job aids; providing supplies; and mobilizing communities and stakeholders. However, SEUH overemphasized support for communicable diseases (CDs) compared with support for noncommunicable diseases (NCDs). The supply of medicines and linkages for socioeconomic support are priorities for improving urban poor health conditions, but KII and FGD participants noted that the SEUH design did not address these needs explicitly.

Injury prevention and control, first aid, and referral services. The SEUH design focused on capacity building and planning, design and revision of tools and guidelines, and mobilization, but did not provide for supplies for injury prevention and control, which were essential needs of UHEP. The design also omitted support for establishing linkages between the public and private clinics and hospitals.

Conclusions

Overall, SEUH was relevant to UHEP priorities and was positively perceived by stakeholders but was not sufficiently practical in relation to the needs of UHEP and of the urban poor, which cut across NCDs, CDs, MCH, and injury control/prevention. These needs were only supported by SEUH to varying degrees. Support for NCDs was limited to improving UHE-p knowledge and skills about NCDs but did not address service delivery needs, which rendered the design less practical to the needs of UHEP and of the urban poor. Cancer, diabetes, epilepsy, and injuries were commonly cited in KIIs and FGDs as priority health problems among the urban poor, but SEUH support for these conditions was limited. SEUH, however, emphasized supporting MCH services technically and materially, which is consistent with the UHEP strategy. In addition, UHEP, and consequently SEUH strategies, target the urban poor living in a home setting and do not include strategies for meeting the health needs of the homeless poor—a significant gap in the UHEP implementation manual. The SEUH design also did not offer direct funding of system-level infrastructure costs, limiting implementation effectiveness because of the government’s persistent funding gaps. Additionally, while the design included support for hygiene and environmental health through the WASH initiative, the sectoral convergence approach suffered due to the lack of government policy for multisectoral involvement on WASH.

Despite these gaps, evaluation participants viewed the SEUH design favorably—from a systems-strengthening perspective, the SEUH design touched on all UHEP priorities, targeting capacity building, community and stakeholder mobilization, SBCC and IEC, and referrals. The evaluation team, therefore, concluded that SEUH’s systems approach, involving the gradual shifting of capacity building and system support to the government, is feasible. This view is justified by the evidence of GoE taking over some system-level capacity-building initiatives, such as the IRT.

Recommendations

UHEP’s various priorities require multiple sources and support mechanisms beyond USAID. The Water, Sanitation, and Health (WASH) sectoral convergence, for example, requires a very high level of government and donor support for advocacy and revision of sectoral policy guidelines. Such revisions should target improvements in urban planning to allocate dumping grounds for solid and liquid waste, resources for collection and removal of solid and liquid waste, and construction of WASH facilities.

Future activities should also include strategies for improving access to health services by the homeless urban poor.

The SEUH design put more emphasis on CDs, but the observations from this evaluation exposed NCDs as an equally significant health burden on urban poor populations. For this reason, future activities should include approaches for addressing both CDs and NCDs directly or by establishing viable linkages with other stakeholders. Furthermore, although several USAID-funded activities operate in urban areas, the SEUH design did not provide substantial guidance on avenues for coordination and collaboration with other IPs. Future activities should specify expected linkages between the follow-on Activity and other IPs, particularly those that directly support the delivery of health services.

EVALUATION QUESTION 2: TO WHAT EXTENT WERE THE USAID-SUPPORTED URBAN HEALTH EXTENSION ACTIVITY’S IMPLEMENTATION PROCESSES AND STRATEGIES EFFICIENT?

The evaluation team investigated the efficiency of SEUH implementation processes by examining coordination with other stakeholders and sectors and SEUH’s organizational structure. The team also examined SEUH implementation context and the specific activities SEUH undertook to create an enabling environment for efficient implementation.

Coordination. Evidence of strong coordination between SEUH and the FMoH, RHBs, C/THOs, and health centers was established. SEUH also coordinated with the members of technical working groups (TWGs) at national and regional levels—for example, the sanitation and hygiene TWG, Woreda Transformation TWG, and the health management information systems (HMIS) TWG. Within the health sector, SEUH co-located staff within government offices and provided direct support for government priorities and plans. It also facilitated the distribution of logistics, supported improvements in data recording and reporting systems, participated in joint supervision of the RHB, and supported RHB planning and review meetings. These approaches were instrumental in facilitating efficiency in SEUH coordination, particularly with health sector stakeholders. SEUH built capacity and empowered the FMoH, RHBs, C/THOs, and health centers to lead coordination efforts within their respective levels of authority. However, coordination with other sectors was inefficient because of the lack of a guiding policy, limited engagement of sector heads, high staff turnover, transfers of government staff, the view that UHEP was an activity of the health sector and prioritization of political issues due to ongoing political tensions. These factors affected the efficiency of SEUH in mobilizing support and resources from other sectors, and in implementing UHEP priorities.

SEUH organizational structure. SEUH’s staffing structure was aligned with the result areas and ensured that a technical expert was assigned to each result. SEUH established national and regional offices, but the staffing was technically much stronger and more diverse in the larger regions and cities (Addis Ababa; Amhara; Oromia; Southern Nations, Nationalities, and Peoples (SNNP); and Tigray) than in the smaller regions and city administrations (Dire Dawa and Harari). Cluster coordinators were co-located with the C/THOs and are a critical link between SEUH, towns and health centers, and the community but are overwhelmed by their scope of work and the vast geographic areas of responsibility. Some SEUH respondents suggested that the number of direct reports to the Chief of Party (COP) was numerous and felt that the regional managers reporting to the COP should be reconsidered.

Enabling environment. Several factors facilitated the creation of a positive enabling environment for SEUH and UHEP implementation. Findings from the KII and FGDs widely credited SEUH for using participatory processes and for providing direct support to the GoE UHEP priorities. SEUH reportedly emphasized empowering local stakeholders and strengthening documentation systems and guidelines. SEUH supported the revision of the UHEP implementation manual, for example, which helped to clarify the roles of the UHEP stakeholders. SEUH also helped to establish UHEP forums and platforms for the implementation of SEUH-supported initiatives.

Collectively, the structure of SEUH, coordination efforts, and activities geared toward creating an enabling environment resulted in several positive outcomes:

First, the revised UHEP implementation manual improved the delivery of SEUH technical assistance. Developed through consultative processes with the FMoH, RHB, and C/THOs, the manually created household categorization based on economic and health needs; reassigned UHE-p duty stations to health centers; defined roles, responsibilities, reporting structure, data recording, and reporting systems; and delineated supply chain guidelines. These elements also helped to improve UHEP implementation efficiency.

Second, SEUH helped to create the first-ever strategy of Ethiopia on urban hygiene and sanitation. This strategy was completed in consultation with seven line-ministries and signed by participating ministries. A memorandum of understanding (MoU) and joint action plan were also developed and signed by the sector offices.

Third, SEUH support resulted in the development of data recording and reporting tools for UHEP that enabled systematic collection and reporting of UHEP service statistics, increasing the visibility of the UHE-p work and results at the health centers and RHBs. Recognizing the value from these data, some health centers started to fund the costs of reproducing data collection and reporting tools using the retained health center revenues.

Fourth, SEUH conducted training of trainers (TOT) in each region. These trainers served as regional resources for cascading the comprehensive public health training (CPHT) and IRT of UHE-ps, a task which was rolled out by the government. Additionally, through participatory processes and improved availability of guidelines, tools, and job aids, SEUH strengthened the capacity for supportive supervision and social mobilization by the RHBs, C/THOs, and the health centers.

Despite these positive outcomes, some barriers to implementation efficiency remained. The need for multisectoral involvement to handle UHEP's overlapping activities was a significant challenge—for example, the multiple needs for WASH implementation (dumping grounds, space for construction of latrines, education) affected implementation efficiency because of coordination and cross-sectoral resource allocation issues. Also, political upheavals, high staff turnover in government offices, and low engagement of the office heads created a poor environment for implementation. Respondents also observed that unplanned additions to SEUH scope during implementation impeded efficiency, such as support for acute watery diarrhea (AWD) and the Primary Health Care Unit (PHCU) approach of the FMoH. Additionally, UHE-p working conditions and motivation were pointed out as challenges to implementation efficiency and sustainability of results due to the high turnover of UHE-ps. Last, the lack of a clear strategy for meeting health needs of the homeless urban poor limited the efficiency of service delivery for this group, and the high mobility of this group made it difficult to undertake follow-ups of referrals and defaulter tracking.

Conclusions

SEUH efficiency was evident mostly in its work with the FMoH, RHBs, C/THOs, and the health centers. Co-location of staff within government offices and direct support to the priorities and plans of the government improved SEUH efficiency because it allowed the cluster coordinators to participate in joint supportive supervision and other UHEP activities undertaken by the RHB. SEUH emphasized building the capacity of the local stakeholders, which inculcated a sense of ownership and fostered implementation efficiency by establishing a pool of trainers at the regional and federal levels. These trainers were used both by the GoE and by SEUH to cascade the training to the regional levels. However, significant challenges to efficiency included poor multisectoral coordination, political instability, high staff turnover and transfers in government offices, and low engagement of the sector office heads. These factors affected not only implementation efficiency but also SEUH's contribution to the UHEP priorities (discussed in Evaluation Question 3).

One of the main milestones of the SEUH implementation was their facilitation of the FMoH efforts to establish the first-ever urban hygiene and sanitation strategy of Ethiopia and the signing of MoUs with line ministries. This achievement laid a solid foundation for the implementation of cross-sectoral interventions for improving urban hygiene and sanitation.

Recommendations

Future activities should continue to strengthen the capacity of government offices to lead UHEP implementation. The alignment of the SEUH design with the government UHEP priorities increased SEUH efficiency because of their direct support to the GoE interventions. Similarly, participatory implementation approaches contributed to SEUH efficiency. Therefore, future activity designs should, to the extent possible, ensure alignment with GoE strategies and apply participatory implementation approaches. The lack of a guiding policy for intersectoral convergence for WASH is a significant limitation that should be addressed in future Activities. While the line ministries have endorsed a strategy on urban hygiene and sanitation, and have signed MoUs, steps to ensure the implementation of the strategy and the MOUs and monitoring are required.

EVALUATION QUESTION 3: WHAT ARE THE MAIN CONTRIBUTIONS OF THE ACTIVITY TO STRENGTHENING OF THE GOE'S UHEP?

SEUH's contributions to improvements in quality, management, demand, and utilization of health services are summarized below.

Quality improvement. SEUH supported GoE efforts to increase the number and technical competencies of UHE-ps through pre-service and in-service training; leadership, management, and governance (LMG) training; and strengthening capacity for home-based screening for CDs and NCDs. SEUH provided support for the training of 1,928 UHE-ps and 2,263 government officials on CPHT and IRT. Additionally, 1,067 health professionals received LMG training facilitated by SEUH. The LMG training improved the capacity of some urban health teams to improve quality and revenue generation through better leadership, management, planning, and monitoring.

The evaluation team observed good UHE-p data recording and documentation practices, and the use of data for decision making was evident at all evaluation locations (national and regional). For example, in all locations visited, UHE-ps reported using community profile information to target beneficiaries. The evaluation team reviewed routine UHEP reports that were shared up to the RHB level. There were several accounts of UHE-ps using service records to track defaulters and return them to care.

SEUH provided technical and material support for pilot testing of the PHCU initiative, service data recording, the establishment of quality improvement (QI) teams in a sample of health centers, and strengthening the client referral system. Though not universal, the QI team's approach reportedly resulted in improved linkages and coordination between the health centers and UHE-ps. Key informants also noted that referrals by UHE-ps have increased due to the improved linkages and coordination between the UHE-ps and the health centers and the effective tracking of defaulters. Increased use of child vaccination services, FP, antenatal care (ANC) and postnatal care (PNC) services were reported in the FGDs and KIs and was confirmed by the service statistics on referrals. Between 2015 and 2017 (years with complete data), women who were referred for ANC/prevention of mother-to-child transmission (PMTCT) of HIV services in all supported regions increased from 4,172 to 11,065; and the number of children referred for immunization increased from 7,028 to 12,730. Referrals for other services also increased—during the same period, the number of individuals referred for HIV/tuberculosis (TB) services increased from 4,034 to 8,467; MCH/FP client referrals increased from 3,937 to 8,434; and facility delivery referrals increased from 546 to 1,108.

SEUH assisted FMoH and the RHBs technically and logistically to develop and, in some instances, to revise referral slips, registration books, and defaulter tracing strategies. On a small scale, SEUH also

supported the renovation and furnishing of UHE-p offices. In the towns and city administrations that received support with pilot-testing of the PHCU approach, improvements in access to the health services were reported and confirmed by the service statistics. The evaluation team established that tracking and completion of referrals, better follow-up, and continuity of care for clients receiving routine services improved, and a robust transfer of skills among the team members resulted from the PHCU. The motivation of UHE-ps and their acceptance by the communities was also reported to have improved because of their working alongside the more senior health center staff.

Strengthening UHE-p management structures. SEUH provided technical and material support for the revision of the UHEP implementation manual, which standardized planning, implementation, and monitoring approaches for UHEP. Before the revision of the manual, variations were reported to have existed in the implementation approaches of regions, primarily because of the lack of standardized job aids and operational procedures.

Improving UHE-p motivation. SEUH applied nonfinancial incentives to motivate UHE-ps. Examples documented by the evaluation teams include preservice and in-service training opportunities; performance-based recognition; distribution of umbrellas, desktop computers, and office supplies; renovation of UHE-p duty stations in the kebeles and health centers; and ensuring constant availability of job aids, tools, and guidelines. Most of the participants in the UHE-p FGDs were pleased with these motivational interventions of SEUH but wanted salary raises and a defined strategy for career progression.

Demand creation. SEUH supported demand creation efforts aimed at increasing the use of facility-level reproductive health (RH), family planning (FP), human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS), MCH, and preventable CD services. Specifically, demand creation strategies included IEC and SBCC, and PPPs with media institutions to air the SEUH-supported messages. Community mobilization campaigns, such as community health days, hand washing days, pregnant women conferences, breast cancer walks, HIV catch-up campaigns, and African Child Days were also undertaken. The demand creation initiatives helped to improve UHE-p mobilization capacity and skills. SEUH established PPPs with public media, thereby leveraging resources as the media houses ran the SBCC and IEC messages at no cost to SEUH.

Regional platforms. SEUH conducted management training, facilitated learning, and experience-sharing events and trips and provided technical support to build the institutional capacity of RHBs, C/THOs, and health centers. Additionally, SEUH invested in evidence generation and promoted a data-use culture. SEUH support was also instrumental in strengthening the UHEP commodity supply and distribution system and in distributing toolkits, registers, and guidelines for the UHE-ps. Some key informants stated that cluster coordinators helped with the delivery of commodities, toolkits, and service delivery aids to the C/THOs, who then supplied them to the health centers to supply to UHE-ps.

Sectoral convergence for urban sanitation and waste management. SEUH worked to create partnerships and to foster political will. Capacity building, evidence generation and use, and technical and financial support were conducted to promote intersectoral collaboration and commitment to supporting WASH initiatives. Furthermore, SEUH conducted an assessment of the private sector to gauge the potential for engaging in urban sanitation and waste management services. The findings were used to establish a PPP implementation guide and alternative PPP business and management model. SEUH facilitated the development and signing of an integrated urban sanitation and hygiene management strategy and supported the RHBs to cascade and customize the strategy to their regional contexts. As previously mentioned, SEUH's performance on sectoral convergence was poor—SEUH lacked a structure for coordination and collaboration across sectors, and the commitment of the sectors to implementing WASH initiatives was poor.

Gender. In line with UHEP strategy, more support was rendered to health services for women and children than to services for men. Under the IRT, however, SEUH trained UHE-ps on gender-sensitive programming. Data collection tools were also designed to capture gender-based dimensions in UHEP implementation. SEUH implemented income-generating activities (IGAs) with women, on a small scale. In Kemisie, for example, SEUH worked with the THO to establish an IGA for a group of women living with HIV, where the beneficiaries run the operations of the public toilets built with support from SEUH.

Conclusions

SEUH contributed to the increasing availability of human resources for health (HRH) through CPHT, IRT, and LMG training. These pieces of training strengthened the competencies of the UHE-ps and their managers as demonstrated by the observations from KIIs and FGDs and the increase in uptake of UHE-p services. Based on the qualitative evidence, the QI initiatives of SEUH have succeeded in improving skills, the use of recording and reporting tools, referrals, and defaulter tracking. The evaluation team established evidence of data use for planning, supervision, and implementation monitoring and improvement at different levels of UHEP implementation, which likely motivated improvements in data collection and reporting. The successful PPP between SEUH and media entities resulted in cost savings to SEUH but most importantly demonstrates the viability of leveraging resources through non-cash contributions from private sector entities. SEUH's performance on sectoral convergence was, however, weak, due primarily to the lack of a formal structure for multisectoral coordination and collaboration, which was outside of the direct control of SEUH. Frequent transfers of staff in government offices and the shortage of WASH specialists in SEUH due to the withdrawal of the WASH sub-partner also affected intersectoral convergence outcomes negatively.

Recommendations

SEUH helped to create reliable systems for data collection, reporting, and use, which have taken effect in UHEP. SEUH played the lead role in analyzing and facilitating discussions on the UHEP monitoring data. To ensure sustainability, future activities should strengthen the capacity of specific government offices at the RHB and C/THO to analyze, convene, and lead the dissemination and data use efforts. Intersectoral convergence is a challenging task that requires higher-level government involvement. While the SEUH could undertake advocacy efforts, the GoE should develop formal guidelines for intersectoral engagement in urban WASH initiatives. Related to PPP, the model applied by SEUH with media entities was a success. Future activities should map UHEP priorities against the private sector companies in the implementation locations and identify possible non-cash contributions of such companies to UHEP results.

EVALUATION QUESTION 4: TO WHAT EXTENT ARE THE STRENGTHENING ETHIOPIA'S URBAN HEALTH ACTIVITY STRATEGIES AND INTERVENTIONS SUSTAINABLE?

SEUH sustainability strategies, embedded in each IR, aimed to strengthen the capacity of the FMoH, RHB, and C/THO to implement UHEP successfully. Evaluation results show that the following SEUH components are most likely to be sustainable:

- IRT because the FMoH has allocated funding for cascading refresher training.
- Health center capacity to supervise UHE-ps because the skills and tools have been developed and the structure for UHE-p supervision is now well defined within the scope of the health centers.
- Production and distribution of tools and guidelines, but evaluation participants opine that the quality will decline.
- Though still in infancy, the integrated urban sanitation and hygiene sanitation strategy has been endorsed, with UHEP positions now included in the human resources

structure and paid by the FMoH. These positions will remain part of the FMoH staffing structure.

- Implementation of the PHCU reform will continue because it is a component of the broader primary health care reform (PHCR) strategy of the FMoH. Thus, UHE-p mentorship and support will continue because it is fully integrated into the FMoH strategy.

There are multiple potential challenges to the sustainability of SEUH strategies. Resource limitations are the main challenge. Service delivery and quality improvement require the commitment of more financial and material resources for interventions such as logistics, supervision, and training. Second, the lack of a policy backbone for intersectoral collaboration was also a significant limitation to the success of the intersectoral work on WASH. Third, poor coordination between the training institution and RHB was reported, which resulted in low enrollment for the next generation UHE-p training.

Conclusions

Most of the SEUH results are far from being sustainable due to resource limitations. For the results that are reportedly sustainable, the quality will be lower unless donor support continues. Furthermore, although the urban health strategy and MoU have been signed with line ministries, these are still new, and there is no means to enforce implementation. Unless revisions are made to sectoral policies and guidelines to mainstream and provide resources for WASH, the intersectoral interventions will not be sustainable. Additionally, as mentioned in Evaluation Question 3, the UHE-ps are not motivated enough. Unless their concerns about poor pay and career progression are addressed, UHE-p turnover will likely continue to be high.

Recommendations

The evaluation team recommends planning timely and efficient strategies for the supply of commodities to work toward sustainability of SEUH results. Otherwise, UHEP will not be able to match the growing demand for urban health services. A future activity should support the government with increasing the understanding of the roles of different sectors in urban WASH initiatives and establishing policy guidelines and resource commitments to support urban WASH priorities in support of intersectoral coordination. Furthermore, because the support for system-level improvements appears promising—given evidenced government ownership of initiatives such as IRT—future initiatives should continue supporting system improvements.

EVALUATION PURPOSE AND EVALUATION QUESTIONS

EVALUATION PURPOSE

The United States Agency for International Development (USAID)/Ethiopia Strengthening Ethiopia's Urban Health (SEUH) Activity supports the Government of Ethiopia (GoE) Urban Health Extension Program (UHEP) in its effort to improve the quality of urban health services, strengthen referral linkages, build institutional and technical capacity of regional health bureaus, and promote intersectoral collaboration on urban health challenges. This final performance evaluation of SEUH, was conducted from August to December 2018. It documents lessons learned about SEUH design, implementation efficiency, and sustainability of results.

EVALUATION QUESTIONS

This evaluation investigated four evaluation questions (EQs):

1. How relevant and practical were the design and implementation approaches of the USAID-supported SEUH Activity in relation to the GoE's UHEP? *(The purpose of this question was to examine the extent to which different components of the Activity such as health service quality improvement, demand creation, capacity building, and sanitation/waste management were aligned with the GoE's urban health extension program priorities and to assess how the Activity was perceived and valued by stakeholders in terms of changing the design into practice).*
2. To what extent were the USAID-supported Urban Health Extension Activity's implementation processes and strategies? *(To answer this question, the evaluation team examined the strategies/approaches used to coordinate the implementation of the activity with the GoE at different levels and whether those strategies/approaches were flexible to adapt to changes, created enabling environment for coordination, and effective for the timely implementation of activities).*
3. What are the main contributions of the Activity to the strengthening of the GoE's UHEP? *(This question was used to determine how the Activity interventions supported the GoE efforts under the UHEP, e.g., resourcing, capacity building; service delivery; mobilization, evidence generation, tools, and guidelines).*
4. To what extent are the SEUH Activity strategies and interventions sustainable? *(This evaluation question was used to answer whether the Activity strengthened organizational capacity of City/Town Health Offices [C/THOs], regional health bureaus (RHBs) and the Federal Ministry of Health [FMoH] to plan, implement and monitor UHEP, has put a strategy in place to ensure sustainability of its intervention efforts/ensure government ownership, and identify ways that could further strengthen regional platforms to ensure sustainability).*

The primary users of this evaluation are USAID/Ethiopia, the FMoH and other GoE entities, implementing partners (IPs), and other donors involved/interested in supporting health services for the urban poor and vulnerable populations. The findings will guide decisions by the United States government (USG) on the allocation of resources in support of UHEP. The findings and recommendations can also inform design and implementation of future similar activities, as well as broader intersectoral learning and collaboration with other stakeholders on improving the health of urban poor populations.

ACTIVITY BACKGROUND

ACTIVITY CONTEXT

Ethiopia is currently experiencing one of the fastest rates of urban growth in the world. According to World Bank estimates, Ethiopia's cities are growing faster than the country, at 3.8 percent versus a national 2.5 percent growth (2010–2015). A USAID-funded analysis conducted by the Institute for Security Studies (ISS) under a subcontract with Social Impact, Inc. (SI) found that Ethiopia's urban population has more than tripled since 1991, growing from 6.4 million in 1991 to approximately 19 million in 2017 (Donnenfeld et al., 2017). This growth represents an average growth rate of about 4.7 percent during that period. The same analysis found that urban population growth is expected to continue and that close to 39 million people, or 26 percent of the population, will be living in urban areas by 2030. In urban areas, poverty and inequality are rising sharply. Urban areas in Ethiopia are under-resourced to address the health needs of the approximately 20 million people currently residing in them, and there is a continuous stream of new people migrating to these areas seeking health care and employment.

Urban residents have more opportunities than rural residents to access public services, a wide variety of employment prospects, and social and community networks. Despite these advantages, a high number of urban dwellers face hardships and inequalities accessing health care, education, and social services; adequate housing, water, and sanitation; and appropriate and adequate food supply. For the most part, urban populations do not produce their food but rely on purchasing food for their nutritional needs. With their limited income, this leaves poor urban populations suffering from poor nutrition. Furthermore, rapid urban population growth has placed an enormous strain on urban planning, necessary service systems, and the development of critical infrastructure. Overall, infrastructure and systems have failed to grow or adapt to keep pace with the rapidly growing needs of the population despite evidence of a declining proportion of urban dwellers living in slum housing. (Recent United Nations-Habitat data [2016] show that the percentage of urban dwellers living in slum housing declined from 95 percent in 1990 to 76 percent in 2009.)

Although the health situation in urban areas, in general, is considerably better than in rural areas, the urban poor continue to be at a disadvantage. The results of the 2016 Ethiopia Demographic and Health Survey (EDHS) show that 21 percent of births among urban women were not delivered in a health facility. Thirty-two percent of urban women do not have antenatal care (ANC) visits until their second trimester, and during ANC services, only 34 percent of urban women are informed about the signs of pregnancy complications. Fifty-five percent of urban women still deliver at home, and only 32 percent receive postnatal care (PNC) in the first two days after labor. Neonatal mortality in urban areas is similar to that in rural areas (41 vs. 43 per 1,000 live births). Only 28 percent of urban children suffering from diarrhea get oral rehydration salts (ORS) and support for continued feeding. There remains an unacceptably high prevalence of stunting among urban children (31 percent urban vs. 46 percent rural). Given these statistics, the situation among poor urban women is expected to be even worse.

Approximately 80 percent of the urban populations live in slums characterized by substandard housing and a lack of basic sanitation, services, and infrastructure. Eleven percent of the urban population still accesses drinking water from non-improved sources, while only 14 percent of urban households have access to an improved toilet facility. Health statistics specific to slum dwellers in urban areas are not well documented. Urban health statistics may not portray the health of the urban poor due to the mix of wealthy and poor neighborhoods nearby, and in-depth analysis by socioeconomic status has not to date been carried out using EDHS data.

In 2009, the GoE developed the UHEP, an innovative plan to ensure health equity by creating demand for essential health services through the provision of health information at a household level and access

to services through referrals to health facilities. UHEP is an explicit part of the GoE's Health Sector Development Plan IV. To address the health services crisis and communicable disease epidemics in urban Ethiopia, the GoE has recognized the need to improve outreach efforts through the introduction of a skilled and rapidly deployable cadre of health workers, the urban health extension professionals (UHE-ps).

ACTIVITY OVERVIEW

The USAID/Ethiopia SEUH Activity is a \$19,999,743 five-year activity awarded to John Snow Inc. (JSI) with an award # AID-663-A-13-00002 and implemented by the same in partnership with Addis Ababa University (AAU) and Emmanuel Development Association (EDA). The Activity is implemented in 49 towns in Amhara, Harari, Oromia, Southern Nations, Nationalities, and Peoples (SNNP), and Tigray regions as well as the two city administrations of Addis Ababa and Dire Dawa. The program has the potential to benefit approximately 2.6 million people, representing about 13.7 percent¹ of the urban population. SEUH implementation began in June 2013 and will close out in March 2019. It is a follow-on to the previous USAID/UHEP Activity, also implemented by JSI, between 2009 and 2013.

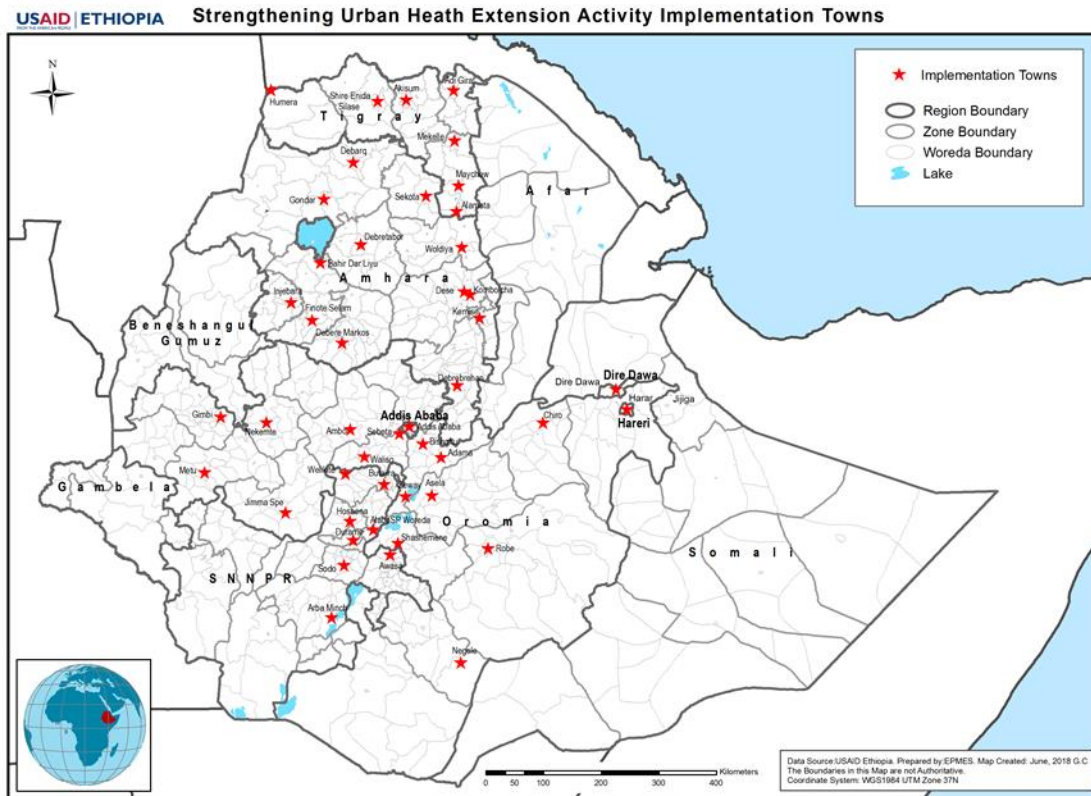
SEUH aims to support the GoE UHEP, which aims to expand access to crucial health services to vulnerable populations in urban centers throughout the country through the deployment of nurses who act as UHE-ps in urban communities. SEUH's goal is to strengthen the UHEP system to make essential HIV; tuberculosis (TB); maternal and child health (MCH); solid and liquid waste management services; and water, sanitation, and hygiene (WASH) available at the household and community levels.

SEUH implementation towns and city administrations are listed below and are also shown in Figure 1 (47 towns and two city administrations).

- Addis Ababa Administration (Akaki Kality, Arada, Yeka, Nifas Silk Lafto, Kolfe Keranio)
- Amhara (Bahir Dar, Gondar, Dessie, Debre Markos, Debre Tabor, Debre Berhan, Injibara, Finote Selam, Woldiya, Kemisie, Debark, Sekota, Kombolcha)
- Oromia (Adama, Jimma, Nekemte, Shasheme, Bishoftu, Assela, Sebeta, Bale Robe, Wolliso, Batu/Ziway, Metu, Ambo, Negelle, Chiro, Gimbi)
- SNNP (Hawassa, Wolaiyta Sodo, Arba Minch, Hossana, Wolkite, Hallaba, Butajira, Durame Boditi, Yirgalem)
- Tigray (Mekelle, Shire, Adigrat, Axum, Maychiew, Humera, Alamata)
- Harari (Harar)
- Dire Dawa Administration

¹ The calculation is based on an estimated urban population of 19 million in 2017.

Figure 1: Geographic Locations of SEUH Implementation



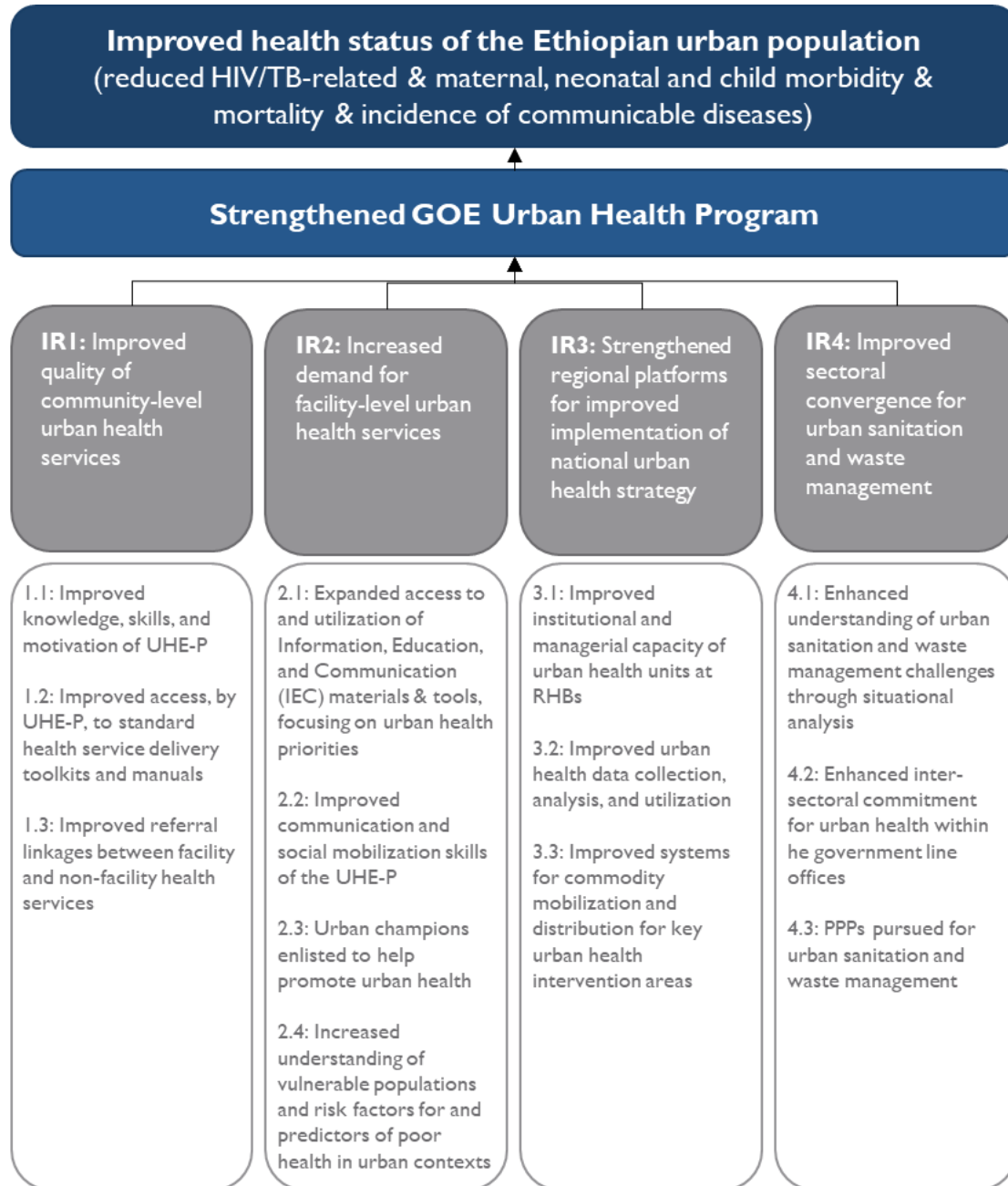
SEUH helped GoE improve the quality of community-level health services by strengthening referral linkages, building the institutional and technical capacity of RHBs, and promoting intersectoral collaboration to address urban health challenges. SEUH capacity-building activities targeted various levels of government office staff, including FMoH, RHBs, C/THOs, health centers, UHE-ps, and UHE-p supervisors. Although neither USAID nor the IP has modified the program or budget, FMoH has redesigned some UHEP components since SEUH started—specifically, the urban health service packages, the role of UHE-ps, and training and capacity-building modalities. FMoH made these changes to better respond to the complexity of urban-based causes of morbidity and mortality, with a focus on urban slums in the federal and regional cities and towns. FMoH decided to replace the enrollment requirements for UHE-ps (nurses) with those for generic professionals and began enrolling qualified students who finished high school in a three-year training program. Following FMoH’s decision to pilot-test a family health team approach to providing care at the community level, FMoH also asked SEUH to support the establishment of a family health team at one of the health centers in Addis Ababa. Under this support, a team of three to four health workers (a health officer or BSc nurse, a diploma nurse, and the UHE-p) would go out to the community as a team to provide expanded preventive and curative community-level care.

THEORY OF CHANGE

The theory of change guiding SEUH posits that if the GoE’s UHEP is strengthened through increased quality, usage, and management of community-level urban services, then the health status of the Ethiopian urban population will be improved.

SEUH is designed around a results framework that shows how it will contribute to strengthening the GoE's urban health program, which will eventually to improve the health status of the Ethiopian urban population. There are four intermediate results (IRs), each with a set of sub-IRs, as depicted below.

Figure 2: SEUH Results Framework



CRITICAL ASSUMPTIONS

The SEUH monitoring, evaluation, and learning (MEL) plan lists four critical assumptions for achieving the expected results:

- I. The FMoH and RHBs/zonal health departments (ZHDs) will continue to provide support and funding for the SEUH Activity comprehensive plan, and other

- contextual factors such as the political and economic environment in the country will remain stable.
2. SEUH Activity maintains excellent and professional relationships with key players and organizations, developed through implementing and working very closely with the FMoH and RHBs/ZHDs on the USAID/UHEP Activity.
 3. Current GoE policies and procedures remain substantially unchanged during SEUH Activity implementation.
 4. There will not be a drastic increase in the attrition rates to the extent that will affect the availability of the workforce to implement UHEP. SEUH Activity assumes that the investment of the program on the provision of skills development and transfer through in-service training and mentoring will not be affected by high attrition.

EVALUATION METHODS AND LIMITATIONS

This evaluation employed a mixed-methods design, which included document review, primary qualitative data collection involving key informant interviews (KIIs) and focus group discussions (FGDs), direct observation data records, WASH interventions and UHE-p duty stations, and secondary analysis of project monitoring data and the EDHS surveys of 2011 and 2016. The application of each method is described in detail below. Additionally, in Annex II, an evaluation design matrix shows how each method was used to answer applicable evaluation questions.

DOCUMENT REVIEW

Several documents were reviewed to generate evidence on SEUH performance. In 2013 and 2014, as a component of the design of SEUH implementation approaches and priorities, several assessments were conducted. The GoE also organized focused benchmarking and experience-sharing visits to other developing countries implementing urban health programs. These and several other documents were reviewed to establish evidence related to the activity design, implementation, and progress toward expected results and lessons learned during implementation. The following essential documents/categories of documents were reviewed:

- Activity Cooperative Agreement and technical proposal
- SEUH Activity Monitoring, Evaluation, and Reporting (MER) Plan
- Indicator tracking sheet (Performance Monitoring Plan, PMP); 2013–2018
- SEUH Activity Annual workplans
- SEUH Activity Quarterly, Semi-Annual, and Annual Activity Reports
- Training materials and reports
- Routine performance monitoring reports
- SEUH Activity studies and assessments on the Ethiopian urban health context, including but not limited to Human Resources Management Assessment; Service Quality Assessment; Public-Private Partnership (PPP) Rapid Assessment; Formative Behavior Change Communication Assessment; Analysis of UHE-p core functions; Situation Analysis of Urban Sanitation and Waste Management; Vulnerability Study
- FMOH strategy documents and revised health service guidelines for UHEP
- SEUH Activity technical assistance inputs (manuals, guides, tools, action plans)
- Any internal or independent evaluations or data quality assessments (DQAs) done on the UHEP or SEUH Activity, or Ethiopia's UHEP, for background and context
- A brief external literature review focusing on analyses of urban populations' health status in Ethiopia, Ethiopia's UHEP, or best practices in other urban health extension programs, to properly situate the evaluation design, data collection approaches, and results

PRIMARY DATA COLLECTION

Primary data were collected through KIIs with the SEUH implementers, GoE counterparts at various levels (federal, regional, city/town, and health center), USAID/Ethiopia, and other health and non-health stakeholders involved with implementation directly or indirectly. The team also conducted FGDs with UHE-p and UHEP beneficiaries in areas where USAID has supported UHEP and interviewed male beneficiaries living within the catchment areas of the sampled health centers.

1.1.1. KEY INFORMANT INTERVIEWS

KIIs were conducted with 79 participants to gather information on specific themes under each evaluation question. Key informants included individuals from JSI, Addis Ababa University College of Public Health, USAID, FMOH, EDA, the RHBs of selected regions, C/THOs, and health centers, as well as city town mayors. They were selected based on their roles and engagement with SEUH. KIIs were also conducted with stakeholders who interact with SEUH, have received support from SEUH, and/or are involved in SEUH implementation. Table 1 provides a summary of the designations of the key informants sampled. The sampling section provides a description of how the key informants were selected.

Table 1: Categories of Key Informants

| Key Informant Category |
|---|
| SEUH Activity Staff KIIs <ul style="list-style-type: none"> • Regional managers • Technical leads • MEL leads • Cluster coordinators • EDA staff working with SEUH • Addis Ababa University staff working with SEUH • USAID/Ethiopia |
| FMOH KIIs <ul style="list-style-type: none"> • Primary care and health extension directorate |
| Regional KIIs <ul style="list-style-type: none"> • Environmental Sanitation and Hygiene bureau • Regional health bureau; Regional Health Science college |
| Community-level KIIs <ul style="list-style-type: none"> • Government officials working in the City Administrations/Town Offices • Town health office staff • Municipality office staff • Water office staff • Education office staff • UHE-p supervisors • UHE-p cluster coordinators |

1.1.2. FOCUS GROUP DISCUSSIONS AND MALE BENEFICIARY INTERVIEWS

The FGDs aimed to investigate perceptions about SEUH interventions, results, challenges, and improvement strategies. The evaluation team conducted 22 FGDs with two categories of FGD participants: (i) UHE-ps (11 FGDs) and (ii) female beneficiaries living within the catchment areas of SEUH-supported facilities (11 FGDs). Each FGD had 8 to 12 participants. One-on-one interviews were with three men in each location where the female beneficiary FGDs were conducted. The main reason for targeting FGDs at women only—and not men—was that UHEP interventions prioritize health services for women and children. SEUH cluster coordinators and UHE-p supervisors assisted the evaluation team to locate female and male beneficiaries of UHEP, but they were not allowed to sit in the FGDs.

1.1.3. DIRECT OBSERVATION

The evaluation team used an observation checklist to observe SEUH interventions in water, sanitation, and hygiene; income-generating activities (IGA) supported by SEUH; data collection tools and reporting systems; and UHE-p workplace conditions.

1.1.4. SAMPLING OF EVALUATION PARTICIPANTS

Site selection. This evaluation was conducted in Amhara, Harari, Oromia, SNNP, and Tigray regions, and in Addis Ababa and Dire Dawa city administrations. The evaluators conducted KIIs with participants at the regional, city/town, and health center levels and held FGDs in the catchment areas of two to three towns. The choice of the evaluation regions was arrived at in consultation with the SEUH technical team and USAID, but the selection of towns and health centers was made independently by the evaluation team. Two criteria guided the selection of the towns: the length of time receiving SEUH support and the number of interventions supported by SEUH at each city/town. SEUH implementation was conducted in phases 1–3, within which each town was added into SEUH support. The selection criteria ensured representation of towns within each phase. Secondly, SEUH prioritized the services they provided based on the critical needs of the town. In some towns, particularly those in phases 2 to 3, fewer services (one to two) were supported, but in some towns, three or more services were supported. The evaluation team categorized the towns based on those that received support for fewer than three services and those that received support for three or more services and made selections that represented these categories.

KII selection. To select KII participants, the evaluation team obtained a list of technical SEUH staff and regional and town/community individuals who were directly involved with the implementation of SEUH and UHEP. The categories listed in Table I guided the selection. The evaluation team consulted with SEUH to confirm the roles played by various individuals in SEUH/UHEP implementation before selecting them to the sample.

FGDs and male beneficiaries. The health center supervisors and SEUH cluster coordinators and regional staff in each location assisted the evaluators to invite UHE-p to FGDs. The UHE-p assisted the team in identifying women who were beneficiaries of UHEP for the women beneficiaries FGD and male beneficiaries for the one-one-one beneficiary interviews.

SECONDARY DATA ANALYSIS

The team analyzed quantitative data from secondary sources. These sources included the SEUH MEL database and the EDHS women datasets for the 2011 and 2016 surveys. Service statistics were analyzed to establish the extent of service delivery and utilization and SEUH performance against targets. The EDHS analysis was exploratory and intended to examine possible changes in the utilization of services supported under UHEP among women living in the SEUH-supported urban areas. The analysis explored the changes that occurred between 2011 and 2016 in contraception use; water sources and type of toilet used by households, places of deliveries for children born in the past five years from the time of each survey, and uptake of voluntary counseling and testing (VCT). The initial intention of the evaluation team was to analyze data from women in the lowest socioeconomic quintiles, but this subsample turned out to be very small and was likely to yield unreliable results. Consequently, the analysis was conducted on all women living in the urban areas of the supported regions. The findings are not intended to measure the performance of SEUH directly, but provide contextual explanation changes in the indicators examined, and for triangulation with the results from monitoring data, KII and FGDs.

Data were analyzed using the complex samples package of the Statistical Package for Social Sciences (SPSS) software. This procedure was used to improve the accuracy of the findings by adjusting the standard errors (SEs) arising from the non-probability sampling and to allow for generalization of findings. The EDHS uses a complex samples design involving a two-stage stratified cluster sampling procedure and non-probability selection of clusters and households (as opposed to simple random

sampling). The point estimates of the population parameters for 2011 and 2016 are presented in the tables in Annex V as percentages. Additionally, the SEs and confidence intervals (CI) of the percentages are also provided in the tables.

QUALITATIVE DATA ANALYSIS

Transcripts from KIIs and FGDs were analyzed manually based on the themes and sub-questions contained in the data collection tools. Emphasis was placed on comparing the responses from the across participant categories, cities/towns and regions with the view to identify similarities and differences in the opinions obtained.

ETHICAL CONSIDERATIONS

This performance evaluation was submitted to SI's in-house Institutional Review Board and was approved in the exempt category. The evaluation team also obtained informed consent from the KII and FGD participants before conducting the interviews/FGDs. For KII and UHE-p FGD participants, written consent was obtained, but for the beneficiary FGDs, verbal consent was obtained because many of them were illiterate.

GENDER AND SOCIAL ANALYSIS

The evaluation collected data that took into consideration gender and other social dimensions such as people with disabilities, low-income families, children and other disadvantaged members living in the activity implementation areas. Data collection tools included questions for assessing SEUH results in different population groups. Data are analyzed and reported showing gender comparisons and other social groups, as feasible.

LIMITATIONS

This evaluation was conducted in all SEUH regions; however, data were collected from a sample of implementation cities/towns using a purposive sampling procedure. The findings, therefore, may not reflect SEUH performance in cities/towns that were not visited. This limitation was partially mitigated by conducting secondary analysis of monitoring data from all locations.

The quality of evidence from secondary analysis of monitoring data depends on the quality of that data as supplied to the evaluation team. This is especially the case with service statistics. The evaluation team did not undertake verifications of data quality but reported any issues experienced with the data so that users can interpret the results cautiously. The team, however, consulted with the IP to resolve issues with the data. The common problem was missing data and inconsistencies between the data and previously reported results.

The evaluation team consulted with the SEUH team to obtain insights for sampling. While the team did not necessarily take instruction from SEUH to select actual evaluation sites, any biased selection of sites resulting from the information obtained from the implementing partner may have affected the accuracy of the findings. To mitigate this limitation, the team implemented a robust criteria for selecting the sample, which involved selecting a sample from each SEUH implementation phase and including locations with few (<3), and those with multiple (3+) SEUH interventions. At the request of USAID and JSI, additional locations (Harar, Dire Dawa, and Kemisie) were also included in the sample. This approach resulted in a diverse sample of SEUH implementation locations being selected into the sample, which allowed for broader comparison of findings across SEUH implementation areas. Additionally, during analysis, the findings on the use of health services were triangulated between methods to establish a sound basis for conclusions.

DATA QUALITY ASSURANCE APPROACHES

The evaluation team considered the issues of data quality at all stages of the evaluation, from the design to the data analysis stages.

Design stage: During the design, an exhaustive tool development process involving all team members was undertaken. The team also consulted extensively with the IP and with USAID to ensure that the tools measured the appropriate interventions of SEUH and to ensure that the selection of evaluation sites and fieldwork procedures was appropriate.

Data collection stage: During data collection, the evaluation team was split into two groups—one group led by the evaluation team leader/Ethiopia Performance Monitoring and Evaluation Service (EPMES) COP, and the other led by the EPMES Evaluation Methods Specialist. On a daily basis, the evaluation team completed the findings summarization form, documenting the key findings from the FGDs and KIIs. These forms were shared with the team leader, who reviewed and provided feedback to the team to guide the subsequent FGDs and KIIs. Additionally, a conclusions and recommendations matrix was also prepared. For the quantitative data from the IP, the team used the regular data collection tools used by the IP to identify appropriate variables for analysis from the datasets shared by the Implementing Partner. The evaluation team consulted extensively with the monitoring and evaluation staff of the IP to ensure a deeper understanding of the datasets, obtain responses on the data gaps identified by the evaluation team, confirm the analyses generated, and get justification for missing values.

Data analysis stage: The team triangulated the data collected from the qualitative methods with the data collected through the quantitative methods to establish patterns in the findings and to draw lessons, conclusions, and recommendations.

FINDINGS AND CONCLUSIONS

EVALUATION QUESTION 1: HOW RELEVANT AND PRACTICAL WERE THE DESIGN AND IMPLEMENTATION APPROACH OF THE USAID-SUPPORTED SEUH ACTIVITY IN RELATION TO THE GOVERNMENT OF ETHIOPIA’S UHEP?

1.1.1. RELEVANCE AND ALIGNMENT OF SEUH WITH UHEP PRIORITIES

Table 2 maps the relationships between UHEP priorities and SEUH support.

Table 2: UHEP Priorities and SEUH Result Areas

| UHEP Priorities | SEUH Support |
|---|--|
| Hygiene and environmental health <ul style="list-style-type: none"> ○ Solid and liquid waste disposal ○ Personal and family hygiene ○ Food and water safety ○ Latrines | <ul style="list-style-type: none"> ○ Information, education, and communication (IEC), behavior change communication (BCC) materials ○ Community mobilization ○ Capacity development ○ Evidence generation and use ○ Advocacy ○ PPP identified on sanitation and waste management |
| Family health <ul style="list-style-type: none"> ○ MCH ○ Nutrition ○ Family planning (FP) ○ Youth and adolescent health ○ Immunization | <ul style="list-style-type: none"> ○ Capacity building and planning ○ Tools and guidelines ○ Supplies ○ Mobilization |
| Disease prevention and control <ul style="list-style-type: none"> ○ Malaria ○ TB and leprosy ○ HIV and AIDS ○ Noncommunicable diseases (NCDs) ○ Mental health | <ul style="list-style-type: none"> ○ Capacity building and planning ○ Tools and guidelines ○ Supplies ○ Mobilization |
| Injury prevention and control, first aid and referral services | <ul style="list-style-type: none"> ○ Capacity building and planning ○ Tools and guidelines ○ Mobilization |

As indicated in Table 2, USAID designed SEUH to support all UHEP priorities, but the degree and type of support varied from one priority to another. The primary support provided by SEUH focused on improving urban health systems and concentrated on the capacity building of UHE-ps and UHEP managers, community mobilization and education, and improving referrals between the community and the health centers.

The SEUH design included interventions to support the *Hygiene and Environment health* component of UHEP. Under the IR4, SEUH included support for enhancing understanding of urban sanitation and waste management challenges, enhancing intersectoral commitment for sanitation and waste management, training UHE-ps, community-level sanitation and waste management interventions, and advocacy on PPP. Under IR2, the SEUH design incorporates development and dissemination of

appropriate hygiene behavior change messages. SEUH also included sectoral convergence as one of its strategies for supporting UHEP with hygiene and environmental health initiatives.

SEUH's design also included support for *family health*, disease prevention, and control (see Table 2). Again, most of the support is for capacity building, education, and referrals. In line with the UHEP priorities, MCH services were significantly prioritized and implemented in all SEUH-supported towns and cities. The SEUH design aimed to address other health needs of the urban poor, including diarrheal disease, diabetes, high blood pressure, and HIV. SEUH implemented community-based HIV/AIDS prevention and control interventions in urban areas, as documented in SEUH reports and confirmed in the KIs and FGDs. Although NCDs such as cancer, diabetes, and epilepsy present universal health care needs in SEUH-supported communities, inadequate support was provided in the SEUH design for these health conditions. SEUH design did not address the needs of adolescents and youth and did not directly address the health needs of in-school youth. Adolescents and in-school youth are equally important target groups within the urban poor.

The UHEP priorities for *injury prevention and control* includes first aid education, strengthening referral linkage, and provision of first aid. The SEUH design was weak in its support for this component. However, it did include elements of community education, UHE-p capacity building, and referrals under IRI. Apart from community education and training, injury control received little attention in the SEUH design (FGD with UHE-p and AAU/SPH 2017).

Cross-cutting. SEUH designed service data recording (SDR) tools to support all UHEP priorities, but this component was not listed as a priority under UHEP. Although these tools are in place, the FMOH has not prioritized integrating UHEP SDR tools with the national health management information systems (HMIS) tools, but the FMOH and RHBs have accepted the tools. Furthermore, apart from the structured components of UHEP, new priorities arose during implementation. The prominent ones include acute watery diarrhea (AWD) and support for internally displaced people (IDP). SEUH made adaptations to their design to support these initiatives.

1.1.2. DESIGN GAPS BETWEEN UHEP PRIORITIES AND SEUH RESULT AREAS

Another substantial gap in the SEUH design was the lack of strategies for addressing the health needs of the homeless urban populations. This gap may have been influenced by the fact that the UHEP strategy did not specify the homeless urban poor as a target group. UHEP, and consequently SEUH approaches, were most suited for reaching vulnerable urban groups living in a home setting. Another gap in the design is the lack of strategies for serving the needs of people with disabilities.

SEUH's design also did not provide for direct interventions for poor urban populations working in industrial parks but assumed that these groups were receiving services in their homes within the targeted communities. Low-salaried industrial park workers are more likely to include young and older adults, who tend to be vulnerable to HIV and to have limited knowledge of and access to family planning. Due to the several industrial parks being established by the government, the number of low-salaried workers will continue to rise in the towns and cities and should be factored in the design of future activities. KIs also revealed that HIV prevalence is high among students taking evening classes and homeless people, but these groups were not directly targeted in the SEUH design.

Key informants from the FMOH, RHB, and SEUH stated that government commitment to providing resources, such as funding, human resources for health (HRH), supplies, and technical support to UHEP is low compared with the support given to the rural health extension workers (HEWs). Although this is not a weakness in the SEUH design, deliberate interventions to advocate with the GoE to increase resource allocation for UHEP are desired. Furthermore, the number of UHE-ps compared with the recommended standard of one UHE-p to 500 households in the revised UHEP implementation manual was inadequate. The Harari region is the only exception that meets the recommended ratio of

households to UHE-p because of the small size of the region and the commitment of the regional leaders to interventions that motivate the UHE-ps.

Some KII respondents held the view that the SEUH design was too broad, and USAID requested multiple additions during SEUH implementation (e.g., AWD, a shift in the quality improvement (QI) strategy from model health centers to the family health teams). SEUH's breadth affected implementation quality due to limitations in resources. Furthermore, whereas the UHEP design targeted both communicable diseases (CDs) and NCDs, the SEUH support focused on CDs. A KII from USAID revealed that USAID assistance in health programs targets CDs. Some interviewees also observed that the SEUH design lacked focus.

“Lacks focus—activities are scattered, likely because of the large UHEP number of packages. It touches on several topics/areas. Not enough resources to address all needs. IR4 is not adequately funded.” (SEUH KII)

Another gap in the SEUH design was the lack of formal guidelines for intersectoral coordination and collaboration in UHEP implementation. Although there was a requirement for SEUH to work across sectors, a formal policy for involving non-health sectors and pooling resources was lacking. USAID should have included support for developing such a policy in the SEUH design. The absence of such a policy resulted in poor implementation of the sectoral convergence tasks. Similarly, the SEUH design did not explicitly specify avenues for creating linkages with other USAID activities and other stakeholders involved in nutrition programming. Specifying linkages with other USAID Activities in the design would have influenced SEUH to include relevant tasks in their implementation plans, which could have broadened the Activity results.

Stakeholders also perceived that SEUH did not fully define the coordination and geographic coverage requirements for the implementation of hygiene and sanitation initiatives—whereas UHEP targets national coverage, SEUH used a gradual implementation process that had reached only a few towns at the time of this evaluation. The gradual implementation approach, therefore, affected achievement of WASH results. Within the towns reached, the nature of support varied, with the focus on mobilization and capacity building. Furthermore, the SEUH design did not include funding for the procurement of logistical needs for UHEP hygiene and environmental health interventions. Additionally, the water initiatives were implemented in only two regions (Amhara and Tigray) out of seven, due largely to the withdrawal of WaterAid from the SEUH partnership.

SEUH Implementation Approaches

- Adaptive and participatory
- Co-location of the regional and town-level SEUH staff within government offices
- Joint planning and review processes
- Direct support to the priorities, guidelines, plans, and tools of the GoE
- Experience sharing; Evidence-based planning, management, and implementation
- Health System Strengthening (HSS) (training, tools, manuals and guidelines, referrals linkages)
- Promoting intersectoral collaboration
- Building local capacity with the government and local institutions taking responsibility for cascading initiatives with their resources, e.g., IRT training

1.1.3. IMPLEMENTATION APPROACHES AND THEIR RELEVANCE

SEUH implementation approaches were found to be consistent with UHEP's implementation strategies, as the findings from evaluation participants and the review of technical documents reveal. The UHEP implementation approaches include:

- Community participation.
- Strengthening collaboration and integration between relevant sector offices.
- Continuous capacity-building activities.
- Equitable health service delivery.
- Quality improvement.
- Sustaining a robust monitoring and evaluation system in UHEP.

1.1.4. ANALYSIS AND CONCLUSIONS

The SEUH design was aligned with the GoE UHEP to a large extent. SEUH supported several priorities of UHEP, but greater attention was paid to capacity building than to providing direct support for service delivery. Generally, CDs appear to have received more attention than NCDs and injury prevention and control and first aid. SEUH also lacked a strategy for providing UHEP services to the homeless urban poor. Regardless of these gaps, the fact that SEUH aligned its design with the GoE approaches and systems was essential to building strong working relations with GoE structures.

A system-focused design, allowing for gradual shifting of capacity building and system support to the government, was practical given evidence of GoE commitments to sustaining some system-level SEUH capacity-building initiatives.

SEUH did not have a provision for directly funding system-level infrastructure, which limited the effectiveness of the design given the shortage of system support to UHEP. Although the SEUH design did not have provisions for flexibility to emerging needs, several additions were made during implementation.

1.1.5. RECOMMENDATIONS

SEUH is the only implementer supporting UHEP. Considering the plurality and diversity of health needs of urban poor populations and the large number of urban poor inhabitants, more stakeholders should be recruited by the GoE to support UHEP. The needs around NCDs and WASH are particularly inadequately addressed and call for significant government and donor support. FMOH considers interventions against NCDs a priority; accordingly, USAID's limited focus on NCDs should be revisited. An activity such as the SEUH should also be designed to allow space for balancing between emerging government needs and activity priorities.

The large population of homeless urban poor presents substantial health care needs that have been exacerbated by the political instability that Ethiopia experienced during SEUH implementation. The designs of future initiatives for urban health should include strategies for improving access to health care by the urban homeless poor. Future urban health activities should also support the government with developing a policy that defines the roles of line ministries in WASH implementation, including requirements for allocating resources for WASH activities and logistics. Apart from FMOH, support for WASH sectoral convergence among line ministries is weak due to the lack of supporting government policy. Also, given the resource limitations in the Activity-supported areas, more attention (including resource allocation) should be directed at material support (such as the construction of WASH facilities). This can be achieved by increasing the engagement and contribution of line ministries and expanding the sources of donor support for WASH.

EVALUATION QUESTION 2: TO WHAT EXTENT WERE THE USAID-SUPPORTED URBAN HEALTH EXTENSION ACTIVITY'S IMPLEMENTATION PROCESSES AND STRATEGIES EFFICIENT?

The evaluation team investigated the efficiency of SEUH implementation processes and strategies by examining the efficacy of SEUH's coordination efforts with other sectors, its organizational structure, and its enabling environment.

1.1.1. COORDINATION

Findings show that SEUH applied a multilevel coordination strategy. The strategy involved coordination with the federal, regional, and city administrations and towns and with the health centers through whom they indirectly reached the communities through UHE-ps.

Stakeholder Coordination

Federal level. At the federal level, the coordination efforts focused on the development of UHEP manuals, guidelines, and tools. Examples include the UHEP implementation manual, community health information systems (CHIS) guidelines and tools, referrals guidelines, job aids, brochures, leaflets, urban hygiene and sanitation strategy, training modules, and the planning and execution of the urban health conference. SEUH provided technical assistance to FMoH and served as a member of various national technical working groups, such as the CHIS and the health extension program (HEP) optimization task force. SEUH also supported the implementation of FMoH's primary health care reform (PHCR) strategy and supported FMoH with evidence generation. For example, SEUH conducted a mapping of public and communal latrines and various other studies conducted with FMoH.² Other support provided by SEUH at the federal level included technical assistance for strategic planning of urban sanitation and waste management. SEUH recruited and seconded 11 technical assistants (TAs) to FMoH. The TAs supported FMoH with developing guidelines and tools to improve the quality of health service delivery.

Regional level. At the regional level, SEUH coordinated with the RHBs and health science colleges and universities. The coordination involved joint planning, resource allocation, and activities implementation, capacity-building contextualization of urban hygiene and sanitation strategy, experience-sharing events, and joint supportive supervision of UHEP. SEUH developed UHE-p service data record forms and reporting formats in collaboration with the RHBs.

City administration and town level. At the cities and towns, the SEUH coordination efforts focused on training and joint supportive supervision, urban sanitation and waste management, joint activity planning, and review meetings. SEUH also coordinated with stakeholders to plan and conduct experience-sharing events, compile performance data, and foster data utilization. Other areas of coordination included the distribution of guidelines, tools, and supplies for the UHE-ps. Working with the C/THOs, SEUH also coordinated with city/town WASH Forums (which comprised sectors such as health, education, municipality, law enforcement, water and sewerage offices, environmental protection offices, city beautification offices, and finance offices) to implement integrated urban hygiene and sanitation strategies.

Community and health center level. The health centers are the closest institutions to the urban poor. SEUH worked with the health centers to conduct supportive supervision, community health campaigns, and monthly review meetings and to implement quality improvement initiatives. Health centers are critical links between SEUH and the communities, particularly given that by law, development actors are

² Situation analysis of urban sanitation and waste management in Ethiopia, 2015; Analysis of the Core Functions, Issues, and Challenges of Human Resource Management for Urban Health Extension Professionals, 2015; Formative Behavior Change Communication (BCC) Assessment, 2015.

restricted from engaging directly with the government community structure, such as the Women Development Army (HDA) and the kebele administration. SEUH coordinated with health centers directly and with the communities through the health centers on service data recording, verification and reporting (including the pilot-testing of the CHIS in some locations), referrals, and defaulter tracking. SEUH also coordinated with the health centers on community-level data and to promote local data utilization for planning at the health centers.

Other stakeholders. SEUH coordinated with schools, micro-enterprises involved in waste management, other IPs, and private companies. Technical areas of coordination included the following:

- The Centers for Disease Control and Prevention (CDC) on HIV interventions through seconded staff who are based within the multisectoral HIV response team in the town health departments to avoid duplication of efforts. The nature of the coordination was mainly through review meetings and woreda-based planning activities organized by town health departments.
- Academic institutions: Mekelle University, Gondar University, Bahir Dar University, and Menelik Health Science College) on capacity-building initiatives. Representatives from these universities were trained as trainers and were engaged in cascading the training at regional levels.
- Other IPs such as Challenge Tuberculosis (CTB) implemented by a consortium led by Koninklijke Nederlandse Chemische Vereniging (Royal Dutch Chemical Association) (KNCV). The collaboration with CTB was to focus on strengthening community-based TB interventions. SEUH and CTB developed terms of reference identifying potential areas of collaboration, which included developing an urban model for TB detection and adherence to treatment. The primary emphasis was on leveraging resources. Despite putting together a strategy and developing terms of reference, the plan was not implemented. SEUH also collaborated with the John Hopkins Center for Communication Programs to undertake training of trainers (TOT) for strategic behavior change communication (SBCC) and community mobilization.
- Public media groups. This was targeted to address demand creation activities. For example, the media forum in the SNNP region designed and developed two posters to promote health messages on HIV/AIDS and antiretroviral treatment adherence. Moreover, the forum prepared five radio spots and broadcasted in 16 languages in the SNNP region. Similar coordination was reported with the Amhara mass media agency and a similar media forum in Mekelle. An example of SEUH's coordination with a private company is its work with Meta Abo Brewery S.C., owned by Diageo (a global beer and spirit maker and distributor), aimed to increase awareness of the harmful effects of underage drinking (JSI SEUHP fiscal year (FY) 16 annual report, 28).

Coordination Approaches

Co-location and supporting government priorities and plans. By co-locating staff at the RHBs in some regions (Harar and Dire Dawa region) and attaching cluster coordinators at the THOs, the SEUH staff effectively built relationships with the government entities, which increased the acceptance of SEUH staff and initiatives. SEUH also ensured that their activities fully aligned with the priorities and plans of the FMOH, RHBs, and C/THOs. Their initiatives centered on strengthening government systems and capacity, which also resulted in improved efficiency in their coordination efforts. SEUH fully worked under the leadership of the government, concentrating their efforts on system strengthening and generating and promoting the use of evidence. The revision of the UHEP implementation manual helped to clarify the roles and responsibilities of the different entities involved in UHEP implementation, which resulted in improved coordination.

Support for logistics distribution. SEUH supported the revision of the UHEP implementation manual to address the supply chain requirements for UHEP. A series of meetings were held with RHBs, C/THOs, and HCs and other stakeholders on UHEP supply needs as indicated in the revised manual,³ which improved the supply of these materials to UHE-ps. Informants also stated that SEUH assisted the RHBs with the supply and distribution of HIV testing kits in a timely manner. SEUH helped with the delivery of such materials to the C/THOs where the health centers pick up their supplies.

Coordination of data recording and reporting systems. The systems for data recording, review, and reporting from the community all the way up to the region were probably among the best-coordinated efforts achieved by SEUH. SEUH played a significant role in the development and refinement of service data recording tools. SEUH also supported the health centers with data compilation through their monitoring systems and electronic capture of service data, analysis, and local data use at the health centers and C/THO teams.

Joint supervision. SEUH participated in UHE-p supervision and mentoring, working together with the C/THOs and UHE-p supervisors at the health centers. This strategy facilitated a more in-depth understanding of the challenges on the ground and laid the foundations for active collaboration, joint planning, implementation, and adaptations.

Planning and review meetings. SEUH conducted regular review meetings with health centers and C/THOs. Similar meetings were also conducted with the RHBs to help with planning, to address activity bottlenecks, and to advocate for UHEP support. Planning meetings covered issues such as supervision, monthly and quarterly results reviews, and planning of learning trips and were also used for feedback to the UHE-p supervisors, C/THOs and RHBs. The feedback loop was highly praised by the UHE-ps, their supervisors and key informants for influencing improvements in data quality and use in decision-making.

Despite these efficiencies in SEUH stakeholder's coordination approaches, the coordination was reportedly efficient only within the health sector. As noted before, the intersectoral coordination was weak, mostly because of the lack of formal structures and resources for coordination and for joint implementation of UHEP tasks across sectors.

1.1.2. EFFICIENCY OF COORDINATION

The SEUH coordination efforts aimed to build the capacity of government institutions and to rally various groups to support UHEP interventions. Their approach involved empowering FMoH and the RHBs, C/THOs, and health centers to lead coordination efforts within their respective levels of authority. The SEUH made this happen by providing technical, logistical, and financial support to strengthen government systems. This SEUH coordination was reliable and efficient, mostly influenced by the direct support to the government systems and plans and co-location staff in some activity-supported locations.

Most of the evaluation participants provided positive comments about the efficiency of SEUH coordination and collaboration efforts. Within the health sector, SEUH was credited for its efficiency in pulling together the health sector actors to support system-level improvements. The success of the first-ever urban health conference was attributed to the effectiveness and efficiency of SEUH technical support to foster FMoH leadership. This support helped fortify the leadership of FMoH to rally sector ministries. Such success would not have been possible had SEUH chosen to play the lead role.

³ The UHEP implementation manual states that UHE-p should be supplied with short-acting contraceptives, HIV test kits, dipsticks for pregnancy testing, dipsticks for diabetes, rapid diagnostic test, iron capsules, paracetamol, anti-malaria drugs, and first aid kits.

SEUH's advocacy with FMOH to approve relocating the UHE-ps from the supervision and operational offices of the kebele administration to the health centers. Although this change has taken place in all regions except Oromia, UHE-ps in virtually all regions are very happy with this shift:

"It has been a while since we moved from the Kebele to this health center. Being stationed in the health center helped us a lot: We started to see ourselves as health professionals. The community started to consider us as a health professional. We have learned a lot from the health center staffs. We had a chance to work with the family health team. All the above increased our motivation to serve." (UHE-p FGD, Addis Ababa)

Participants in the towns and cities evaluated reported that SEUH coordination efforts were generally successful except for coordination efforts for intersectoral convergence. SEUH reportedly ensured timely distribution of logistics, facilitated regular meetings, and conducted training. Cluster coordinators were praised for being timely in their support, demonstrating the love of their jobs and being responsive to the requests for support. In Assela, a key informant noted that their SEUH cluster coordinator served as a role model to them. The passion that the cluster coordinator had for his job influenced him to love his work. Unfortunately, the expressed commitment to SEUH interventions is, to some extent, being misunderstood by some people in the towns, who think that this commitment to SEUH and UHEP is due to their being paid by the Activity, a view that is incorrect. The participant noted that of all IPs that work in their community, SEUH pays the lowest per diems, yet their office and health centers work closely with SEUH.

"The love they give us initiates us to do our work without any payment—it makes us do more without personal benefit. Many nongovernmental organizations (NGOs) are working here, but what makes SEUH different is they are work-centered." (THO KII, Assela)

Similar sentiments were echoed at most of the evaluation sites. There was virtually a universal view about SEUH efficiency within their work with the health sector. The efficiency was founded on the emphasis SEUH placed on participatory processes, guidelines and manuals, thorough documentation processes, review meetings, and adequate supervision. A key informant in Ambo commented that:

"SEUH is very efficient... during supervision, their approach to mentoring and coaching is not harsh; manuals are provided during training, they send other (extra) manuals and tools to the THO, who then gives to the health center, then to UHE-p. When any supplies are delivered to our office, we inform the health centers to collect them. There have been no delays to-date." (UHE-p Supervisor KII, Ambo)

Another key informant commented that:

"SEUH approach is participatory. I have no words to appreciate them; they are like mother and father. If I call them for any materials, they send immediately even by post." (THO KII, Assela)

In Ambo town, a key informant described SEUH coordination efforts as more evident and successful on WASH activities. The Activity started by evidence gathering, mainly collecting profile information about the town on WASH-related issues and mapping the key players to engage. Ambo University was identified as a critical group to bring on board for two significant reasons: they produce a large volume of solid and liquid waste due to their large student population, and they have the academic expertise needed to conduct research and to inform the WASH strategies.

"The best coordination is on WASH, and some changes have been observed, such as sanitary conditions in the town—thru the collaboration, they mobilized sector offices to collect solid waste, and also provide information about sanitation." (UHE-p Supervisor KII, Dire Dawa)

Another success in SEUH coordination efforts related to facilitation of local learning events. While learning events were not conducted in all sites, where it happened (Assella, Bishoftu, Debremarkos), it succeeded in influencing adaptation. This outcome can be summarized in the views of one key informant in Assela.

"Experience sharing was "turu, baredu, gari (very good)...In Adama, we saw model kebele's which did more. Before the visit to Adama, we were doing the basic services, such as family planning. When we visited Adama model Kebele, we saw a lot more services provided... We saw the daily recording systems and service delivery and WASH program implementation... We saw pilot Kebele's operating fully like a health post filled with materials similar to those at the health center. They could handle emergency cases and refer clients more easily... Client volumes in hospitals and HCs reduced..." (THO KII, Assela)

1.1.3. MAIN OUTCOMES FROM THE SEUH COORDINATION ACTIVITIES

Revised UHEP manual. SEUH coordinated with the FMoH and RHBs to revise the UHEP implementation manual. The new implementation manual introduced service provision based on household categorization (economic and health service needs), clarified duty station, roles, and responsibilities of UHE-p supervision and reporting structure, standardized data recording, and reporting system guidelines for the UHEP supply chain.

Urban hygiene and sanitation strategy. SEUH helped to establish the first-ever strategy on urban hygiene and sanitation. SEUH coordination efforts led to the signing of a memorandum of understanding (MoU) and joint action plan among principal government sector offices⁴ to strengthen the collaboration between GoE stakeholders for improved urban sanitation and waste management. SEUH establishes/revitalized the WASH town/city level, and to some extent improved sectoral convergence on sanitation and waste management. The outcome of this convergence is meager in most locations where interviews were conducted due to several obstacles (such as delayed initiation of sectoral convergence activities by SEUH, and the lack of commitment from the GoE sectors). However, few accomplishments as a result of the convergence were reported in some towns. Below is an example from Debromarkos town, Amhara region.

SEUH's work with EDA in towns where EDA had previous presence implementing WASH, and other interventions (Dessie town, Debrebirhan town, Yeka and Akaki Kality sub cities) facilitated smooth coordination with principal government sector offices and stakeholders for the efficient implementation of WASH interventions. EDA used its existing resources (such as office vehicles purchased by other projects and staff paid by other projects) to facilitate implementation of SEUH activities, thus leveraging resources. The fact that EDA had experience in implementing WASH and other interventions in its target towns facilitated its smooth coordination with principal government sector offices and stakeholders to implement SEUHP. The excellent reputation EDA had by previously working with crucial government actors contributed to efficiency in the implementation of SEUH interventions in these four towns/subcities. This coordination with EDA helped in improving sectoral collaboration and commitment to implement the urban WASH strategy jointly.

Improved documentation reporting systems. Together with GoE, SEUH developed service data recording and reporting tools. The tools captured data on services provided by UHE-p directly. During supervision, SEUH checked adherence to protocol and quality of collected data. Data were compiled weekly and monthly to be reported to the health center and RHB, respectively. SEUH assisted the

⁴ The signatories included Federal Ministries of Health; Water, Irrigation and Electricity; Urban Development and Housing; Finance and Economic Cooperation; Education; Forest, Environment and Climate Change (MoFECC); and Culture and Tourism.

printing of recording and reporting tools. Eventually, health centers recognized the value of the collected data and started to cover the cost of printing by themselves (e.g., a health center in Dire Dawa).

Regional capacity for training. Capacity-building training included TOTs on core public health training, integrated refresher training, supportive supervision, and social mobilization. Participants were from RHBs, C/THO, health centers, and EDA and regional SEUH staffs. Following the TOTs, the training was cascaded to the UHE-p.

Coordination Challenges

Despite the positive outcomes from SEUH coordination efforts, the Activity faced several challenges. Feedback from participants suggests that SEUH coordination efforts were affected by the following:

- The busy schedules and competing priorities of sector office representatives limited progress in the intersectoral coordination.
- The outbreak of health emergencies such as AWD resulted in shifts in SEUH implementation to respond to such emergencies.
- Political factors—there was a general view that the government support for UHEP was low compared with the support given to the rural health extension program. Additionally, political instability resulted in greater attention given to political issues, making it difficult to coordinate with other sectors, and also affected the timely implementation of SEUH initiatives.
- The lack of a guiding policy for sectoral coordination
- The general perception that UHEP was the sole responsibility of the health sector, which resulted in weaker support from other sectors.
- High turnover of sector office representatives who had been trained by SEUH and were committed to supporting SEUH and UHEP.
- SEUH's unfulfilled plans to implement WASH initiatives in some towns (e.g., Shashemene and Halaba towns) affected the quality and intensity of coordination with respective municipality offices in these towns.
- The widespread complaints about SEUH's low per diem rate (130 Birr per day) reportedly demotivated some government officials, which limited their interest in participating in coordination meetings and training.
- Resource constraints, such as the number of SEUH staff, including cluster coordinators and vehicles, were also evident during the interviews.

1.1.4. POTENTIAL MISSED OPPORTUNITIES

Although SEUH coordinated and collaborated with several stakeholders, several other collaboration opportunities were not used. For example, evaluation participants stated that the coordination with the urban housing and urban development offices at federal and town levels was weak, yet this sector is critical for the successful implementation of WASH initiatives, such as the construction of latrines liquid and solid waste management. SEUH did not also coordinate with partners involved in large-scale infrastructure construction in urban areas and the emerging industrial parks, which would have supported planning and implementation of initiatives for proper solid and liquid waste management in their operational areas. Although SEUH planned to work with the industrial parks, evidence of any such initiatives was lacking.

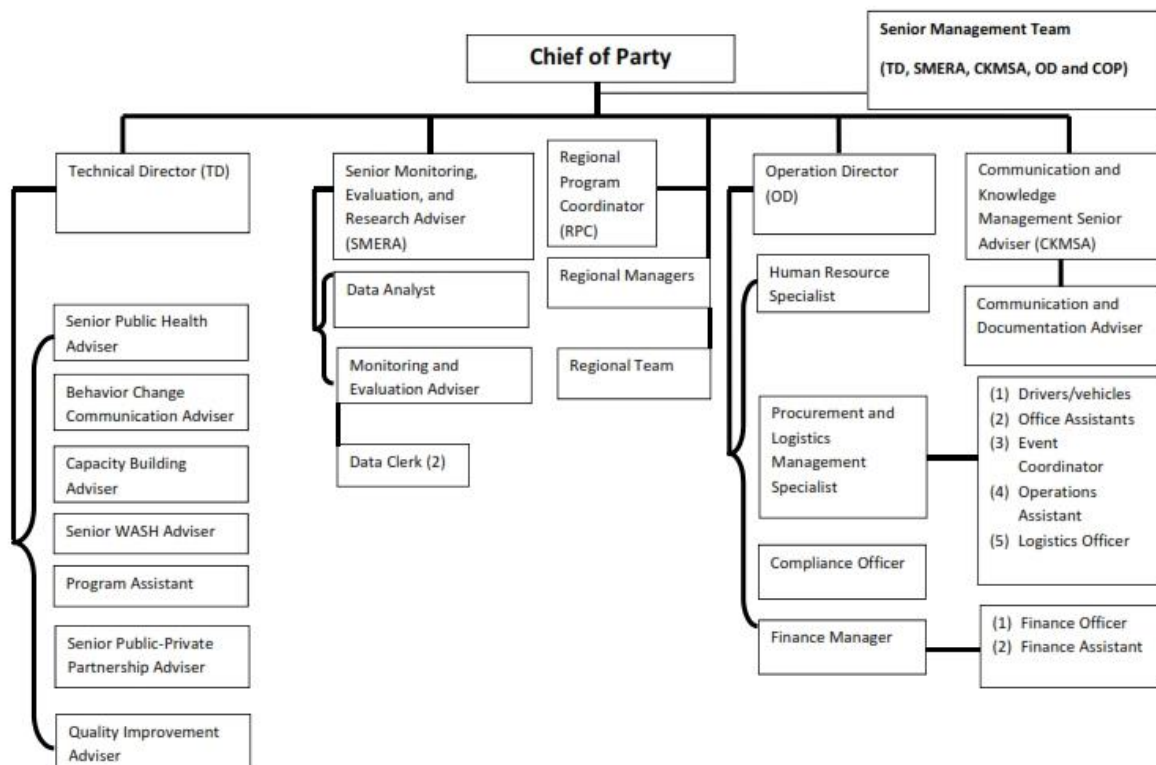
Furthermore, while there were greater avenues for SEUH to coordinate with schools, groups supporting street children, and youth centers, this coordination was minimal. The evaluation team also found that coordination with public higher training institutions (universities) hosting thousands of young students who are highly vulnerable to reproductive health/FP and HIV was limited. In Ambo, for example, a key informant noted that HIV counseling and testing (HCT) conducted by a CDC-supported

activity among evening students and street populations had revealed a high prevalence of HIV. Furthermore, opportunities exist for SEUH coordination with government offices implementing the Urban Productive Safety Net Program. This has the potential of expanding access to socioeconomic and livelihood opportunities for urban poor populations. SEUH also had the opportunity to coordinate with private entities, including micro and small enterprises, for waste management, which would have facilitated SEUH's effort to promote urban sanitation and waste management initiatives. Limited examples of such coordination were observed in Addis Ababa and Adama and seemed to yield positive outcomes.

1.1.5. SEUH OPERATIONAL STRUCTURE

The critical positions under SEUH included the Chief of Party (COP); a Technical Director, a Senior Monitoring, Evaluation, and Research Advisor, an Operations Director, a Communication and Knowledge Management Senior Advisor, and regional managers reporting to him (reference the SEUH organogram). All directors and advisors listed above reported to the COP.

Figure 3: SEUH Organogram



Offices and staffing: SEUH used a regional structure with offices in each Activity region. Field offices were established in Amhara, Oromia, SNNP, Harar, and Tigray regions, and in Addis Ababa and Dire Dawa city administrations. Staffing was designed to respond to the technical and operational needs of the Activity. The experts at central and regional levels included public health advisors, behavioral change and communication advisors, capacity-building advisors, WASH advisors, and QI advisors. The technical director oversaw the activities of the advisors. Experts in monitoring and evaluation were also located centrally and regionally. An administrative team was also there at central and regional levels. The project had cluster coordinators near implementation sites (towns) in all the above regions except Harar and

Dire Dawa, where the whole regional SEUH team was co-located at GoE's regional health bureaus. These two regions (Harar and Dire Dawa city administration) are incredibly understaffed. One cluster coordinator was assigned to support three towns, and cluster coordinators were co-located in one of the town health offices they supported specifically with the disease prevention and health promotion team. The cluster coordinators worked in close collaboration and harmony with the respective town health office teams and used public transport for most of their travel. In Harar and Dire Dawa, the technical team (the regional manager and a public health officer) replaced the cluster coordinator.

Activities related to improving intersectoral convergence (IR4) for improved urban sanitation and hygiene were planned to be conducted by one partner, WaterAid. However, WaterAid dropped out of the partnership. This affected the success of the IR4 activities. Initially, SEUH hired one WASH advisor to work with the cluster coordinators, but this became insufficient as the WASH activity towns expanded. Recruitment of WASH advisors for each region was prioritized but was not fully implemented in all regions.

1.1.6. APPROPRIATENESS AND EFFICIENCY OF THE SEUH ACTIVITY STRUCTURE

One informant observed that the volume of direct reports to the COP was very large and needed reconsideration. Notably, the key informants observed that the burden of having the regional managers reporting to the COP was big and needed reconsideration.

“Regional managers should have reported to the technical director. The COP has too much work.” (SEUH Regional Manager)

At the initial implementation stage of the activity, one cluster coordinator was assigned to oversee SEUH work in five towns. This was not feasible. Later, additional cluster coordinators were recruited for a ratio of one cluster coordinator to three towns. Although this is an improvement, several informants, including those who were not cluster coordinators, revealed that this is still substantial for one cluster coordinator:

"Even if their (SEUHP team) activity is good, the things they have to consider is the human resource. It is better if you assign more than one person for three towns. It is too much for one cluster coordinator. It is preferable to place staff within each town." (Key informant, Ambo Town)

The SEUH structure had the cluster coordinators sitting at the THOs. This facilitated smooth coordination and working relationships with key government sectors and minimized communication barriers and costs associated with transportation and communication. Cluster coordinators were a critical link between the SEUH regional offices, the sector offices at the town level, and most importantly the health centers and the communities. Having cluster coordinator positions at the grass root level contributed to improved and stronger coordination of activities and stakeholders, better oversight of the community-level implementation of UHEP, and better monitoring of results and mentoring of the government officials involved with UHEP.

Although the WASH activities were supposed to be undertaken by a sub-partner, Water Aid, this result suffered when Water Aid dropped out from the partnership. The transition to hiring WASH advisors was insufficient for the WASH scope. Furthermore, the hiring of WASH advisors was undertaken after two years of SEUH implementation and only in three regions (Amhara, Oromia, and SNNP). This affected progress in the implementation of IR4 activities. Urban waste management was considered a top priority for the urban poor in all towns and cities evaluated.

Furthermore, public-private partnerships (PPP) were not significantly accommodated in the SEUH structure. Strategies and guidelines for private sector engagement on urban sanitation and waste management were lacking. A focal position for PPP was also not provided for in the SEUH structure.

The SEUH FY18 semi-annual report suggests that financially viable models that attract the involvement of the private sector in sanitation and waste management service delivery do not exist.

1.1.7. ENABLING ENVIRONMENT

Evaluation findings show that SEUH's work to create an enabling implementation environment has mostly been effective within the health sector. SEUH used participatory processes and provided direct support to the GoE UHEP priorities, a critical factor in gaining the trust and support of FMoH. The SEUH approach also centered on building the capacity of the government systems and personnel to lead, and the empowerment of local stakeholders to deliver interventions is also an essential approach to creating an enabling environment. The Activity conducted capacity-building training, such as the core public health training, integrated refresher training (with TOT to federal and regional staffs), leadership, management, and governance (LMG) capacity enhancement training to RHB, ZHD, C/THOs, and health center staffs. The LMG training has two components: facility-level and WASH-focused training. Other pieces of training that helped to create an enabling environment included QI training provided to members of QI teams at facilities, training on supportive supervision, training on basic emergency WASH responses, occupational health and safety training to street waste collectors (focusing on AWD), and TOT on PHCR (SEUH annual reports FY14-18). Besides, SEUH facilitated and organized different urban health-related workshops and a national urban health conference. The urban health conference hosted in partnership with FMoH has been an excellent opportunity to advocate urban health to several stakeholders. SEUH also supported UHEP optimization workshop.

The role played by SEUH in assisting FMoH with the revision of the UHEP implementation manual was instrumental in creating an enabling environment for its implementation. The clarification of the roles of the stakeholders and the better definition of implementation approaches helped to streamline the operations and recognition of SEUH within the FMoH and among stakeholders. Additionally, by supporting the GoE to establish and sustain UHEP forums and platforms, the influence of the Activity within the health sector was bolstered, and its relationship with the FMoH and other stakeholders was strengthened. The SEUH approach was based on evidence. The material support, especially with tools and necessary logistics, has helped with solidifying their relations with FMoH, the regions, C/THOs, and the health centers.

SEUH worked closely with regional and town health offices and kebele administrations to ensure a conducive working environment for UHE-ps. To build the motivation of health workers, SEUH awarded health centers with best-performing QI teams with a desktop computer with 3G internet connection to promote healthy competition among health centers to provide more accessible and quality services to the communities they serve. SEUH renovated some UHE-p offices in some towns to influence the towns to cascade the renovation of other health centers. For example, SEUH renovated UHE-p duty stations at Adama (Kebele 04 and 09), Shashemene (Bulchana Kebele), Jimma (Awetu Mendera Kebele), Batu (Kebele 01 and 02), Nekemte (Kesso sub-city) and Butajira (Kebele 5, in collaboration with woreda health office, Butajira HC, and the UHE-p). The renovation sometimes also included the provision of office furniture (Ref. SEUH annual report FY16-17). Another approach to motivate UHE-ps was the provision of supplies, equipment, and job aids to improve acceptance of UHE-ps by their communities as professionals and to improve their working conditions. Equipment supplied by SEUH included blood pressure apparatus, thermometers. Some informants stated the community members had previously doubted the health-related skills qualifications of UHE-ps but seeing them using medical equipment helped to correct that negative viewpoint from their communities. Another area of enabling environment creation and motivation of the UHE-ps was the push from SEUH to have the UHE-ps relocated from kebele administration supervision to health centers. SEUH facilitated the decision process by generating evidence, supporting experience-sharing visits, and providing technical support and advocacy activities. The shift remarkably brought a favorable environment to better implement mentoring, coaching, supervision, and monitoring practices in the UHEP implementation process.

However, in Oromia, this shift did not happen. Most key informants supported the retention of UHE-p under the kebele administration noting that in most towns in Oromia, the health centers were sparsely distributed. Shifting the offices of the UHE-ps to health centers would have resulted in them walking several kilometers to their communities each day. They also observed that most health facilities do not have adequate office space to house the large number of UHE-ps. SEUH also organized local and international experience-sharing visits and events for UHE-ps and government health office managers (such as visits to Thailand, a middle-income country where similar public health challenges were addressed).

Senior alignment meetings were carried out with heads of sector offices involved in the WASH platform to motivate them to support the implementation of action plans developed by their staff during WASH LMG training. Examples included Yeka sub-city, Arada sub-city, and Adama town (Ref. SEUH activities map). WASH LMG training was provided to sector office heads and technical members of WASH forum sectors. Additionally, SEUH established WASH forums in its implementation towns to create an enabling environment for effective and efficient urban health implementation. These activities resulted in improved local capacity for the management of WASH activities, harmonized stakeholder contributions, and promoted the construction of latrines. Results from secondary analysis of the EDHS data show an increase in households with a pit latrine across all regions and of flush toilets in Addis Ababa, Harar, and Oromia. These results are, however, general and not directly attributable to SEUH although the SEUH interventions may have contributed.

Though not an extensive activity, SEUH supported the formation of alternative PPP approaches and management models to enhance the engagement of the private sector in urban sanitation and waste management.

1.1.8. BARRIERS AND ADAPTATIONS TO IMPROVING IMPLEMENTATION EFFICIENCY

At the federal and regional levels, lesser priority given to urban health extension (relative to the rural health program) by the GoE was a big challenge that affected all aspects of SEUH implementation. High turnover of UHE-ps and GoE officials was a critical barrier to implementation, as reported by many informants and also documented in consecutive JSI-SEUH annual/semi-annual reports (FY 17-18). The trained UHE-ps who left were replaced by new non-trained UHE-ps (Ref. JSI SEUHP FY18 semi-annual report) requiring the same level of capacity-building resources. Shortage of UHE-ps (thus allocation of more than 500 households per UHE-p) was also a common problem resulting in an overworked and less motivated team. In many towns, a UHE-p served more than 1,000 households. Concerning efficiency, a possible positive adaptation the activity made was the initiation of the integrated refresher training package. The PHCR could also be a more pragmatic way of addressing many of the urban health challenges. SEUH's involvement in the reform initiative was a positive development.

1.1.9. CONCLUSIONS

Compared with the intersectoral activities of SEUH, implementation efficiency was more evident in the SEUH work with FMoH and the RHBs, C/THOs, and health centers. This was facilitated by the co-location of staff within government offices, and direct support to the priorities and plans of the government improved SEUH efficiency. The SEUH cluster coordinators participated in the joint supportive supervisions of the RHB. SEUH emphasized building the capacity of the local stakeholders, which inculcated a sense of ownership and fostered implementation efficiency.

One of the main achievements and measures of the efficiency and effectiveness of the SEUH coordination strategies was evidenced by their facilitation of the FMoH efforts to establish the first-ever urban hygiene and sanitation strategy of Ethiopia. This strategy was ratified by the signing of MoUs with line ministries. Both the strategy and the signed MoUs lay a solid foundation for the implementation of cross-sectoral interventions to improve the urban hygiene and sanitation conditions.

Major challenges to efficiency, however, exist, with the main ones being poor multisectoral coordination, political instability, high staff turnover and transfers in government offices, and poor engagement of the sector office heads.

1.1.10. RECOMMENDATIONS

SEUH results demonstrate the viability of activities that work to build the leadership capacity of the government offices. By supporting system strengthening and government priorities and letting the government take the lead role, SEUH gained a strong relationship with FMoH and the RHBs, C/THOs, and health centers. Future activities should continue to strengthen the capacity of government offices to lead UHEP implementation. Also, evaluation findings show that alignment of implementation priorities and strategies with GoE and using participatory implementation approaches, which engage all stakeholders in the planning and execution of activities, increases the efficiency of implementation. For example, working within the GoE UHEP strategy motivated FMoH and RHB participation, and bolstering their capacity to lead the implementation of their own strategy fostered sustainability through the commitment of FMoH and RHB resources. Furthermore, by co-locating SEUH staff within the RHBs, their engagement with the regional staff on local planning and implementation was influenced. Future activities should, therefore, as much as possible, ensure design and implementation alignment with GoE strategies and priorities to promote government ownership and to increase prospects for sustainability of development initiatives and results. The lack of a guiding policy for intersectoral work is a significant threat to success. For activities such as WASH, a government-level strategy or policy directive could lay the foundation for better participation in WASH activities. While the line ministries have endorsed a strategy on urban hygiene and sanitation, and have signed MoUs, steps to ensure the implementation of the strategy and the MOUs and monitoring are required.

EVALUATION QUESTION 3: WHAT ARE THE MAIN CONTRIBUTIONS OF THE ACTIVITY TO STRENGTHENING OF THE GOE'S UHEP?

To respond to EQ 3, the evaluation team examined what SEUH did to build capacity and to increase the utilization of health services among urban poor populations. The evaluation themes covered SEUH's contributions to improving the quality of services, UHEP management, demand creation, and utilization of health services.

1.1.1. IMPROVING THE QUALITY OF COMMUNITY-LEVEL URBAN HEALTH SERVICES

SEUH support for quality improvement (QI) concentrated on:

- Increasing production and technical competencies of the UHE-ps.
- Strengthening the UHE-p management structures.
- Improving uptake of UHEP health services.

The below results describe the process, outputs, and outcomes of SEUH support for UHEP.

Increasing production and technical competencies of the UHE-ps

The main tasks undertaken by SEUH included providing technical support to training institutions in the design and production of training materials. SEUH supported the design of a new curriculum for training the next generation of UHE-ps. SEUH supported both pre- and in-service pieces of training.

Preservice training. This type of training, targeting clinical nurses working as UHE-ps without any previous UHE-p training, conducted over three months in the regional science colleges in the SNNP region, Amhara, and Harari and Dire Dawa city administration. SEUH reports state that the activity supported the colleges financially and technically, including procuring and supplying training materials, enhancing the skills of the trainers, and monitoring the quality of the training. SEUH technical support included revising

the training curriculum, preparing training implementation plans, monitoring training quality, and mentoring trainers and trainees.

Next generation training. Due to the turnover of clinical nurses working as UHE-ps, the GoE started the next generation training targeted at 10th-grade leavers enrolling in the UHE-p training program. In collaboration with FMoH, SEUH funded and provided technical support for the development of a new national UHE-p training curriculum.

SEUH reports document that 453 students had enrolled in the UHE-p during the life of the activity. Of these students, 424 completed the training at the regional health science colleges in the SNNP region, Harari, Dire Dawa, and Amhara. Despite these results and the reported support from SEUH, feedback from the training institutions suggests that SEUH support for the next generation UHE-p was insignificant. They also observed that there are several outstanding challenges with the curriculum, a view that was also supported by some participants in the RHBs. First, there is a concern that the curriculum is a blueprint of rural HEW training programs, which are not contextualized for urban settings. For example, WASH-related activities and concepts in the curriculum are the same as in the rural (HEW) training program, but approaches and mechanisms of disposal and management of solid and liquid waste in urban and rural areas differ:

“Honestly speaking we are going to produce the same professionals; there is no difference between HEW and generic UHE-ps training programs” (KII, the SNNP region)

Moreover, there was a concern from the key informants and UHE-p FGDs that there was no difference in the selection criteria and required competencies for enrolling in the rural HEW versus the next generation UHE-p training program. They cited differences between urban and rural areas in socioeconomic conditions and the lower educational requirements for rural HEW (10th grade) as key considerations for ensuring that the UHE-p curriculum is designed as a more advanced course. Moreover, several key informants also raised a concern that the next generation UHE-p training has not yet been recognized formally in government HRH strategies and programs. For example, there is no classification of UHE-ps in the certificate of competency (CoC) centers/technical and vocational education and training (TVET) agency, but there is a CoC exam for Level III and Level IV rural HEW training program.

In-service training. In-service training included comprehensive public health training (CPHT) and integrated refresher training (IRT). SEUH support was mostly concentrated on strengthening UHE-p clinical and nonclinical skills. SEUH supported the development of in-service training modules, duplication and distribution of training materials, training of trainers (TOT), and cascading of the training down to the UHE-ps. One of the significant contributions of the activity was the development of the core public health training modules for the competency-based training curriculum grounded in fundamental urban health problems. Based on the opinions of the key informants, the CPHT resulted in improvements in the skills and knowledge of UHE-ps. This was evident from the FGDs with UHE-ps and KIIs. Similarly, the activity provided technical guidance in the subsequent development of the IRT modules for UHE-ps, where the previous core public health training modules developed by the activity were used as reference and input to produce the IRT modules. The training outputs are reported in the “*Outputs of SEUH support for UHE-p capacity building*” section below.

Leadership management and governance (LMG) training. Another notable in-service training support that SEUH provided was the LMG training for RHB, C/THO and health center staff. The training aimed to build the capacity of managers and supervisors to identify and resolve bottlenecks to quality health service provision and effective UHEP implementation. Specifically, the LMG training for health center staff aimed to improve the quality of health services by improving the work climate, management systems, and individual responsiveness to change. SEUH supported FMoH with the training of RHB, C/THO and health center staff on LMG. Selected health center staff from Bahir Dar, Debre Markos,

Hawassa, Welayita Sodo, Mekelle, Aksum, Addis Ababa, Dire Dawa, Harari, Adama, and Shashamane benefited from this training.

Improving capacity for home-based screening for CDs and NCDs. The capacity-building training and provision of supplies (e.g., nursing bags with essential kits) contributed to strengthening UHE-p skills and improved accessibility of community-level urban health services. While the training imparted skills, the practical application of those skills enhanced mastery and improved UHE-p sense of professional growth and motivation. SEUH support enhanced home-based health education on different topics and screening and testing for selected health problems.

Pilot testing of the PHCR. Evaluation participants in Addis Ababa, Amhara, Dire Dawa, the SNNP region, and Harari reported that SEUH was one of the key partners to pilot test and scale up PHCR in urban areas. SEUH mainly provided technical support to FMoH in the process of developing the Primary Health Care Unit (PHCU) reform implementation guide and availing all the PHCU tools (e.g., data collection tools) during the piloting exercise. The PHCU, dubbed the Family Health Team Approach, involved UHE-ps, health officers, nurses, environmental health experts, and other professionals as required.

Feedback from participants suggests that FMoH intends to scale up the PHCU approach as part of the broader primary health care reform strategy. Evaluation findings indicate that the family health team approach is a very promising strategy, and SEUH provided technical and material support for the pilot testing of PHCU and also helped with the documentation and dissemination of results.

Improving service data recording. SEUH established strong data recording and reporting systems and built the capacity of the UHE-ps in capturing service data in all the supported towns and cities. Specifically, SEUH introduced an SDR tool to improve data documentation and reporting system in the supported towns and cities.

Establishment of QI teams in a sample of health centers. SEUH introduced the QI team initiative to facilitate ongoing facility and community health quality improvement in 73 health centers. The QI team approach primarily focused on using objective information to analyze and improve systems and service delivery. Initially, SEUH set up and developed a standard operating procedure which is a guiding manual on QI team formation process and how it functions to improve the quality of service in line with the demand of UHEP. After the establishment of the QI team, SEUH supported the training of QI team members where 810 members of the QI teams received training on quality improvement concepts and strategy. The outputs and outcomes of this support are described in the “*Outputs of SEUH support for UHE-p capacity building*” subsection.

Referral system strengthening. SEUH supported referral linkages by developing and distributing standard referral slips and undertaking supportive supervision and mentoring activities. Specific tasks for improving the referral system include:

- Providing referral slips and registration books to UHE-ps
- Establishing QI team
- Supportive supervision
- Capacity-building training for UHE-ps
- Supporting and facilitating review meetings including monthly referral performance review meetings
- Preparing and distributing referral toolkits & directories
- Technical support and facilitation to establish urban referral taskforce at the FMoH

Outputs of SEUH support for UHE-p capacity building

Training outputs. A total of 1,928 UHE-p were trained through the SEUH-supported CPHT and 2,263 received IRT training. Similarly, 133 and 622 selected government officials received TOT training on

CPHT and IRT, respectively. On the other hand, LMG training benefited 1,067 health professionals working in regional health bureaus, town health offices, and health centers (431 received only one round of the training and 636 completed all rounds of LMG training).

Respondents of evaluation interviews reported that the in-service training and other capacity-building support provided to UHE-ps play a crucial role in filling the knowledge and skill gap among UHE-ps and potentially enhanced their motivation to provide better service to the community. Respondents perceived that training on HCT service increased access to and utilization of HCT & FP services and linkage with health centers in the majority of the visited towns.

“...Before we took the family planning training organized by JSI, we only used to refer clients for FP service. It was after the training that we started providing injectable FP service...”

Moreover, respondents believe that the core public health training and the IRT training resulted in establishing standardized in-service training systems for UHE-ps, which is considered by FMOH and RHBs as one of the remarkable achievements of the activity.

LMG outputs. The LMG training provided by SEUH contributed to improving the capacity to identify and resolve bottlenecks to quality improvement. However, the result of the LMG training seems to differ from one town to another. In some health centers, the training was reported to have resulted in an improved capacity of the health center staff to resolve the quality of health services. The LMG training is further credited for improving internal revenue generation (due to enhanced skills on leadership, management, planning, and monitoring), reduced waiting time, resolved electric power problems, and improved capacity of diagnostic labs of HCs. This evaluation demonstrated that the LMG training was one of the useful ways for health centers to improve the quality of the service as well as to establish an efficient service delivery system. The training influenced staff to emphasize root-cause analysis in defining measurable activities and critical actions to resolve barriers that enabled teams to provide efficient service delivery.

“The LMG training brought remarkable change to resolve quality related problems; for example, one of the HC in Nifas Silk Lafto Sub City able to mobilize resource and purchased power Generator to remove power-related challenges. Nowadays, the maternity ward is giving service for 24 hours without any interruption. Moreover, the same HC able to purchase Ultrasound and established a working relationship with the nearby Hospital to engage the hospital staff on part-time bases for ultrasound reading.” (KII, Addis Ababa RHB)

Key informants from other RHBs also noted the positive outcomes of SEUH LMG training. In Addis Ababa, the health bureau fully funded two rounds of LMG training for 105 individuals from Amoraw and Gerji HCs (Bole Sub-city), Woreda 6 HC (Nefas Silk Lafto Sub-city), and Entoto #2 HC (Yeka Sub-city).

Another example of the success of LMG training comes from the Hayat health center in Addis Ababa. A key informant spoke about a complaint from clients about the waiting time. Through the root-cause analysis, Hayat health center conducted their study and found that clients spent too much time in the registry, mainly because of the incompetence of staff, shortage of workforce, personality issues, and manual processes. To address this issue, the health center added more manpower, trained the staff, automated their record system (computerization) and started the Mastercard identification system and also improved the payment collection system by adding another room next to the card room so that clients don't have to walk to different locations for records and payments. This helped to reduce the need for clients to go to various places for different services, and so helped to cut the waiting times. In this process, SEUH helped with training in root-cause analysis but the health center came up with their solutions.

PHCR outputs. In the towns where it has been pilot-tested, the strategy has reportedly resulted in:

- Improved access to health services for the urban community, which the teams provide in community centers, such as youth centers, schools, and worksites.
- Improved completion and tracking of referrals because referred clients get directed to health providers working within the same team.
- Improved follow-up and continuity of care for clients receiving routine services such as chronically and bedridden patients.
- Robust transfer of skills among the team members and from the more highly qualified health center staff to the UHE-p because of the diverse composition of their skill sets within the team. The skills transfer also helped improve the motivation of UHE-ps.
- Greater acceptance of the UHE-p by the community as professionals because of their working alongside the more highly qualified health center staff.
- Increased community satisfaction with UHE-p services.

Despite these perspectives on quality improvement resulting from the implementation of the family team approach, some limitations were reported. Factors that were reported to have affected effective implementation of the Family Health Team (FHT) approach include the shortage of health workers with different skill mix (e.g., social workers, mental health professionals) and the absence of specific and clear operational and management guidelines. For example, the THO and UHE-p supervisors said that financial guidelines on how the team collects service fees from users while providing services at the household level were lacking.

Service data. A positive output from SEUH support was the establishment of a data recording and documentation system in all supported towns. Specifically, the registration books, the introduction of the SDR tool, and subsequent technical support to ensure its implementation was a remarkable achievement in improving UHEP data management and reporting system. Besides, with the help of SEUH, the UHEP performance data are now included in the reports in some regional states such as the SNNP region and Addis Ababa city administration. As a result of the improved reporting of UHEP performance, the evidence is being used in planning and decision making, particularly at the lower levels.

Though the reporting system was designed, feedback from the SEUH staff indicates that UHEP data has not yet been endorsed for national utilization.

"SEUH asked the policy and planning directorate (PPD) at the FMoH to create a national community reporting system, but the PPD reportedly said the urban health program had not matured and was not uniform enough to develop a reporting system yet. The success of the urban health reporting system has been achieved in some regional states." (SEUH KII)

QI team outputs. Findings from most of the towns and city administrations visited by the evaluation team demonstrate that the QI team approach achieved tangible results. The QI team approach resulted in improved linkage and coordination between the health centers and UHE-ps. Key informants credited the QI team approach for the reduction in improved defaulter tracing and linking, referrals coordination, and enhanced uptake of UHEP services (e.g., ANC, FP, PNC, child immunization). For example, in Biftu Adama health center in Adama, the clients referred by UHE-ps increased from less than 100 to more than 1,000 within one year after the initiation of the QI teams approaches as reported by key informants. As reported by key informants, assigning referral focal persons at health centers, placing a box for referral slip collection, and better documentation of referral feedback slips resulted in improving the referral system.

However, the performance of the QI team varied across health centers. The QI teams in Nekemte and Adama (Oromia), Welayita Sodo (SNNP region), and Addis Ababa (e.g., Kolfe Keranio & Kebena HC) were considered exemplary in QI and efficiency of the service delivery system because of the higher level of commitments of health center staff and the active follow-up support. On the other hand, in an area such as Halaba town (SNNP region), the established QI team is in a nonfunctional state; no regular

team meeting takes place, and the linkage between the facility and UHE-ps was fragile and made no tangible results in the identified measurable activities.

Referral system improvement outputs. As reported in the KIs, improved linkages and coordination between the UHE-ps and the health centers resulted in better tracking of defaulters and implementation of referral systems and increased referrals made by UHE-ps to the HCs, in particular on child vaccination services, FP, ANC, and PNC. Section 4.3.3. “Exposure to SBCC and Changes in the Use of Health Services” presented later provides more data on the changes in the use of services.

Strengthening UHE-p management structures

SEUH identified UHE-p management structures as one of the intervention areas for improving the quality of community-level urban health services.

The revision of the UHEP implementation manual. The review of the UHEP implementation manual was undertaken to standardize the planning, implementation, and monitoring of UHEP implementation. Specific changes included:

- Identification of clear service delivery mechanism including household categorization and prioritization approach
- Integration of relevant and context-based service packages
- Better implementation strategies
- UHE-p management structure and accountability (better definition of roles and responsibilities)
- Better reporting and data management system

The activity supported the revision of the manual through technical guidance, financial support and the subsequent regional level contextualization and familiarization of the revised implementation manual with the critical UHEP stakeholders including FMOH, RHB, UHEP experts/focal persons and other relevant stakeholders. SEUH technical supports in the process of UHEP implementation manual revision includes the development of terms of reference for revising the manual, facilitating the establishment of a technical group at the FMOH, organized consultative workshop and supported validation assessments in selected towns to substantiate findings generated from the national consultative workshop. Upon approval of the revised UHEP implementation manual, SEUH further extended the support to ensure contextualization and familiarization of the revised implementation manual through organizing following workshops.

Improving the motivation of UHE-p. SEUH has implemented non-financial incentive interventions, such skills improvement through preservice and in-service training, performance-based recognition, distribution of umbrellas for UHE-p, providing desktop computers and office supplies, renovation of UHE-p duty-stations in the kebele's and health centers and ensuring constant availability of job aids, tools, and guidelines.

Outputs related to improvements in management structures

Evaluation participants had very definite views about the revision of the UHEP implementation manual. The following bullets summarize the perceived benefits of the manual review.

- It removed fragmented service delivery and, in many cases, improved UHEP performance and implementation. Before the revision of the implementation manual, regions and towns were implementing UHEP based on their specific contexts. For example, application of some parts of UHEP packages was not uniform. Moreover, there were no standard job aids and operational procedures to guide UHEP planning, implementation, and monitoring.
- The revised implementation manual enhanced the interaction between UHE-p and health facilities as a result of better UHE-p management structure. Additionally, after the

revision of the manual, the change on the reporting system and precise definition of UHE-p role & responsibilities brought accountability of UHE-ps.

- It created better strategies to reach vulnerable urban community members. The household categorization approach based on different socio-economic and health status parameters made mechanism improved the ability of UHEP to reach poor and vulnerable urban populations.
- A better definition of roles and responsibilities—supervision structure, relocation of the UHE-p offices to the HC from the Kebele (except in Oromia and SNNP region).
- Moreover, the revised manual improved and created opportunity to integrate additional community-level health care service in UHEP such as Mental Health, hypertension, cervical cancer counseling, and referral services and HCT service as a result of a better system for referral, supplies, and precise definition of roles and responsibilities of UHE-ps.

Despite these benefits, evaluation respondents identified some limitations and gaps with the manual. The manual mainly focuses on the urban poor living within a household setting but lacks guidance on implementation strategies for reaching the homeless urban population. The manual was also prepared before the development of the family health team approach and therefore does not include guidance on the procedures for this new strategy. Besides, household categorization based on socioeconomic conditions is mostly subjective.

SEUH's contribution to incentivizing UHE-ps, however, had mixed reviews although the majority views were positive. On the positive side, the UHE-p FGD participants appreciated SEUH support with the renovation of offices, the supply of equipment and office furniture and for establishing a system of performance-based awards, e.g., certificate awards. A majority were also pleased with the relocation of their duty stations and supervision to the health centers—a move that relieved them for random assignments to support kebele administrative and political activities. Furthermore, the relocation to the health center supervision improved the perception of self-esteem of the UHE-p because individuals with higher health services qualifications were supervising them. The UHE-p stationed at the health centers had a greater feeling of being health professionals in contrast to their experience working from the Kebele offices. However, many feel that their salary is low, that they lack career growth opportunities and think that UHEP is low in the government priority when compared with the rural HEW. These findings are consistent with the contents of the SEUH semi-annual report (2018), which observes that the establishment of a financial and non-financial incentive scheme for UHE-p is still a significant challenge to the UHEP implementation. The report points out that career development pathways including transfers, education, certification, training, compensation and appropriate job descriptions for UHE-p are critically affecting the motivation of these professionals. Moreover, in some towns, work overload was also reported:

"We are always looking an opportunity to leave this job ... there is no clear government direction on our career development. Other than short-term training, there is nothing created for UHE-ps to develop our profession. Additionally, ideally one UHE-p is responsible for 500 households, but in the actual practice we serve more than 500 households; for example, some UHE-p are responsible for more than 1000 households." (UHE-p FGD, Oromia Region)

1.1.2. DEMAND CREATION INTERVENTIONS

Under IR2, SEUH was mandated to increase the demand for facility-level health services, including reproductive health (RH), family planning (FP), HIV/AIDS, tuberculosis (TB), maternal and child health (MCH), and preventable communicable diseases (CDs). According to SEUH program documents, limited understanding of health services available at facilities, misconceptions about illness, and costs of health services and day-to-day demands on individuals' time are some of the leading causes of delay in seeking

or underutilization of urban health services. SEUH designed and implemented several interventions to address these issues and to increase the demand for facility-level urban health services. This section outlines the main contribution and outputs of these interventions.

Strategic and behavioral change communication (SBCC). SEUH designed SBCC messaging materials and education and recording tools based on the findings of their formative research, field experiences, local knowledge, and expert input. Participants in the SBCC strategy development included representatives of FMOH, SEUH, RHBs, and UHE-ps. Following the development of the strategy, SEUH developed various SBCC materials. These included the family health card, which was adapted to the urban health context and flip charts, job aids and posters with critical messages on urban health issues. SEUH supported and monitored the utilization of these SBCC materials and tools by UHE-ps. These materials were used in demand creation efforts and for health education and counseling services during the house visits at the community level and outreach campaigns in schools and community events.

Public-private partnerships (PPPs) for SBCC and IEC. SEUH established partnerships with public media entities to promote urban health issues and to influence changes in health behaviors. These included partnerships with regional media entities such as Dimtsi-weyane FM radio 102.2, Fana Broadcasting, Amhara Mass Media Agency, FM 100.9, FM stations in Addis Ababa, and Oromia Radio & Television Organization. Under these partnerships, the media entities accepted to provide free airtime for the SEUH-supported SBCC and educational programs. SEUH created media forums constituted with representatives from government and private FM radios, newsletters, television broadcasting centers, and FMOH communication department. SEUH provided technical support (including training and content development) and developed the SBCC and educational materials and tools. SEUH also produced and aired radio magazine programs and television and Radio spots, songs, and documentaries to promote key reproductive, maternal, newborn, and child health (RMNCH), HIV/AIDS and WASH behaviors and health-seeking behavior and demand for facility-based services. The radio magazine programs, in particular, promoted facility-based services, healthy behavior, and services provided by UHE-ps, and the programs were aired in Amhara (Malefiya), SNNP region (Malefiya) and Oromia (Dansa), and other implementation regions. An independent audience survey was not conducted to assess the listenership and effectiveness of these radio magazines. The SEUH 2018 semiannual report states that audience feedback gathered by the broadcasting media entities showed that the radio programs were highly targeted, presented entertainingly with valuable information, and addressed the government's focus on health issues. According to the same report, feedback from the radio station journalists also attested that the *Malefia* radio program was catchy and audience-oriented.

Furthermore, as part of its PPP to increase demand for services and promote healthy behavior, SEUH partnered with Diageo, an international brewing company, to raise awareness of the harmful effect of underage drinking in 31 high schools, 19 youth centers, and households reached through the UHE-ps.

Community mobilization campaigns. SEUH undertook and supported community mobilization campaigns. These included community health days, hand-washing days, pregnant women conferences, Breast Cancer Walks, HIV catch-up campaigns and African Child Days. These campaigns were used to increase awareness about UHEP services and to mobilize the urban poor to seek the package of health services provided by the UHE-ps and the health centers. Counseling, screening, testing, and treatment for health conditions were conducted. Health services in HIV, sexually transmitted diseases, cancer, pregnancy and diabetes, and immunization were provided, but these services were irregular.

Communication and social mobilization capacity building. SEUH implemented several activities to improve the communication and social mobilization skills of the UHE-ps. Before conducting community mobilization capacity building, SEUH carried out a rapid assessment on community mobilization and interpersonal communication skills of UHE-ps. Based on the findings of the rapid assessment, the interpersonal communication module was developed, and Community Mobilization Behavior Change Communication (CMBCC) training was designed and provided to UHE-ps. The evaluation found that the

CMBCC and interpersonal communication training helped in enhancing the UHE-ps' knowledge and skill in interpersonal communication, health education, counseling, and community mobilization. Furthermore, the health education toolkits developed by SEUH and provided to UHE-ps enhanced their knowledge and skill on health education and community mobilization, which consequently helped to improve the quality and effectiveness of community mobilization and demand creation activities at community level.

"...The CMBCC training provided by SEUH to UHE-p provided the practical skill to conduct effective communication and counseling with all community members, including those who used to resist their services..." (UHE-p FGD, Adama)

"...Access to and quality of MNCH education services has improved as a result of the community mobilization and behavior change communication training received and counseling tools provided by SEUHP..." (UHE-p FGD, Ambo)

"...Because of the training is given by JSI, UHE-p managed to organize a series of events or meetings during which they educated the community on non-communicable diseases, and this has enhanced community awareness on NCDs. Community awareness about Diabetes has increased because UHE-ps gave special attention to diabetes by conducting house to house visit to each household..." (UHE-p FGD, Halaba)

SEUH carried out several studies to understand urban health dynamics, including identification of high-risk individuals and health-seeking behavior in urban contexts and generate evidence for design and development of evidence-based and context-specific urban health demand creation tools and activities. Accordingly, SEUH conducted different studies related to SBCC, including the urban vulnerability assessment, which focuses on maternal, newborn, and child health (MNCH), FP, WASH, and HIV/AIDS, Formative Behavior Change and Communication (BCC) assessment, Knowledge, Attitude, and Practices (KAP) surveys and situational analysis of urban sanitation and waste management in Ethiopia. The findings of these assessments were used by the SEUH team to design the demand creation/community mobilization strategy and develop IEC/BCC materials contextualized to urban health contexts, which were later used by the UHE-ps to carry out household-based and outreach health education and counseling activities.

Demand creation outputs

From the demand creation activities of SEUH, several SBCC messaging materials, job aids, and recording tools were developed. The job aids helped to improve the skills of the UHE-ps and to standardize communication talking points, which contributed to improvements in the quality of service. The SBCC strategies reportedly influenced health-seeking behavior and subsequently increased in uptake of urban health services in the supported towns. This view is based on the qualitative findings. The data presented in Figures 4 and 5 and Table 3 reflect the contributions of the demand creation activities to the utilization of services. SEUH PPPs with public media resulted in leveraging resources for running media campaigns because the media houses ran the SBCC programs at no cost to SEUH. Additionally, the Activity trained the public media staff on the UHEP messaging.

1.1.3. EXPOSURE TO SBCC AND CHANGES IN THE USE OF HEALTH SERVICES

The ultimate aim of SEUH support was an increase in access to and utilization of community-level health services among the urban poor living in the supported towns. Moreover, feedback from KIIs and FGDs shows that exposure to SBCC materials and enhanced capacity of UHE-ps to deliver SBCC services may have contributed to the improvements in screening, counseling, and referral services for NCDs such as cervical cancer, mental illness, and high blood pressure. Changes in the use of other health services based on SEUH monitoring data are reported in subsequent tables and figures.

SBCC. A 2018 service quality assessment conducted by SEUH found that community awareness about UHE-p services was not uniform across the health services included in the UHEP package. As shown in Table 3, knowledge of environmental health, vaccination, and health education services were generally higher than the awareness of services such as first aid and referral services, home-based HIV care and support services, child growth monitoring, and nutrition screening services.

Table 3: Percentage of Individuals Who are Aware of, and Who Have Used Specific Services Offered by the UHE-ps

| Services Provided under UHEP | Level of community awareness about service by UHE-ps (n=589) | Reported Utilization (n=589) |
|--------------------------------------|--|------------------------------|
| Environmental health services | 89.4% | 75.7% |
| Health education | 76.3% | 56.5% |
| Child vaccination | 67.3% | 39.2% |
| First aid | 7.3% | 2.2% |
| Referral services | 9.2% | 3.1% |
| HIV care and support | 14.3% | 3.7% |
| Nutrition screening services | 16.4% | 9.7% |
| Postnatal care | | 7.8% |

Source: SEUH Activity Report “Quality of Health Services in Urban Health Extension Program and its Associated Challenges in Ethiopia: A baseline Descriptive Study.”

The same report also showed that environmental health services, health education services, and child immunization have been among the services reported to have been used by most of the community members, while services such as first aid, referrals, HIV/AIDS care, and support and PNC had meager rates of utilization.

PPPs with the public and private media (both electronic and print) increased engagement of the media to disseminate messages and provide health education on priority urban health topics using their own air time. Some of the contributions made by media agencies in Addis Ababa who participated in SEUH media engagement platform are indicated in Table 4 below.

Table 4: Urban Health Issues Addressed by Different Media

| Media Agency | Type of media | Urban Health issue addressed |
|---|----------------|---|
| Addis Zemen | Print | <ul style="list-style-type: none"> - Solid waste management practice in Addis Ababa, its associated health and environmental problems, and possible solutions including recycling. - Malnutrition, its effect, and government response. |
| Addis Lisan | Print | <ul style="list-style-type: none"> - World AIDS day - The current status of HIV prevalence in Addis Ababa, including most vulnerable population groups and targeted services to reach this group - MNCH services in the PHCU and the challenges related to service quality - SEUH-initiated LMG, its result |
| Ahadu FM Radio 104.3 (Wanaw Tena Radio Program) | Broadcast (FM) | <ul style="list-style-type: none"> - Proper latrine utilization of households in Addis Ababa - “HIV the current challenge of Addis Ababa.” |
| FM 98.1 | Broadcast (FM) | <ul style="list-style-type: none"> - Discussions on the overall UHEP service package including major activities of UHE-ps. |

| Media Agency | Type of media | Urban Health issue addressed |
|--|---------------------|--|
| Sheger FM 102.1 | Broadcast | - The challenges of women that are living on the street such as Reproductive health (RH) and related health problems including HIV and sexually transmitted infection (STI) |
| Zami 90.7 FM Radio (LiyouGebeta Radio Program) | Broadcast | - The increasing prevalence of HIV in the city and updated service packages including the new HIV test algorithm. - Exempted and waiver fee health services in primary health care units for underserved (poor) community. - The waste management practice in Addis Ababa and lessons learned from the case of Koshe was also aired. - Pharmaceutical stock management and community nutritional knowledge and practices have been addressed in the past four months. |
| Ethiopian Herald Magazine | Printing | - Issues that require higher level decision making such as: "Not to waste the waste" was a column about how to minimize, handle, and recycle waste at all levels; Hazardous waste management, occupational health and safety practices, and HIV programs were also addressed. "Curbing the misuse of Antibiotics" was another program produced in this magazine. |
| Addis Ababa RHB (AARHB) Communication Office | Print and Broadcast | The Addis Ababa RHB communication office mainly uses Addis television and FM 96.3 to do programs and news about all issues related to public health services available at public health centers and hospitals with a particular focus on the UHEP including - - the series of training sessions provided by health bureau on IRT for UHE-ps - LMG training for selected PHCU implementing health centers. - Community TB screening and linkages issues. |
| SEBEZ Media (Ahadu Radio) | Broadcast | - Hand washing practice (SEUHP facilitated an interview with the WASH expert from the FMOH) |

Source: SEUHP Semi-Annual Report, June 2018. *The utilization of health services (EDHS analysis).*

As mentioned in the methods section, secondary analysis was conducted on the EDHS 2011 and 2016 datasets. This analysis was exploratory and intended to measure changes in the indicators of use of health services and WASH (water sources and toilet types of households) among all women living in the urban areas of the SEUH implementation regions regardless of their socio-economic status. This analysis is not a direct measure of SEUH or UHEP results, but only provides a contextual view of changes in the target health and WASH indicators, which are also a component of the UHEP priorities. The results in Tables 5 to 9 include all SEUH implementation regions. Detailed tables with region-specific comparisons are included in Annex V.

Family planning use. As shown in Table 5, the use of family planning among all sexually active non-pregnant urban women remained the same (41%). However, while the use of long acting reversible (LARC) methods increased from 5.3% in 2011 to 18.1% in 2016, there was a decline in the use of short acting methods (SAM) from 48.4% to 37.5%. These findings suggest that the increase in LARC use may have resulted from the SAM method switchers. The use of permanent methods is very low.

Table 5: Percentage of Sexually Active Non-Pregnant Urban Women Using Specific Family Planning Methods

| EDHS Year | | FP Methods used | | | | | | |
|-----------|--------------|-----------------|----------|---------|----------------------|------------------|---------------------|----|
| | | None (%) | LARC (%) | SAM (%) | Permanent method (%) | Other method (%) | Total (%) | |
| 2011 | Estimate (%) | 41.0 | 5.3 | 48.4 | 1.7 | 3.6 | 100 | |
| | SE (%) | 2.6 | 1.0 | 2.9 | 0.5 | 1.0 | Not Applicable (NA) | |
| | 95% CI | Lower | 36.0 | 3.7 | 42.7 | 1.0 | 2.0 | NA |
| | | Upper | 46.1 | 7.6 | 54.2 | 3.1 | 6.3 | NA |
| 2016 | Estimate (%) | 41.0 | 18.1 | 37.5 | 0.5 | 3.0 | 100 | |
| | SE (%) | 2.4 | 1.6 | 2.5 | 0.2 | 0.6 | NA | |
| | 95% CI | Lower | 36.4 | 15.1 | 32.8 | 0.2 | 2.0 | NA |
| | | Upper | 45.7 | 21.5 | 42.5 | 1.2 | 4.3 | NA |

Facility deliveries. Compared with the 2011 EDHS, a large percentage of urban women in the 2016 survey delivered their more recent child (born within the past five years) in a health facility. Home deliveries declined from 44.2 percent (SE=4.1%; 95% CI [36.3, 52.4]) in 2011 to 13.6 percent (SE=3.4%; 95% CI [8.4, 21.5]) in 2016. Most of the deliveries reported by women in the 2016 EDHS either took place in a government health center (42.5 percent) or hospital (34.3 percent) 95% CIs [36.6, 48.9] and [28.0, 41.2] respectively.

Table 6: Percent of Distribution of Places of Delivery Used by Urban Women during the Birth of the Most Recent Child Born within the Last Five Years

| Years | | Place of delivery | | | | | Total | |
|-------|--------------|-------------------|---------------------|--------------------------|-----------------------|-------------|-------|----|
| | | Own or other home | Government hospital | Government health center | Other public facility | Other place | | |
| 2011 | Estimate (%) | 44.2 | 22.5 | 24.1 | 1.2 | 8.0 | 100 | |
| | SE (%) | 4.1 | 3.4 | 3.9 | 0.6 | 1.7 | NA | |
| | 95% CI | Lower | 36.3 | 16.4 | 17.3 | 0.5 | 5.2 | NA |
| | | Upper | 52.4 | 30.0 | 32.5 | 3.4 | 12.1 | NA |
| 2016 | Estimate (%) | 13.6 | 34.3 | 42.5 | 0.9 | 8.5 | 100 | |
| | SE (%) | 3.3 | 3.4 | 3.2 | 0.5 | 1.3 | NA | |
| | 95% CI | Lower | 8.4 | 28.0 | 36.4 | 0.3 | 6.3 | NA |
| | | Upper | 21.5 | 41.2 | 48.9 | 2.8 | 11.5 | NA |

HCT. The EDHS results show a slight drop (4 percent) in the percentage of urban women who have ever been tested for HIV. Note however that the CI for the 2011 results is wider (10.8 percent) compared with the CI for the 2016 results (6.3%).

Table 7: Percent Distribution of Urban Women Who Have Ever Been Tested for HIV

| Years | | Ever been tested for HIV? | | |
|-------|--------------|---------------------------|------|------|
| | | No | Yes | |
| 2011 | Estimate (%) | 24.7 | 75.3 | |
| | SE (%) | 2.7 | 2.7 | |
| | 95% CI | Lower | 19.7 | 69.5 |
| | | Upper | 30.5 | 80.3 |
| 2016 | Estimate (%) | 28.7 | 71.3 | |
| | SE (%) | 1.6 | 1.6 | |
| | 95% CI | Lower | 25.6 | 68.1 |
| | | Upper | 31.9 | 74.4 |

Water sources and toilets. Tables 8 and 9 show the findings related to water sources and toilet types of households in the 2011 and 2016 EDHS. There is virtually no change in the water sources used by urban households between the two surveys. The majority relies on water piped to a neighbor's house or a public tap. Very few households have water piped to their dwelling. With regard to toilets, the findings from the 2011 and 2016 EDHS, present a promising picture. Between 2011 and 2016, the percentage of urban households with a pit latrine rose from 66.7 percent to 74.4 percent, 95% CI [55.9, 76.1], [70.3, 78.2] respectively, an increase of approximately eight percent between 2011 and 2016. Households with a flush toilet also increased by six percent.

Table 8: Percent Distribution of Water Sources Among Households

| Years | | Water source | | | | | | |
|-------|--------------|-------------------|------------------------------|----------|-----------------------|-------------------------|-------|-----|
| | | Piped to dwelling | Piped to neighbor/public tap | Borehole | Protected well/spring | Unprotected well/spring | Other | |
| 2011 | Estimate (%) | 6.0 | 80.2 | 1.4 | 5.0 | 4.6 | 2.9 | |
| | SE (%) | 1.6 | 3.4 | 1.2 | 1.6 | 1.8 | 0.6 | |
| | 95% CI | Lower | 3.4 | 72.6 | 0.2 | 2.6 | 2.1 | 2.0 |
| | | Upper | 10.1 | 86.1 | 7.6 | 9.4 | 9.6 | 4.3 |
| 2016 | Estimate (%) | 4.2 | 83.0 | 2.6 | 4.9 | 1.6 | 3.6 | |
| | SE (%) | 0.9 | 3.2 | 1.7 | 2.1 | 0.6 | 0.5 | |
| | 95% CI | Lower | 2.8 | 75.9 | 0.7 | 2.1 | 0.8 | 2.8 |
| | | Upper | 6.3 | 88.4 | 9.4 | 11.0 | 3.4 | 4.7 |

Table 9: Percent Distribution of the Type of Toilet Among Urban Households

| Years | | Toilet type | | | | | |
|-------|--------------|--------------|-------------------------------|--------------------------|-------------|-------|-----|
| | | Flush toilet | Ventilated improved pit (VIP) | Pit with or without slab | No facility | Other | |
| 2011 | Estimate (%) | 7.9 | 2.1 | 66.7 | 17.4 | 5.8 | |
| | SE (%) | 2.3 | 0.6 | 5.2 | 5.8 | 0.9 | |
| | 95% CI | Lower | 4.4 | 1.2 | 55.9 | 8.7 | 4.3 |
| | | Upper | 13.8 | 3.7 | 76.1 | 31.8 | 7.9 |
| 2016 | Estimate (%) | 13.8 | 1.6 | 74.4 | 5.6 | 4.5 | |
| | SE (%) | 1.5 | 0.4 | 2.0 | 1.4 | 0.7 | |
| | Lower | 11.1 | 1.0 | 70.3 | 3.4 | 3.4 | |

| Years | | Toilet type | | | | |
|--------|-------|--------------|-------------------------------|--------------------------|-------------|-------|
| | | Flush toilet | Ventilated improved pit (VIP) | Pit with or without slab | No facility | Other |
| 95% CI | Upper | 17.1 | 2.5 | 78.2 | 9.1 | 6.0 |

The utilization of health services (SEUH evaluation findings). The findings described here describe the results that are directly linked with the interventions of SEUH. For all monitoring data presented in this section, note that the 2014 and 2018 data are partial because of the timing of SEUH inception and the evaluation.

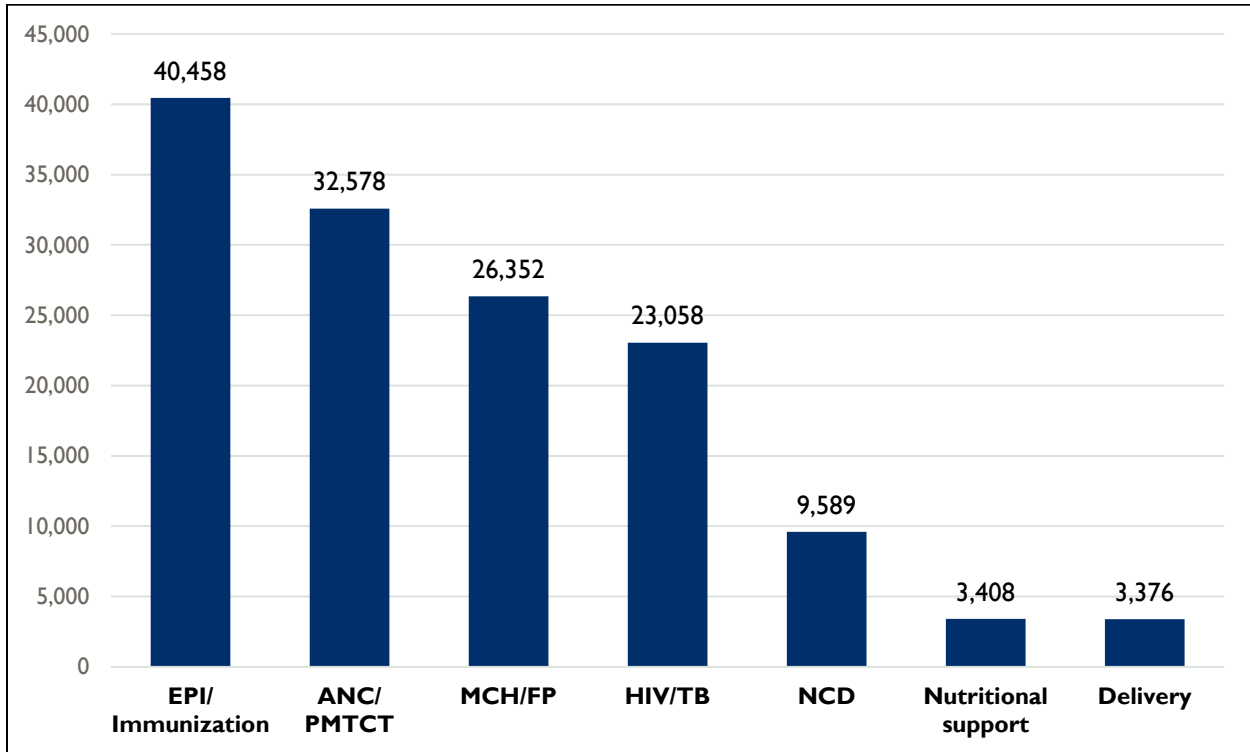
There were variations in the level of HCT by region/city administration. The reasons for these variations were different based on the type of services. In some regions (Harar, Amhara, SNNP, and Oromia), HCT was conducted through referrals to health centers as well as home-based testing. This may have resulted in more significant numbers of individuals tested. In the regions where the home-based HCT services were not implemented, the concerns included the reluctance of the region to accept home-based HCT because of uncertainty about the quality of counseling and privacy of the clients. Participants also cited the easy availability of facility-based testing services in the communities as another reason for the reluctance to accept home-based testing. Screening and referral were, however, undertaken. Even in the cities where home-based HCT was conducted, frequent shortages of testing kits were reported. Another concern raised about home-based HCT was the fact that standard home-based HCT policy guidelines in Ethiopia had not been developed. This resulted in the reluctance of some RHBs and town health offices (THOs) to support routine/regular household-level HCT service provision by UHE-ps. Instead, the UHE-ps were advised to conduct screening and referrals of individuals to the health center. Some of the UHE-ps were uncomfortable with performing home-based HCT because of their lack of confidence in their pre- and posttest counseling skills. They wanted the testing to take place at a health facility where privacy is assured, and the clients can receive adequate support and advice in response to the result of their test. Furthermore, some UHE-ps were also afraid to conduct home-based HCT due to the fear of the possible community reaction should they get to know that someone in their community tested positive. As shown in Table 10, a total of 42,170 urban dwellers were counseled and tested for HIV in the supported towns—640 (1.5 percent) were found to be reactive to the HIV test. For all other CDs and NCDs, the chronic lack of screening/testing kits was widely reported, which also affected the quality of UHE-p services.

Table 10: Number of Beneficiaries Tested for HIV

| | Addis Ababa | Amhara | Dire Dewa | Harari | Oromia | SNNP Region | Tigray | Total |
|---------------------------|-------------|--------|-----------|--------|--------|-------------|--------|---------------|
| Indicators | | | | | | | | |
| Tested | - | 13,716 | 3,427 | 871 | 16,993 | 4,280 | 2,883 | 42,170 |
| Reactive | - | 145 | 38 | 14 | 321 | 96 | 35 | 649 |
| Percent/prevalence | | 1.06 | 1.11 | 1.61 | 1.89 | 2.24 | 1.21 | 1.54 |

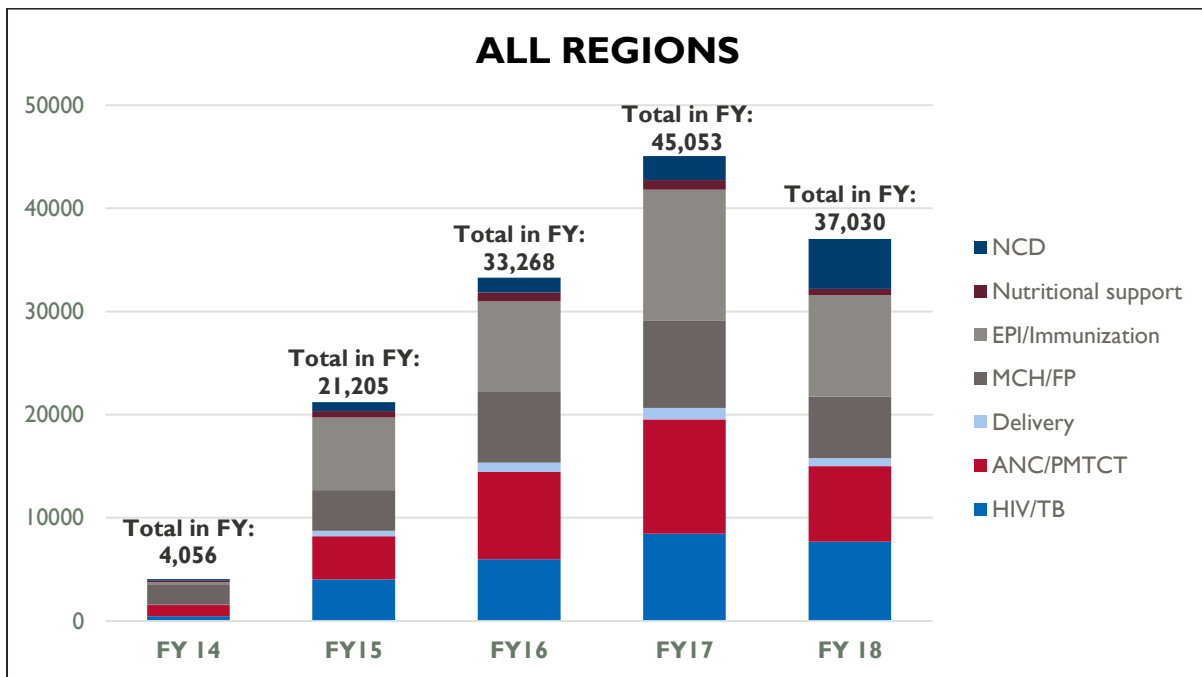
During the KIIs with UHE-p supervisors and the UHE-p FGDs, the evaluation team obtained opinions indicating that the trend in the completion of referrals increased due to the support provided by SEUH for UHE-p supervision, documentation and follow-up if defaulters. The most substantial referrals captured in the monitoring data were for the emergency plan for immunization (EPI) activities and antenatal care (ANC)/PMTCT. Moreover, as a result of strengthened linkages between UHE-ps and the health centers, defaulter tracing is improving. Defaulter tracing has specifically been effective in increasing the utilization of child immunization, ANC follow-up, PMTCT, FP, and other RMNCH services increased because of the activity support. Referrals for facility deliveries, nutritional support, and NCDs are low.

Figure 4: Total Number of Individuals Referred to a Facility by Service Type (FY14 to June 2018)



Source: Analyzed from SEUH monitoring database

Figure 5: Breakdown of Referrals by Year and Type of Service



Source: Analyzed from SEUH monitoring database

However, as reported by key informants, there are still gaps and areas that need improvement in the referral system. There is an incomplete referral system loop, and the proportion of completed referrals is still low in most of the towns and cities visited. Unsatisfactory completion of the referrals by community members and submission of the referral slips at the point of service was reported to be poor in some areas. Documentation of the referrals and feedback by the UHE-ps was also reported as an area that needs improvement. Completion of the referrals was also said to be impacted by the quality of service at the health centers. Participants noted that there were instances where clients were referred to health centers but upon getting to the health centers, the services referred for were either lacking, poorly delivered or incomplete. The shortage of testing kits, specific medications or qualified health providers, and noncompletion and the return of referral slips with feedback by the health center providers are examples of the gaps that affected the greater success of the referral system.

Sanitation, waste management, and water. In the towns where SEUH implemented the WASH initiative, households were provided with technical assistance to construct pit latrines, access safe liquid and solid waste disposal facilities, and design and install hand-washing facilities near the latrines. Findings from the KIIs and FGDs showed that health-seeking behaviors for sanitation and waste management increased. For example, key informants in Oromia reported that some community members and groups started to exert pressure on their city administration officials to put in place infrastructure for the proper discharge of solid waste.

"...Community awareness and health-seeking behavior for sanitation and waste management services have significantly increased. As a result of increased awareness, some community members even started putting pressure on the city administration to dispose of garbage properly..." (SEUH staff, Oromia region)

The SEUH monitoring data were analyzed to examine the performance of SEUH sanitation and waste management indicators. Figure 6 shows the targets versus achievements on sanitation and waste management indicators, while Table 11 shows the achievement by region. Overall, SEUH exceeded their targets for supporting households to gain access to safe solid and liquid waste disposal and to construct a hand washing facility near their latrines. They failed, however, to meet their target on the construction of basic latrines.

Figure 6: Target vs. Achievement of Sanitation and Waste Management Services (FY14 to June 2018)⁵

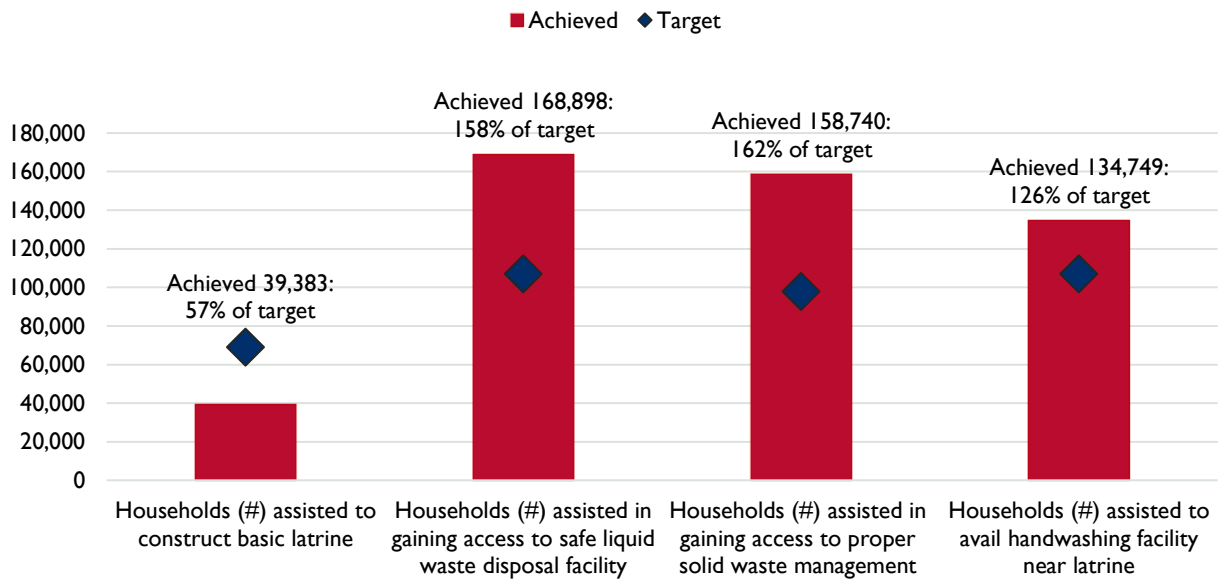


Table 11: Number of Households Assisted by SEUH to Construct/Access Specific WASH Facilities

| Region | Households (#) assisted to construct basic latrine | Households (#) assisted in gaining access to safe liquid waste disposal facility | Households (#) assisted in gaining access to proper solid waste management | Households (#) assisted to avail handwashing facility near latrine |
|--------------|--|--|--|--|
| Addis | 647 | 11,433 | 11,075 | 14,373 |
| Amhara | 9,134 | 54,976 | 40,710 | 35,540 |
| Dire Dawa | 219 | 2,534 | 2,381 | 2,012 |
| Harari | 357 | 3,138 | 4,024 | 2,484 |
| Oromia | 12,148 | 31,933 | 40,357 | 19,386 |
| SNNP Region | 14,730 | 59,916 | 55,855 | 49,326 |
| Tigray | 2,148 | 4,968 | 4,338 | 11,628 |
| Total | 39,383 | 168,898 | 158,740 | 134,749 |

SEUH did not do much in supporting households to improve access to water. Most of the households interviewed in the FGDs cited water as a major problem for their households. The Activity provided training and construction support to improve access to water in only five towns in Amhara and Tigray. The implementation of the initiatives to improve access to water was impacted by the resignation of the designated partner, WaterAid, from the contract. Until the fourth year of the Activity, there was only one staff member assigned to lead WASH activities, which also included water. In the fourth year, regional WASH specialists were hired primarily for emergency WASH-related activities, including water purification and rehabilitation of water points. The water initiatives were implemented in Sekota,

⁵The IP-reported figure on households assisted in constructing basic latrines is very high compared with the value computed by the evaluation team from the activity's dataset.

Kombolcha, and Kemisie in Amhara. For Tigray, the water initiatives were implemented in Adigrat and Alamata. The planned water interventions in the SNNP Region and Oromia were not implemented. Refer also to Annex V to see the detailed results on water sources for urban households in the SEUH implementation regions.

1.1.4. STRENGTHENING OF REGIONAL PLATFORMS

Training to enhance managerial capacity. SEUH supported LMG capacity enhancement training for RHBs, ZHDs, C/THOs, and health center staff. The LMG training aimed to enable urban health leaders to identify and fill gaps that have hindered the effective implementation of the UHEP. The training is designed for health care providers and health workers and is believed to improve work climate, management systems, individual responsiveness to change, and delivery of high-quality health services in an equitable manner to ultimately improve health outcomes. SEUH also supported Integrated Supportive Supervision and coaching skill training for UHEP program officers and supervisors as well as HC technical staff and UHEP officers to enhance their skill, knowledge and attitudes to carry out knowledge-based, appropriate, and fruitful coaching/mentoring practice which is capable of improving performance of UHE-ps so as to increase service uptake and quality of services.

Supporting learning and experience-sharing visits. SEUH, in collaboration with FMOH, organized the first national urban health conference, held on April 3-4, 2017, in Addis Ababa. The conference was organized under the theme *Ethiopia's Urbanization and Its Implication on Health: Acting Now to Save the Future*. The purpose of the conference was to share lessons and experiences among different scientific and experiential backgrounds in urban health and apply them to the case of Ethiopia's growing cities. SEUH also supported structured learning and experience-sharing from the visit to Thailand from October 30 to November 4, 2017, with the aim of facilitating of learning on primary health care and WASH by hosting individuals from government health systems and stakeholders from other countries to translate learning to action through targeted post-visit follow-up. The purpose of the learning trip was to learn how Thailand has developed its national health financing and delivery systems to achieve universal health coverage, understand the critical reforms to the Thai primary health care system and the structures that Thailand has established for integrating health research, and evidence generation for the policy-making process.

Technical support to build institutional capacity of RHBs, C/THOs, and health centers. SEUH provided technical support to RHBs, C/THOs, and health center staff to develop tailored and context-specific workplans based on the revised UHEP implementation manual. Furthermore, RHBs were technically supported to conduct integrated supportive supervision in urban areas. Integrated supportive supervision (ISS) falls under the jurisdiction of RHBs and is a necessary step to ensure and monitor the quality of services delivered within government health facilities and at the community level. As part of this effort, SEUH provided technical and logistical support to RHBs in planning for ISS visits, reviewing checklists, supporting the execution of ISS, and preparing and implementing action plans based on the feedback from the ISS. SEUH also provided targeted technical support to C/THOs and HCs and helped them conduct regular supportive supervision to UHE-ps and their supervisors. SEUH worked with town health offices by jointly planning and conducting joint supportive supervision for skill transfer and provided targeted technical support to C/THOs and HCs and help them conduct regular supportive supervision and review meetings to create a platform for improved implementation of UHEP through continuous performance monitoring efforts. SEUH also supported the city/town level program quarterly review meetings and monthly UHE-p supervisors' review meeting technically and logistically.

To strengthen the implementation of the data management system of the UHEP, SEUH supported the implementation of data management used at C/THO level (i.e., collection, collation, analysis, reporting, and use) through regular ISS and on-site coaching. Furthermore, SEUH contributed to the development of operational guidelines, user manuals, and CHIS tools and supported the pilot-testing by producing

CHIS recording tools and guidelines and by cascading of training to UHE-p and their supervisors in SEUH supported towns/cities. SEUH technically supported the revision, familiarization, implementation, and standardization of the UHEP implementation manual conducted familiarization workshops for decision-makers and both facilitated and participated in the monitoring the application of the requirements of the manual at the regional, town and health center levels. SEUH also developed and provided service provision toolkits as well as referral tools, and a referral directory that guides UHE-ps on where they should refer clients, how they should refer, and how to follow-up on the completion of referrals.

Evidence generation and use on urban health issues. SEUH established an Urban Health Development to serve as the center of excellence and knowledge hub to inform policies and strategies on urban health. The center is charged with generating evidence on urban health and promoting the use of evidence to strengthen the capacity of regional platforms on urban health. The center has conducted several assessments and policy briefs on urban health issues that have been discussed in an urban health think tank. Unfortunately, the think tank is reportedly a loose group without the capacity to effect change. The participation of group members was also reported to be poor.

Provision of supplies and strengthening commodity mobilization and distribution system. SEUH supported the regional platforms to improve methods for commodity mobilization and distribution for key urban health intervention areas. SEUH also carried out a series of discussions and advocacy meetings with RHBs, C/THOs, and HCs and other stakeholders on the supply needs of the UHEP as indicated in the revised UHEP implementation manual. These meetings resulted in getting contraceptive supplies, condoms, and HIV test kits to UHE-ps in SEUH implementation towns. SEUH also conducted a review of the existing gap of essential items that UHE-ps require and prioritized supplies and equipment to be provided such as blood pressure apparatus (sphygmomanometers), nurse's bags, and umbrellas among them. SEUH also provided supplies to UHE-ps such as blood pressure apparatuses, thermometers so that they screen NCDs and measure blood pressure, which increased acceptance and respect of UHE-ps by the community they serve. SEUH also procured and distributed bags and umbrellas to all UHE-ps who reside in SEUH-supported areas.

Results related to the strengthening of regional platforms

Training to enhance managerial capacity. The health LMG training reportedly improved the leadership and management capacity of health system managers in RHBs, C/THOs and HCs to identify and resolve bottlenecks to quality improvement and improved delivery of health services across the health system. Furthermore, in some health centers, the LMG training enhanced the leadership, management, planning, and monitoring skills of the health center staff on local resource mobilization, which increased internal revenue generation, reduced the waiting time of clients, resolved electric power problems, and improved the capacity of diagnostic labs of HCs.

"...The LMG training brought remarkable change to resolve quality related problems; for example, one of the HC in Nifas Silk Lafto Sub City mobilized resource and purchased power generator to remove power-related challenges. Nowadays, the maternity ward is giving service for 24 hours without any interruption. Moreover, the same HC was able to purchase Ultrasound and established a working relationship with the nearby Hospital to engage the hospital staff on part-time bases for ultrasound reading..." (Addis Ababa RHB representative)

"...Biftu health center in Adama was awarded as best performing health center after its staff took the health LMG training and managed to significantly increase the number of deliveries attended in the HC as a result of the training ...", (key informant from town health office, Oromia region)

Support for learning and experience-sharing visits. The national urban health conferences supported by SEUH served as key policy forums to promote the commitment of high-level government officials for urban health issues. Furthermore, the WASH strategy document, i.e., the national Integrated Urban Sanitation and Hygiene Strategy (IUSHS), was officially endorsed. Efforts to sensitize the regional sector offices about the WASH strategy and to provide policy level direction on the WASH strategy was initiated to ensure its implementation. The national urban health conference also attracted stronger political attention to UHEP.

"...For urban health to get priority, it needs to get the attention of political leaders because all managers pay attention to an agenda that is coming from higher political leaders..." (key informant, SEUH Staff)

Knowledge gained and lessons learned from the learning trip to Thailand were also shared with senior management staff at FMOH, and implementation plans were developed to apply the lessons learned.

Technical support to build institutional capacity of RHBs, C/THOs, and HCs. SEUH's support for the revision, familiarization, implementation, and standardization of the UHEP implementation manual contributed to improving the definition and application of roles and responsibilities, data recording and management, and the operations of UHE-ps. WASH indicators developed for rural settings were contextualized to be used in urban areas.

"...Initially, the indicators for UHEP were taken directly from the rural health extension program without any contextualization. As a result, some indicators in the rural HEP, for example, "Households who prepared places for burning solid waste" was not relevant to use it for urban areas. In light with these challenges, SEUHP supported the customization and revision of indicators to be relevant for measuring urban WASH situation...", Key informant (SEUHP head office staff)

The sensitization and familiarization workshops organized by SEUH to introduce the revised UHEP implementation manual also motivated the kebele administrations to provide office spaces for community-level service delivery of the UHE-p. For example, where UHE-p were unable or afraid to conduct HCT at the household level due to privacy factors, some kebeles have provided office space for such services. Furthermore, the decision to shift the duty stations and supervision of the UHE-p from the kebele to health center as provided in the revised implementation manual helped in improving the implementation of the UHEP by creating a favorable environment to better implement mentoring, coaching, supervision and monitoring practices in the UHEP implementation process.

The service provision toolkit prepared and provided to UHE-p by SEUH increased the type of services they offer and the quality of services. SEUH also strengthened referral linkages for urban health service provision by providing referral tools and the referral directory.

As a result of SEUH technical support, supportive supervision system and quality were strengthened, and regular supervision was implemented in line with the government routine.

"...SEUH staff do not go out by themselves for supportive supervision without having the town health office and other staff from the government health system in the team. The training and follow up support provided by SEUHP helped in strengthening the system and quality of supportive supervision of regional health bureaus and town health offices. However, due to a low number of cluster coordinators, the level of supportive supervisions conducted at town level is low..." (key informant from SNNP regional health bureau)

SEUH also catalyzed the RHBs, T/CHOs, and HCs to conduct joint planning and implementation of activities. Regular supportive supervision and review meetings were commonly reported in the regions as a practice that SEUH helped to strengthen. Despite this observation, the evaluation team found that

that the regional platform initiatives were not as effective as the town level platforms. This was mainly attributed to the high staff turnover and reassignments or transfer of health managers, busy schedules of the responsible staff and competing priorities.

SEUH developed CHIS reporting tools for an urban setting, which were piloted in Addis Ababa, Oromia, and SNNP regions. Scale-up of the CHIS will be undertaken by the FMoH. Through the CHIS and the UHEP data recording and reporting system, SEUH also developed an electronic database to facilitate the timely reporting of UHEP performance. With SEUH support, data on the UHE-p reports on the performance were submitted to the RHB. SEUH was also credited for revitalizing the supportive supervision system. SEUH introduced an electronic mobile data collection system—the Open Data Kit (ODK)—to capture supportive supervision findings. These initiatives improved health service data management system because the linkage between UHE-p and health centers has been strengthened through the utilization of standardized recording, reporting and feedback tools and approaches. Furthermore, as a result of SEUHPs support, UHE-p documentation of their work and confidence in their achievement has also increased.

"...If someone complains that I did not do my job, I have a proof of my data recording tools and the referral feedback that I received to show that I have done my job and defend my hard work. However, previously, anyone can accuse me that I didn't do my job and I didn't have anything on my hand to justify the work I have done even if I worked hard...." (UHE-p FGD participant in Halaba town)

"...SEUHPs support contributed to better data recording and documentation in UHEP. Overall there is a significant performance difference between SEUHP intervention and non-intervention towns. Indeed, there has been no attempt to generate concrete evidence to see the difference. However, based on feedback and information collected from different RHB level field visits, we have seen that in towns where there is no strong review meetings and supportive supervision, there is no established UHEP data recording, documentation, and reporting system and motivation of UHEPs is very low compared to the UHE-ps working in the SEUHP intervention towns..." (Oromia RHB representative)

"...The government would not have prepared the daily recording tools if it was not for SEUH. Still, in areas that are not supported by SEUHP, UHE-ps are registering daily activities on a simple piece of paper. SEUH prepared a standard and quality format to register a list of available and provided services and provided a standardized referral tool, unlike other NGOs who prepare their referral tool that will disappear after the NGO phases out...." (Adama THO KII)

"SEUHP is a pioneer in initiating documentation of UHE-ps activities. SEUH provided the data recording tools, supervision, assistance in data cleaning, data analysis, and learning. The data recording tools have guide notes written on them so that UHE-ps quickly understand how to fill them." (UHE-ps FGD participants, Addis Ababa)

"...The service recording tool developed and provided by SEUHP eliminates false reporting. The reporting system used before SEUHP support did not include service level individual-based data..." (Ambo THO KII)

One of the activities implemented under the key result area of strengthening regional platforms focused on providing supplies and strengthening commodity mobilization and distribution system. In this regard, the Activity support was reported to have resulted in improved contraceptives, condoms, and HIV test kits supplies to UHE-p in SEUH implementation towns. SEUH's supply of blood pressure apparatuses and thermometers increased access to health services, including NCD screening services, and improved acceptance and respect of UHE-ps by the community they serve. The regional platforms were noted by

key informants to have been instrumental in advocacy with the RHBs to improving the availability of supplies and commodities.

Despite these results on the strengthening of regional platforms, some gaps exist. The urban health information system has not been linked with the HMIS. Resource and commodity mobilization by SEUH was not directly supported though SEUH has assisted with supplies occasionally and with the distribution of logistics. Due to a low number of Cluster Coordinators, the ability to adequately participate in supportive supervision is low. However, the strategy for SEUH should not necessarily center on participating in all supportive supervisions but strengthening the capacity of the regions to conduct supportive supervision.

1.1.5. SECTORAL CONVERGENCE FOR URBAN SANITATION AND WASTE MANAGEMENT

Intersectoral collaboration is critical to promoting urban health services. It falls under IR4 of the SEUH results framework. To this end, SEUH designed interventions to support and advocate for intersectoral collaboration to help meet the challenges of urban sanitation and waste management by forging partnerships with different stakeholders and foster political will for successful implementation by engaging different leaders and stakeholders from relevant sectors. In summary, activity performance on sectoral convergence was found to be poor due to a lack of clear structure for coordination and collaboration, which made it very difficult to engage the sectors, and participants were often mid- to junior level staff, with limited engagement or interest from the heads, which made the coordination weak.

Despite these challenges, SEUH achieved the following results:

- Facilitated the development and signing of integrated urban sanitation and hygiene management strategy.
- Empowered the RHBs to cascade and customize the approach.
- Generated evidence.
- Conducted capacity-building training.
- Held WASH LMG for relevant government sector offices.
- Supported the adaptation of LMG training to WASH sector.
- Supported the establishment/revitalization of town-level WASH forums.
- Supported construction of public toilets in Kemisie and Mekelle.

Below is a detailed description of the activities and the results of SEUH interventions related to sectoral convergence.

Training and capacity-building support on the urban WASH. SEUH supported the training of UHE-ps using the WASH IRT modules. SEUH developed competency-based training modules and cascaded capacity building training to UHE-p, supervisors, and C/THO staff in SEUH cities/towns. SEUH's WASH training module was customized into the national IRT guideline including water, sanitation and hygiene module and Post training follow up was carried out in all the regions where SEUH is working. SEUH also organized training for WASH actors on basic and emergency WASH response and prevention and control of AWD. As part of its partnership to contribute to efforts to ensure safe drinking water supply and prevention and control of water-related health problems, SEUH conducted three-day training on water quality management for water utility offices, water technicians and technical staffs of Shashemene, Chiro and Hawassa towns. Sensitization workshops were also performed for WASH stakeholders in SNNP, Addis Ababa, Oromia, Amhara, and Tigray regions.

SEUH also customized the health LMG training manual to WASH LMG in collaboration with FMOH and provided training to members of town-level WASH forums in selected implementation towns. The WASH LMG training was designed for health care providers and health workers to improve work

climate, management systems, individual responsiveness to change, and delivery of high-quality health services in an equitable manner to ultimately improve health outcomes. The LMG teams identified measurable results for their respective sectors, and these achievements will be documented during the next reporting periods. In collaboration with WASH LMG trainers selected from universities, SEUHP provided coaching, and post-training follow up support to make sure that trainees organize a results presentation meeting to present and discuss the implementation of their action plan from the training.

Evidence generation and use on urban WASH. Understanding the bottlenecks and challenges for improving sanitation and waste management in urban areas is critical for designing and implementing context-specific and relevant interventions. To this end, SEUH carried out various WASH-related assessments; including a Situation Assessment on Sanitation and Waste management, mapping of public WASH facilities and functionality in 28 cities/towns and an assessment of private sectors involvement in urban sanitation and waste management service delivery in Ethiopia. Some of the evidence from these assessments were used to inform government policies and program improvement. For example, the findings from the situational analysis of urban sanitation and waste management were used as an input to formulate the integrated urban sanitation and waste management strategy. Additionally, the evidence generated from the study done on the situation of private sector engagement on sanitation and solid waste management helped to formulate an alternative PPP approach and management model to enhance the participation of the private sector in urban sanitation and waste management. Furthermore, the findings of these assessments and the identified challenges to promote urban hygiene, sanitation, and waste management were used to design and implement capacity building trainings as well as advocacy and sensitization workshops to create better awareness and understanding on the issue and clarify the role of responsible sectors to address the issue in a coordinated manner.

Technical and financial support to promote intersectoral collaboration and commitment for urban WASH. Following the endorsement of the national Integrated Urban Sanitation and Hygiene Strategy, SEUH provided technical and material support to RHBs for contextualizing the strategy. The contextualization involved the adaptation of the strategy's Strategic Action Plan (SAP), Implementation Guideline (IG), and MoU into the regional contexts with the participation of the Regional WASH actors. SEUH facilitated the regional contextualization workshops and funded the translation of materials to regional languages and printing and distribution of the strategy. Some regions have adopted the strategy, but some are yet to embrace it.

SEUH supported the establishment and revitalization of WASH forums in 13 towns. SEUH facilitated a series of meetings with regional and town level sector offices in collaboration with town health offices. These WASH forums were established among key government sectors to undertake joint implementation of sanitation and waste management activities outlined in the Integrated Urban Sanitation and Hygiene Strategy.

Promoting PPP. One of SEUH's intervention areas focused on promoting PPP for urban sanitation and waste management. SEUH assessed the private sector involvement in urban sanitation and waste management services. Based on the findings, a PPP implementation guide and alternative PPP business and management model was developed. Aligned with this model, SEUH supported the development of a new public communal latrine architectural design and construction of Model Public latrines using PPP management model. The public toilets were constructed in Kemise, Kombolicha, Adigrat, Alamata with financial support from SEUH. SEUH also undertook advocacy for the new public latrine design and management model to be used implemented in 22 World Bank supported WASH project towns in collaboration with the Ministry of Water Resource.

Another area of technical support related to PPP that was undertaken by SEUH was the improvement and standardization of a water bill collection system by the private sector. Dessie, Debre Markos and Adama towns benefited from this support. Also, SEUH created model WASH demonstration sites in selected cities/towns and developed and tested a PPP model on urban sanitation and waste management

and public toilet management models. Regarding capacity building to promote PPP, SEUH prepared training materials on entrepreneurship and business skills and provided training to enhance the management and technical capacity of private sanitation and waste management service providers.

Sectoral convergence results

Under the sectoral convergence, the main findings of SEUH support were the support for the development and signing of integrated urban sanitation and hygiene management strategy. The strategy empowered the RHBs to cascade and customize the strategy to their local contexts and to establish/revitalize the town level WASH forums and signing of MoUs and joint action plans and supported the construction of public toilets in Kemisie and Mekelle towns. Overall, the evaluation showed poor performance of SEUH on enhancing inter-sectoral commitments for urban health within the government line offices, mainly because of the lack of a clear structure for coordination, which made it very difficult to engage the sectors. Participants in the intersectoral convergence meetings and workshops were often mid to junior level staff, with limited authority to make decisions. The engagement and interest from the sector heads were shallow, which made the coordination weak. Furthermore, the financial and human resource limitations from SEUH, coupled with delayed implementation of this result area also contributed to the observed poor performance. The fact that the health sector is not adequately empowered to effectively mobilize principal sector offices on urban WASH also added to weak inter-sectoral collaboration and commitment in most urban areas.

Training on urban WASH. The WASH LMG training increased attention of policymakers and high-level government officials on the importance of urban WASH and created an opportunity to improve the capacity of different sector office staffs on leadership, management, and governance-related issues to mitigate the problem of sanitation and solid waste management. The WASH LMG training provided by SEUHP generally improved common understanding of various sectors on sanitation and waste management.

Evidence generation and use of urban WASH. The findings of assessments conducted by SEUH on WASH-related issues showed and inculcated improved awareness and understanding among responsible sectors and motivated some actors to take necessary action. For example, a presentation of assessment findings in Mekele city prompted the city administration to construct public latrine and shower and improved management of liquid waste disposal from factories and hotels. The assessment findings were also used to provide capacity building support on the urban WASH. This includes the provision of basic WASH training to harmonize level of WASH understanding among key sectors (Municipality, Health, Education, Finance and Economy, Greening and Beautification, Environmental Protection and Forest, Water and Sewerage, and other city/town WASH sectors) to enhance their understanding on WASH issues and their sectoral responsibilities to address the issue. Policy briefs were submitted to FMOH, and the assessment findings were published on different journals. SEUH used its assessment findings to carry out advocacy efforts on urban WASH at various workshops and conferences. Another more recent example is that higher level political decision-makers identified WASH as one of the top four good governance interventions in Addis Ababa. However, there were limitations in a timely translation of the generated evidence into policy and program action.

Technical and financial support to promote intersectoral collaboration and commitment. The evaluation found that the establishment of WASH platforms enhanced sectoral understanding that sanitation and waste management is the agenda for all sectors and require a common agenda and joint action plan. Following the establishment of WASH forums, MoUs and collective action plan that specify responsibilities assigned for each sector were prepared and signed among sectors in WASH platform towns to enhance their commitment for coordinated implementation of hygiene and waste management actions. Even though the MoUs are weak in enforcing accountability, it created a common understanding among members of the importance of collaboration on urban waste management and sanitation. Nonetheless, the implementation of the action plans to-date is very slow.

Because of the efforts related to WASH forums, city and town administrations have started to give more attention to sanitation and waste management issues. For instance, in some of the locations where EDA implements WASH in, the towns and cities have started to allocate budget for solid and liquid waste collection and disposal and to transform the green areas.

SEUH support to promote intersectoral convergence has contributed to improved collaboration among relevant sectors on sanitation and waste management as relevant sectors offices in some towns already started to jointly plan and review WASH related activities. In this regard, a collaboration of sector offices in Debre Markos and Hawassa cities are exemplary. This collaboration helped to integrate and pool resources from different sectors and bring collective action to alleviate urban WASH situation. SEUH support for regular review meetings involving all relevant sectors and kebele administration also contributed to enhancing sectoral collaboration and commitment.

Outcomes on promoting PPP. The advocacy and sensitization activities carried out by SEUH under the PPP initiatives influenced some implementation towns to increase the number of small and micro enterprises engaged in the solid waste collection. However, the PPP interventions implemented by SEUHP were at a higher level, mostly focused on advocacy and capacity building but with little contribution strengthening PPP for urban sanitation and waste management on the ground. The evaluation also indicated that SEUH's efforts to engage the private sector in constructing public latrines, biogas, and other WASH activities were unsatisfactory and unsuccessful. Some of the PPP models tested for example in Hossana and Dessie were unsuccessful. In Hosaena, SEUHP facilitated the establishment of an association under the micro and small enterprise program to engage in the production of briquette (charcoal) from organic waste generated from the town. SEUH also supported the training of members of the association to ensure a viable business initiative and the startup capital for the association could be secured from private entities and micro-finance institutions. However, the association failed to operate the business due to the lack of adequate market linkages, poor promotion and limited market for their products—all pointing to a poor feasibility assessment. Furthermore, SEUH's plan to construct additional model public communal latrines based on the PPP management models in Gondar, Halaba, Shashamane were unsuccessful due to resource constraints. The evaluation also found that the existing PPP system established under government initiative for primary waste collection is fragile and has different bottlenecks to have efficient PPP for solid waste management.

Conclusions

The SEUH contributions to improving the quality of UHE-p health services have been strong. The Activity supported GoE efforts to increase the availability of HRH through CPHT, IRT and LMG training, which resulted in several UHE-p and their managers receiving training to enhance their skills. These pieces of training strengthened the competencies of the UHE-p and their managers as demonstrated by the observations from KIIs and FGDs and are further evidenced by the increased uptake of health services.

Based on the qualitative evidence, the QI initiatives of SEUH succeeded in improving skills, the utilization of recording and reporting tools, referrals and defaulter tracking. The evaluation team established evidence of data utilization for planning, supervision and implementation monitoring and improvement at different levels of UHEP implementation, which likely motivated improvements in data collection and reporting. SEUH also employed a very successful PPP initiative with media institutions which resulted in cost savings to SEUH through the free airtime that was offered for UHEP messaging. Most importantly, this partnership demonstrates the viability of leveraging resources through non-cash contributions from private sector entities.

SEUH's performance on sectoral convergence was weak, however, due primarily to the lack of a formal structure for multisectoral coordination and collaboration, something which was outside of the direct control of SEUH. Frequent transfer of staff in government offices, the shortage of WASH specialists in

SEUH due to the withdrawal of the WASH sub-partner, WaterAid also affected intersectoral convergence outcomes negatively. The interventions to improve household access to water suffered the most, having been implemented only in two out of the seven Activity regions.

Recommendations

SEUH helped to create reliable systems for data collection, reporting, and use, which have taken effect in UHEP. SEUH played the lead role in analyzing and facilitating discussions on the UHEP monitoring data. Future activities should strengthen the capacity of specific government offices at the RHB and C/THO to analyze, convene and lead the dissemination and data utilization efforts. Intersectoral convergence is a challenging task that requires higher-level government involvement. While the SEUH could undertake advocacy efforts, the GoE should develop formal guidelines for intersectoral engagement in urban WASH initiatives. Related to PPP, the model applied by SEUH with media entities was a success. Future activities should map UHEP priorities against the private sector companies in the implementation locations and identify possible non-cash contributions of such companies to UHEP results.

EVALUATION QUESTION 4: TO WHAT EXTENT ARE THE SEUH ACTIVITY STRATEGIES AND INTERVENTIONS SUSTAINABLE?

1.1.1. PERCEPTIONS ABOUT THE SUSTAINABILITY OF SEUH RESULTS AND STRATEGIES

SEUH sustainability strategies embedded within each of the intermediate result areas focus on building the capacity of the health system at FMOH, RHB and THO levels to ensure ownership and sustainability of results. SEUH's sustainability strategies of SEUH included:

- Capacity-building activities through pre- and in-service training.
- Development and implementation of standard tools, manuals, and protocols.
- Improving the quality of health services and demand creation.
- Promoting evidence-based decision making through research on urban health issues.
- Improving the leadership and management skills of health offices at different levels and other sectoral offices.

Outcomes

Capacity building. There was a positive perception from key informants about the sustainability of the IRT training that was supported by SEUH. For example, a training of trainers (TOT) for IRT was provided to people at RHBs and C/THOs through SEUH initiation. These trainers cascaded the training to the UHE-ps. SEUH provided technical and basic material support for the planning and execution of the training. FMOH has now allocated funding for cascading the IRT training at the national level. Most of the key informants believed that the SEUH capacity-building initiatives for UHE-ps would be sustainable after the SEUH closeout. This observation is based on the fact that capacity-building initiatives have been included in the UHEP implementation manual, and training materials, tools, and guidelines have been developed by the Activity and shared with the government offices at all levels and teams of trainers have been established in all regions. However, the LMG for WASH capacity-building training was cited as unsustainable in most of the regions because it has not been fully rolled out in all regions, intersectoral engagement is weak, the resources scale up, and skills implementation monitoring have not been allocated. So far, Addis Ababa is the only example where the LMG training has scaled up directly by the government. Moreover, apart from the MoU signed between sector offices for the hygiene and sanitation strategy, no government entity has been mandated to continue the LMG initiatives. Poor participation of office heads in the LMG training further complicates the sustainability of LMG capacity-building efforts.

“Sustainability of LMG training is unlikely because this training is resource intensive and requires a lot of follow up.” (Adama THO KII)

Quality improvement. The GoE has bought into the quality improvement initiative. To this end, SEUH in collaboration with the FMOH and RHBs conducted a workshop to develop a national quality improvement manual for community-based health services. This workshop was organized with the aim to institutionalize the quality improvement initiative. SEUH was also supported by the health centers management teams. Additionally, the performance of the QI team depends on the management of the health centers—those health centers with positively interested management teams have a higher performance than those with lower interest.

Service delivery and referral system. Key informants and UHEP-p FGDs had mixed views about the continuity of timely production, distribution, and use of SDR tools and referral slips. While most of the key informants occupying senior positions in the government offices held the view that the production, distribution, and use of the SDR tool and the referral slips is sustainable by the government, most of the UHE-p supervisors and UHE-p FGD participants were doubtful. A decline in the quality of materials and irregularities in their supply is, however, expected by KII and FGD participants.

“The UHE-p use a standardized template (a tool to daily register services provided for visited families every day) and submit a monthly report to SEUHP and the health system. The health system may not be able to reprint this tool due to resource limitations and lack of a clear plan on the way forward.” (KII with RHB)

The evaluation team observed that functional equipment for UHE-ps, such as blood pressure apparatuses and thermometers, were lacking in some towns, which impeded the work of the UHE-ps. This observation is also backed by the findings of a 2017 SEUH assessment in Amhara, which found that 90 percent of UHE-ps had no functional blood pressure monitoring apparatuses, thermometer or infant weight scales. The same assessment indicated that there is a lack of dipsticks for pregnancy and diabetes testing, paracetamol, rapid diagnostic test kits for malaria and malaria drugs and water treatment chemicals. The revised UHEP implementation manual materials list these as necessary supplies for UHEP services. KII and UHE-p FGD participants confirmed these observations. Therefore, the sustainability of the results achieved in improving screening and referrals, data recording and reporting, and defaulter tracing may either decline or vary from one region to another, and even within the region, from town to town.

PHCU reform. PHCU reform is likely to be sustainable because of the strong government ownership of this initiative and the commitment of government funding to PHCU. The Harari city administration has gone further than all other regions to allocate a budget for the ongoing PHCU pilot initiative from the municipality funds. Besides, the practice of skill transfer from senior health center staff through joint community service delivery has helped with strengthening UHE-p skills. When fully implemented, the PHCU approach has the potential of creating a reliable system for continuous mentoring and coaching of the UHE-p by the health center staff.

CHIS. Most of the key informants, particularly those who were aware of the CHIS pilot-test, stated the government is committed to scaling-up the CHIS implementation given the desire of the government under the primary healthcare reform, to undertake efforts towards a data collection, reporting and use revolution. A supporting example from the KII at the FMOH is the new mobile-based electronic Community Health Information System being developed by the FMOH to capture data on the Health Extension Program (HEP) including UHEP.

WASH sectoral convergence. SEUHPs result and implementation approaches on WASH sectoral convergence have low prospects of being sustainable because these efforts are still in infant stages and need further government and donor commitment and attention. Large financial, logistical and technical resources are required to implement WASH. SEUH used a gradual roll-out approach to implement

WASH. At the time of the survey, SEUH had mainly conducted data gathering and consultative activities. The weak support from sector offices further renders WASH initiatives unsustainable after the SEUH closeout.

1.1.2. CHALLENGES TO SUSTAINABILITY

Resource-related challenges are the dominant limitation to the sustainability of SEUH results. Though SEUH has developed tools, manuals, and guidelines and fully shared these materials with the government, budget allocation for the reproduction of these materials is inconsistent and currently funded from health center revenues.

“The UHE-ps use standardized tools (e.g., tool to daily register services provided for visited families every day and submit a monthly report to SEUHP and the health system). The health system may not be able to reprint this tool due to resource limitations and lack of a clear plan on the way forward.” (THO KII, Assela)

Moreover, compared with the rural health extension program, some of the key informants (including at FMOH) stated that commitment of the government to prioritizing UHEP and allocating adequate resources for its implementation is still low. This is further evidenced by the fact that the GoE has not advocated enough to increase the donor-support bases for UHE-ps—USAID is the only donor supporting UHEP.

The evaluation also found that human resource challenges are likely to affect the sustainability of SEUH results. Most of the key informants and the UHE-ps observed that the number of UHE-ps is deficient relative to the volume of the urban poor needing health services, which has resulted in work overload for the UHE-ps. Additionally, most of the UHE-ps said their motivation was low due to their work burden, limited incentives available to them, the lack of career progression opportunities and the apparent preference of the rural health extension workers by the GoE compared with UHE-ps.

“... There is no system for the opportunity to education- there is no system to upgrade them, so they continued to leave their jobs. There is no growth or rotation- UHE-ps works in the community all the time. However, there is even rotation in hospital, they are there all the time. They should be allowed to be transferred or have other options. Some UHE-ps have worked in the same place with little change for more than ten years.” (SEUH staff, Amhara)

Sectoral convergence results, in their current state, are not sustainable given that the SEUH interventions are still in infant stages. In most of the towns evaluated, WASH sectoral meetings are not taking place regularly, the participation of sector offices is weak, and the view from other sector offices that UHEP is an activity of the FMOH.

The numerous and diverse needs of the urban poor groups were also cited by KII participants as another significant threat to sustainability. A holistic approach should directly or through linkages with other donors and implementing partners address the economic needs of the vulnerable urban communities and target the better-off households with relevant interventions, e.g., education on sanitation and hygiene.

1.1.3. CONCLUSIONS

Evaluation findings show that most of the SEUH results are still far from sustainable because of deficiencies in resources. The government is still perceived as favoring the rural HEW program more than the UHE-p, and this view is based on the greater opportunities for growth and material support that the GoE provides to the rural HEW. Similar opportunities and support have not been extended to UHE-p. The donor support to UHEP is also limited to USAID.

For the results that are reportedly sustainable, the closeout of SEUH will result in lower quality of outcomes. Referrals, production of tools and the IRT training will continue, but the delivery may not be very good. Other specific areas where quality drops include joint supportive supervision, evidence generation, reporting, and community mobilization efforts. Furthermore, activities around intersectoral convergence are still very weak. While the urban health strategy and MoU have been signed with line ministries, these are still new, and there is no means to enforce their implementation. Unless revisions are made to sectoral policies and guidelines to mainstream and provide resources for WASH, the intersectoral interventions will not be sustainable.

I.1.4. RECOMMENDATIONS

The evaluation team recommends that future initiative should continue to support timely and efficient supply distribution of commodities to work toward sustainability of SEUH results. Donor support is essential to the continued viability of UHEP initiatives; otherwise, UHEP will not be able to match the growing demand for urban health services. A future activity should support the government with increasing the understanding of the roles of different sectors in urban WASH initiatives and establishing policy guidelines and resource commitments to support urban WASH priorities in support of intersectoral coordination. Furthermore, because the support for system-level improvements appears promising—given evidenced government ownership of initiatives such as IRT—future initiatives should continue supporting system improvements.

KEY LEARNINGS AND IMPLEMENTATION ADAPTATIONS

The SEUH evaluation established key learnings and implementation adaptations.

RELEVANCE, PRACTICALITY, AND IMPLEMENTATION EFFICIENCY

This evaluation established that the GoE lacked implementation capacity at different levels. For example, human resources were limited, budget allocation for urban health was very low compared with UHEP implementation needs, and capacity gaps to deliver quality services at the community level were evident. There was also high staff turnover at all levels (e.g., UHE-p reportedly resigned frequently, the mayors and other government employees were frequently transferred). In several of the towns and RHBs visited by the evaluation team, several key informants had not been in their positions from the SEUH start-up. Additionally, the number of UHE-p and the number of households assigned for each UHE-p were too high, and the lack of clear career paths and incentive packages for UHE-p were major demotivating factors.

SEUH made several adaptations to mitigate the effects of these limitations:

Co-location. SEUH staff co-located within the GoE offices at zonal levels and, in some cases, at regional levels (e.g., Dire Dawa and Harari). Co-location of these staff created effective coordination and support. They worked closely with GoE staff in planning and implementing all components of the program and collaborated in training and supportive supervision. They ensured SEUH activities aligned with the GoE plans, facilitating smooth implementation. Overall, this evaluation found that co-location of some positions with the government offices created effective coordination and support for the implementation success of SEUH. Additionally, the co-location of SEUH cluster coordinators facilitated the mentoring, joint planning, monitoring, and implementation of the activities.

Shifting the workstation of UHE-ps to the health centers. SEUH convinced the federal and regional governments to shift the UHEP station from kebele administration to the health center, which improved implementation. It also improved the mentoring, coaching, supervision, and monitoring practices at health center level. The UHE-p stationed at the health centers had a greater feeling of being health professionals in contrast to their experience working from the Kebele offices which is considered as a rational decision to bring better UHEP performance. The decision to shift the station of UHEPs from Kebele to health center largely improved the implementation of the program. The shift improved the mentoring, coaching, supervision and monitoring practices in the UHEP implementation process which can be also considered as one of the driving factors for SEUH achievements.

Defining a career progression path for UHE-ps. One of the key lessons learned from this evaluation is that defining a clear career path and progression for UHE-ps and improving their working conditions such as office space is critical to motivate UHE-ps so as to minimize their attrition and enhance their performance for effective UHEP implementation.

PHCU reform. Evidence from the evaluation shows that this approach has the capacity to meet the health needs of the urban poor comprehensively. However, scaling up piloted initiatives such as LMG and QI, strengthening the primary health care team, and involving all levels of the health care tier are critical to achieving better results from the primary health care reform approach. To ensure effectiveness and sustainability of WASH interventions, it is necessary to engage institutions that generate a lot of waste (such as industrial parks, private factories and industries, universities) in WASH committees and forums.

Flexibility. SEUH's design permitted flexibility in the implementation approaches, which allowed SEUH to customize interventions based on local needs and priorities. SEUH made changes to their interventions and packages to adapt to the context of the regions and the communities.

A *system-focused design*, allowing for a gradual shifting of capacity building and system support to the government, was a practical strategy. It resulted in the GoE making commitments to sustaining some system-level capacity building initiatives of SEUH. The SEUH design focused on systems strengthening, allowing for the gradual shifting of capacity building, and system support to the government. However, several issues emerged during implementation. A strategy for handling those emerging issues must be established during the design stage. For example, the SEUH developed multiple models and worked with the government to scale-up these models. These included models for WASH, QI, and LMG capacity building, which were subsequently scaled-up by the government. The models that the government prioritized and accepted were rolled out by the government using their resources, for example, Addis Ababa, with their resources, scaled up the LMG work on hygiene and sanitation. However, introducing several models within a context of limited capacity both of the GoE and the Activity affected the scale-up of implementation, resulted in differential acceptance implementation modalities across regions based on existing capacity and concerns from regions where the rollout of these models happened in the tail-end of the activity.

The alignment of SEUH with the government strategy was a key learning for how to successfully work with government systems and personnel. SEUH worked closely with GoE in planning and implementing all components of the program. GoE employees at all level were well acquainted with the program, and they collaborated in training, manual adaptation, implementation guideline contextualization, and supportive supervision. Despite this success, there is a risk of being pulled in different directions given the capacity gaps in the government offices and their evolving priorities, which could affect progress. SEUH should ensure plans are included in the design to mitigate the possible effect of such factors on implementation.

*"...SEUH has no different service components and strategy from that of UHEP. It tried to bring alternative and practical implementation approach to strengthen the government UHEP."
(SNNP Region SEUH Staff)*

Breadth of the activity. SEUH was too broad in scope for their funding level and organizational capacity. The WASH component requires a substantial investment of resources and a dedicated team or sub-partner. Also, the focus on WASH education and community mobilization with limited infrastructure support weakened the achievement of WASH results. Fundamental changes during implementation included SEUH involvement in emergency activities (such as acute watery diarrhea), dropping out of WaterAid from the partnership, not implementing graduation strategy and assigning technical advisors (not directly related with SEUH immediate objectives) to the ministry. Other areas supported but not initially in the plan included HIV home-based testing. Initially, there were mixed views in adopting HIV home-based testing. However, after reviewing the lessons learned among the early adopters, Home testing has been accepted as part of the revised UHEP implementation manual recognized as a service that can be provided by HEW-p. Such expansions in services also call for resource expansion.

The intersectoral collaboration for WASH was a major weak point in the performance of the SEUH Activity. Addressing the need for adequate resources for urban WASH and higher-level policy dialogue with relevant sector offices would likely bring a better result under sectoral convergence initiatives. Formal directives from the higher levels of government specifying the contributions from each sector and resource commitments, such as funding and human resources could result in the success of intersectoral work, but this had not happened, resulting in the weak performance of SEUH in this area.

"The scope of SEUH implementation is extensive...The result areas need more focus." (SEUH Staff, Addis Ababa)

“The urban health challenges related to WASH are immense and need substantial investment such as building infrastructure. Activities related to WASH can form another standalone project.” (SEUH Staff, Addis Ababa)

“During the implementation of this project (Activity), what I have noted is emphasis was not given to epidemiological transition, the whole Healthcare tier system not included in the design, health insurance was not addressed in the design and limited Capital investment such as in latrine construction.” (Amhara Regional Health Bureau Staff)

“As women development army leaders we need more health-related training if there are any. Of course, the UHE-p give us training, but we need more.” (FGD participant, Addis Ababa)

Gender. This evaluation established that the UHE-ps provided services to all the available members of a household in the community. In each UHE-p FGD, participants said they served all members of a household without discrimination. As per the implementation manual, UHEP gives priority to households with pregnant women, under-five children, sick person and elderly. The SEUH design put significant emphasis on women and children, but strategies for male involvement and services were lacking. The SEUH design also did not include interventions to address gender-based violence (GBV) or a strategy to increase the engagement of men in the UHEP or work on the gender balance between UHE-ps and their supervisors. These are all critical elements for gender-responsive programming. While these components were included in the SEUH technical proposal, specific interventions were not implemented.

Increasing the number of cluster coordinators. In the smaller towns, the UHE-ps complained about the level of support provided by cluster coordinators (CCs). They complained that the visits were not frequent enough. As the CCs were expected to cover three towns, they were not able to provide support frequently and at the expected levels. The staffing pattern and professional mix seem too thin as one goes away far from the center. At the time of the evaluation, no adaptations had been undertaken by the activity to address the overload on the CCs.

Attempts have been made to engage the private sector; however, the support provided was not sufficient to make a significant difference or impact in ensuring the engagement of the private sector. SEUH planned to engage the private clinics and hospitals in strengthening the referral system but these plans were not been implemented.

The other notable lessons from the implementation of SEUH draw from the PPP model used to establish a strong partnership with the media entities. SEUH employed a very successful PPP initiative with media institutions, which resulted in cost savings to SEUH through the free airtime that was offered for UHEP messaging. Most importantly, this partnership demonstrates the viability of leveraging resources through non-cash contributions from private sector entities.

OVERALL RECOMMENDATIONS

USAID is the only donor that has supported the GoE UHEP. The multiple and diverse needs of urban poor populations require a greater engagement of other donors.

Although the USAID assistance through SEUH has significantly responded to UHEP priorities around CDs, future programs, projects, and activities should also include resources for addressing the rising rates of NCDs among the urban poor.

UHEP and SEUH have effectively reached the urban poor living in home settings but have not put in place a systematic approach for reaching the homeless poor. The government should spearhead consultations with regional actors, donors, and IPs to devise strategies for reaching the urban homeless poor. The mobile nature of these populations and their greater exposure to health risks, however, make them a difficult group to target. Additionally, future support for UHEP should specify strategies for reaching adolescents and youth. Such strategies could help alleviate the health needs of large numbers of adolescents and youth living in urban areas, many of whom come from poor rural households in search for employment and/or education in urban areas.

Initial results from pilot tests of the family team approach implemented under the PHCU indicate a strong potential for improving access to health care for the urban poor, better management and completion of referrals, and tracking of defaulters. It also supports the institutionalization of capacity building of UHE-p through ongoing mentorship by health center staff, which will support mastery of skills. This effort will result in reduced costs for UHE-p training and is a pathway to sustainable capacity building. Support for this approach could help with strengthening HRH for the UHEP.

SEUH and UHEP created a system for targeting poor households in urban areas, but the lifestyles of the better-off urban populations have implications for the health of the urban poor. Inclusive approaches based on well-defined root cause analyses are needed to comprehensively address the health needs of urban populations.

The government strategy to establish industrial parks in the regions will continue to attract the rural poor searching for employment both within the parks and also as domestic workers. This trend will continue to increase. Deliberate interventions in UHEP should target the low-salaried workers from within the parks through PPP, with the companies running the parks.

The SEUH results cast a big shadow on the viability of intersectoral convergence initiatives. Unless the government issues clear formal guidelines to line ministries to support FMoH with the implementation of UHEP initiatives, mobilization of intersectoral support will not succeed. The evaluation team recommends that future activities offer targeted support to FMoH to work with the other ministries to craft policy guidance defining material and technical support contributions of the line ministries to UHEP.

The urban WASH initiatives are in very high demand among the urban poor, but SEUH's capacity to meet those needs is limited. Future donor funding should either establish a separate procurement for urban WASH or ensure that UHEP support establishes formal coordination links with existing WASH initiatives. A successful example observed by the evaluation team exists in Harar city administration, where the town obtained support from the World Bank to produce solid waste bins using the design that was developed by SEUH. These bins were installed in several locations in the city.

The SEUH evaluation results have demonstrated that working within the government's priorities and strengthening the leadership capacity of government officials increase the chances of success in activities that target public health systems to deliver development initiatives. Supporting system strengthening and direct government priorities and letting the government take the lead role is a pathway to sustainability, particularly when the government starts to invest their own resources.

SEUH helped to create reliable systems for data collection, reporting, and use, which have taken effect in UHEP, but this system needs to be reviewed and linked with the HMIS so that it will benefit from government HMIS funding.

ANNEXES

ANNEX I: EVALUATION STATEMENT OF WORK

STATEMENT OF WORK FINAL PERFORMANCE EVALUATION

STRENGTHENING ETHIOPIA’S URBAN HEALTH EXTENSION ACTIVITY

(REVISED-06/21/2018)

I. PURPOSE OF THE EVALUATION

The purpose of the planned final performance evaluation of Strengthening the Urban Health Extension (SUHE) Activity is to document lessons learned in terms of the appropriateness of the design of the Activity, its implementation modality and potential sustainability of the components and results of the Activity for future similar activity design.

More specifically, the evaluation aims to understand the effectiveness of the approaches of the Activity in supporting the Government of Ethiopia’s (GOE’s) Urban Health Extension Program (UHEP) system to reach the Ethiopian urban poor—including its ability to target, identify, and engage key vulnerable populations such as TB and HIV patients, mothers, and children—with appropriate services for the improvement of health status of urban populations in Ethiopia. Additionally, the evaluation examines the sustainability of the current approaches of UHE Activity in terms of human resources for health, institutional support, and relevance to the community.

The primary users of the evaluation results/findings will be USAID/Ethiopia, the Federal Ministry of Health, other GOE entities, and other donors to provide information on approaches to addressing the needs of urban poor populations.

The findings are intended to guide the USG to determine effective allocation of resources in support of GOE programs for urban populations for ultimately greater public health impact. Recommendations will be positioned to directly guide decision-making in areas of emphasis for new approaches for future similar activity design and implementation. The evaluation may also inform broader inter-sectoral learning and collaboration with other stakeholders on urban health development approaches.

USAID’s evaluation policy encourages independent external evaluation to increase accountability to inform those who develop programs and strategies, and to refine designs and introduce improvements into future efforts. In keeping with that aim, this evaluation will be conducted to evaluate the performance of the USAID-funded Strengthening Ethiopia’s UHE Activity support activity being implemented by John Snow, Inc. (JSI) by employing an external evaluator.

II. SUMMARY INFORMATION

| | |
|-----------------------|--|
| Activity Name | Strengthening Ethiopia’s Urban Health Extension Activity |
| Implementing partner | John Snow International |
| Cooperative Agreement | AID-663-A-13-00002 |
| Total Estimated Cost | \$19,999,743 |
| Life of Activity | June 30, 2013 – March31, 2019 |

| | | |
|------------------|------------|---|
| Activity Regions | Geographic | Addis Ababa, Amhara, Oromia, SNNP, Tigray, Harari and Dire Dawa |
| Mission DO | | Increased Utilization of Quality Health Services |
| USAID Office | | Health, HIV/AIDS, Population and Nutrition (HAPN) |
| Activity AOR | | Yoseph Woldegebriel (Ph.D.) |
| Activity Funding | | Health, President's Emergency Plan for AIDS Relief (PEPFAR) |

III. BACKGROUND

A. Problem and Theory of Change

Ethiopia is currently experiencing one of the fastest rates of urban growth in the world. According to the World Bank estimates, Ethiopia's cities are growing faster than the country as a whole, at 3.8 percent versus a national 2.5 percent growth (2010-2015). It is estimated that by 2050, 42 percent of Ethiopia's population will be urban. In these urban areas, poverty and inequality are rising sharply. The urban areas of Ethiopia are under-resourced to address the health needs of the approximately 20 million people residing in urban and peri-urban settings, and there is a continuous stream of new people migrating to urban areas seeking health care and employment.

Compared to the country's rural residents, urban residents have more opportunities to access health, social and education services, a wide variety of employment prospects, and increased access to social and community networks. In spite of these advantages, a great number of urban dwellers face hardships and inequalities accessing health, education and social services; adequate housing, water and sanitation; and appropriate and adequate food supply. Rapid population growth has placed a great strain on urban planning, basic service systems, and the development of critical infrastructure. Overall, infrastructure and systems have failed to grow or adapt to keep pace with the rapidly growing needs of the population. Although the health situation in urban areas is overall considerably better than in rural areas, the urban averages continue to demonstrate the poor health status of the urban population (2010/2011 EDHS).

Thirty-two percent of urban women do not have antenatal care visits until their second trimester, and during ANC services only 34 percent of urban women are informed of signs of pregnancy complications. Fifty-five percent still deliver at home, and only 32 percent of urban women receive postnatal care in the first two days after labor. Neonatal mortality in urban areas is similar to that in rural areas (41 vs. 43 per 1,000 live births).

Only 28 percent of urban children suffering from diarrhea get ORS and support for continued feeding. There remains an unacceptably high prevalence of stunting among urban children (31% urban vs. 46% rural).

HIV prevalence is more than five times greater in women living in urban and peri-urban centers (5.2 percent) compared to rural communities (0.8 percent) (EDHS 2011). Only 76.6 percent of unmarried urban women and men aged 15-49 use condoms every time they have sexual intercourse, and only 70.9 percent of urban women and 67.3 percent of men in urban areas know that HIV can be transmitted from mother to child by breast feeding.

About 80 percent of the urban populations live in slums characterized by substandard housing and a lack of basic sanitation, services, and infrastructure. Eleven percent of the urban population still accesses drinking water from non-improved sources, and only 14 percent of urban households have access to an improved toilet facility. Health statistics specific to slum dwellers in urban areas are not well documented.

Urban health statistics may not portray the health of the urban poor due to the mix of wealthy and poor neighborhoods in close proximity.

In 2009, the GOE developed the Urban Health Extension Program, an innovative government plan to ensure health equity by creating demand for essential health services through the provision of health information at a household level and access to services through referrals to health facilities. This Urban Health Extension Program is an explicit part of the GOE's Health Sector Development Plan IV. In order to address the health services crisis and communicable disease epidemics in urban Ethiopia, the GOE has recognized the need to improve outreach efforts through the introduction of a skilled and rapidly deployable cadre of health workers, the Urban Health Extension professionals (UHE-p).

The hypothesis for such urban health problems in the context of Ethiopia is that: If the GOE's urban health extension program is strengthened through increased quality, usage, and management of community-level urban services, then the health status of the Ethiopian urban population will be improved.

B. Activity Goal and Objectives

From 2009 – 2012, USAID/Ethiopia managed an innovative activity supporting the urban component of the GOE's Health Extension Program, which benefitted approximately 2.6 million people, or 20 percent of the urban population.

Building upon the findings of a May 2012 external evaluation of the initial UHE Activity that affirmed the importance of USAID's continued support to GOE's urban health development plan, USAID/Ethiopia, through its implementing partner John Snow, Inc. (JSI), launched the Strengthening Ethiopia's UHE in June 2013. Strengthening Ethiopia's Urban Health Extension Activity is a five-year activity implemented by John Snow, Inc. (JSI) in Amhara, Harari, Oromia, SNNP and Tigray regions; and Addis Ababa and Dire Dawa Administrations benefiting approximately 2.6 million people which represents 20% of the urban population. Strengthening Ethiopia's Urban Health Extension Activity is follow-on to the previous USAID /UHE Activity that was implemented for five years (between 2009 and 2013). The objective of USAID /SUHE Activity to support the Government of Ethiopia's Urban Health program that aims to expand access to key health services to vulnerable populations in urban centers throughout the country through the deployment of nurses who act as urban health extension professionals (UHE-p) in urban communities. The Activity's goal is to strengthen the Urban Health Extension Program system to make key HIV, TB, maternal and child health, solid and liquid waste management services and water, sanitation and hygiene (WASH) available at the household and community level. The specific intended results of the Activity include the following.

IR1: Improved quality of community-level urban-based social and behavior change communications, personal and environmental hygiene promotion, and referral linkages strengthening.

IR2: Increased demand for facility-level health services including reproductive health, family planning, HIV/AIDS, TB, MCH and preventable communicable diseases.

IR3: Strengthened regional platforms for improved implementation of the national urban health strategy

IR4: Improved sectoral convergence for urban sanitation and waste management.

The activity is implemented in 44 towns of five regions and two city administrations (Addis Ababa, Dire Dawa, Amhara, Oromia, SNNPR, Tigray and Harai regions). The towns/cities in each region are:

- Addis Ababa (Akaki Kality, Arada, Yeka, Nifas Silk Lafto, Kolfe Keranio)
- Amhara (Bahir Dar, Gondar, Dessie, Debre Markos, Debre Tabor, Debre Berhan, Injibara, Finote Selam, Woldiya, Kemisie, Debark, Sekota, Kombolcha)
- Oromia (Adama, Jimma, Nekemte, Shasheme, Bishoftu, Assela, Sebeta, Bale Robe, Wolliso, Batu/Ziway, Metu, Ambo, Negelle, Chiro, Gimbi)
- SNNP (Hawassa, Wolaiya Sodo, Arba Minch, Hossana, Wolkite, Hallaba, Butajira, Durame)
- Tigray (Mekelle, Shire, Adigrat, Axum, Maychiew, Humera, Alamata)
- Harari (Harar)
- Dire Dawa

Capacity building activities target different levels of government office staff including FMOH, RHBs, City/Town Health Offices, Health Centers, Urban Health Extension Professionals (UHE-Ps) and UHE-P Supervisors.

There have been no major programmatic or budgetary modifications from USAID and the implementing partner side since the activity's inception. However, there were some initiatives from the Federal Ministry of Health (FMOH) to redesign the Urban Health service packages, the role of Urban Health Extension professionals, and their training and capacity building modalities in line with the complexity of urban based causes of morbidity and mortality with particular focus on urban slums in the federal and regional cities and towns. Recently, the FMOH decided to replace the current UHE-ps by generic professionals and began enrolling qualified students who finished high school into a three-year training program. In addition, following the FMOH's decision to pilot test a Family Health Team Approach to providing care at the community level, the FMOH requested JSI/SEUHP to support establishment of a Family Health Team at one of the Health Centers in Addis Ababa where a team of 3-4 health workers (a Health Officer or BSc nurse, a diploma nurse and the UHE-p) would go out to the community as a team to provide an expanded preventive and curative community level care. In 2013 and 2014, several assessments were conducted, and GOE organized focused benchmarking and experience sharing visits to other developing countries. The findings and reports of these events shall be reviewed rigorously as part of this evaluation as these are key resources for future Urban Health program implementation (See Annex A for the SUHE Activity Strategic Results Framework and illustrate activities under each IR).

IV. EVALUATION QUESTIONS

There are four evaluation questions that are closely linked to the activities' development hypothesis depicted in the Results Framework (see Annex A). Statements in parenthesis are included in each question to help clarify the types of information that could be included in an analysis to respond to the main question.

- 1) How relevant and practical were the design and implementation approaches of the USAID- supported SUHE Activity in relation to the Government of Ethiopia's UHEP? *(The purpose of this question is to examine the extent to which different components of the Activity such as health service quality improvement, demand creation, capacity building and sanitation/waste management were aligned with the GOE's urban health extension program priorities and also to assess how the Activity was perceived and valued by stakeholders in terms of changing the design into practice.)*
- 2) To what extent were the USAID-supported Urban Health Extension Activity's implementation processes and strategies efficient? *(To answer this question, the evaluation team must look at the strategies/approaches used to coordinate the implementation of the activity with the GOE at different*

levels and whether those strategies/approaches were flexible to adapt to changes, created enabling environment for coordination, and effective for the timely implementation of activities.)

3) What are the main contributions of the Activity to strengthening of the GoE's UHEP? *(This question tries to determine how the Activity interventions supported the GoE efforts under the UHEP e.g resourcing, capacity building; service delivery; mobilization, evidence generation, tools and guidelines etc.*

4) To what extent are the SUHE Activity strategies and interventions sustainable? *(This evaluation question is developed to answer whether the Activity strengthened organizational capacity of City/Town Health Offices, RHBs and FMoH to plan, implement and monitor UHEP, has put a strategy in place to ensure sustainability of its intervention efforts/ensure government ownership, and identify ways that could further strengthen regional platforms to ensure sustainability.)*

Note: Though Learning-related evaluation question is not explicitly defined here as a standalone question, the evaluation findings should be able to help to document the main learning aspects from the implementation of the Activity and, therefore, the report of this evaluation MUST have a section to present the main learnings that came out from the implementation of the Activity.

ANNEX II: EVALUATION DESIGN MATRIX

| Evaluation questions | Main themes | Potential questions | Data collection method (s) | Data Source/type of respondent | Data Analysis method |
|---|---|--|----------------------------|--|--|
| EQ 1: How relevant and practical were the design and implementation approach of the USAID-supported SEUH Activity in relation to the Government of Ethiopia's UHEP | Relevance of the design in addressing GoE priorities under UHEP | What process was used to design the SEUH Activity? | Document review; KII | FMOH and SEUH Activity documents; UHEP staff at FMOH, SEUH Activity Tech. staff; SEUH Activity AOR | Thematic analysis based on themes and sub questions corresponding to each evaluation question |
| | | What are the key components/elements of Ethiopian Urban Health extension program (UHEP)? (examine the rationale to develop the design) | Document review; KII | FMOH and SEUH Activity documents; UHEP staff at FMOH, SEUH Activity Tech. staff; | Thematic analysis based on themes and sub questions corresponding to each evaluation question |
| | Alignment of the Activity design with UHEP priorities | What is the relationship between UHEP and SEUH Activity? Which components/elements of the UHEP were supported by SEUH Activity? Why? How? What gaps existed in the design? | KII | UHEP staff at FMOH, SEUH Activity Tech. staff; SEUH Activity AOR | Thematic analysis based on themes and sub questions corresponding to each evaluation question |
| | Relevance of design to urban health context | In what ways was the SEUH Activity design relevant to the urban health needs? | Document review; KII | FMOH and SEUH Activity documents; UHEP staff at FMOH, SEUH Activity Tech. staff; SEUH Activity AOR | Thematic analysis based on themes and sub questions corresponding to each evaluation question. |
| | | What were the main strengths of the SEUH Activity design? And what were the main limitations? | KII | UHEP staff at FMOH, SEUH Activity Tech. staff; SEUH Activity AOR | Thematic analysis based on themes and sub questions corresponding to each evaluation question. |

| Evaluation questions | Main themes | Potential questions | Data collection method (s) | Data Source/type of respondent | Data Analysis method |
|----------------------|--|--|---|---|--|
| | Appropriateness of the implementation approaches | Which elements of the SEUH Activity were implemented? Which were not? Why? | Document review; KII | FMOH and SEUH Activity documents; UHEP staff at FMOH, SEUH Activity Tech. staff; SEUH Activity AOR | Thematic analysis based on themes and sub questions corresponding to each evaluation question. |
| | | What approaches/ strategies were used? | Document review; KII | FMOH and SEUH Activity documents; UHEP staff at FMOH, SEUH Activity Tech. staff; SEUH Activity AOR; Sectoral Offices; educational institutions; C/THO | Thematic analysis based on themes and sub questions corresponding to each evaluation question. |
| | | What did SEUH Activity do in relation to...? <ul style="list-style-type: none"> • Capacity building • Sustainability • Quality improvement • Demand creation • Service delivery/packages • Regional platforms • Intersectoral convergence • Community information systems | Document review; KII; FGD; secondary analysis of existing monitoring data | FMOH and SEUH Activity documents; UHEP staff at FMOH, SEUH Activity Tech. staff; Sectoral Offices; cluster coordinators; UHE-p; community women | Thematic analysis based on themes and sub questions corresponding to each evaluation question. Descriptive analysis of existing monitoring data |
| | Key design and implementation lessons | What factors facilitated/hampered the design and implementation of SEUH Activity? | KII | UHEP staff at FMOH, SEUH Activity Tech. staff; SEUH Activity AOR; Sectoral Offices; cluster coordinators; UHE-p; | Thematic analysis based on themes and sub questions corresponding to each evaluation question. |

| Evaluation questions | Main themes | Potential questions | Data collection method (s) | Data Source/type of respondent | Data Analysis method |
|--|--|---|--|--|---|
| | | | | C/THO; Educational institutions | |
| | | What adaptations were made to the design and implementation and why? | KII, FGD | UHEP staff at FMOH, SEUH Activity Tech. staff; Sectoral Offices; cluster coordinators; UHE-p; Educational institutions | Thematic analysis based on themes and sub questions corresponding to each evaluation question. |
| | | Did the design adequately address the needs of urban poor and vulnerable groups (gender, persons with disability) | KII, FGD; secondary analysis of monitoring. As a proxy, EDHS secondary data analysis (proxy measure) | UHEP staff at FMOH, SEUH Activity Tech. staff; Sectoral Offices; cluster coordinators; UHE-p; Educational institutions; UHE-p supervisors | Thematic analysis based on themes and sub questions corresponding to each evaluation question. Descriptive analysis of existing monitoring and EDHS data |
| EQ2: To what extent were the USAID-supported Urban Health Extension Activity's implementation processes and strategies efficient? | Theme I: <u>Coordination</u> (FMOH, RHBs, ZHBs, WHO, City/town admin); sectoral coordination (schools, urban beautification agency, water and energy); sub-partners; other donors and NGOs | With whom did the SEUH Activity coordinate? In what ways? | | UHEP staff at FMOH, SEUH Activity Tech. staff; SEUH Activity AOR; Sectoral Offices; cluster coordinators; UHE-p; Educational institutions; UHE-p supervisors | Thematic analysis based on themes and sub questions corresponding to each evaluation question. |
| | | What were the main outcomes of that coordination? | KII, FGD, Document Review | FMOH and SEUH Activity documents; UHEP staff at FMOH, SEUH Activity Tech. staff; SEUH Activity AOR; Sectoral Offices; cluster coordinators; UHE-p; | Thematic analysis based on themes and sub questions corresponding to each evaluation question. |

| Evaluation questions | Main themes | Potential questions | Data collection method (s) | Data Source/type of respondent | Data Analysis method |
|----------------------|-------------|--|----------------------------|--|--|
| | | | | Educational institutions | |
| | | Which other groups could SEUH Activity have coordinated with but did not? Why? How could such coordination have been beneficial? | KII, FGD | UHEP staff at FMOH, SEUH Activity Tech. staff; SEUH Activity AOR; Sectoral Offices; cluster coordinators; UHE-p; Educational institutions; UHE-p supervisors | Thematic analysis based on themes and sub questions corresponding to each evaluation question. |
| | | What were the main coordination challenges? | KII, FGD | UHEP staff at FMOH, SEUH Activity Tech. staff; Sectoral Offices; cluster coordinators; UHE-p; Educational institutions; UHE-p supervisors; female community participants | Thematic analysis based on themes and sub questions corresponding to each evaluation question. |
| | | How were these challenges addressed? (e.g. participation, decision making, resources, identification and targeting, staffing, referrals) | KII, FGD | UHEP staff at FMOH, SEUH Activity Tech. staff; Sectoral Offices; cluster coordinators; UHE-p; Educational institutions; UHE-p supervisors | Thematic analysis based on themes and sub questions corresponding to each evaluation question. |
| | | What is your opinion about the efficiency of coordination of SEUH Activity? | KII, FGD | UHEP staff at FMOH, SEUH Activity Tech. staff; Sectoral Offices; cluster coordinators; UHE-p; Educational institutions; UHE-p supervisors; female community participants | Thematic analysis based on themes and sub questions corresponding to each evaluation question. |

| Evaluation questions | Main themes | Potential questions | Data collection method (s) | Data Source/type of respondent | Data Analysis method |
|----------------------|----------------------|--|----------------------------|--|--|
| | Structure | How was the SEUH Activity organized? <ul style="list-style-type: none"> • Staffing (office location and supervision) • Communication and reporting • Technical and logistical support | Document review; KII; FGD | SEUH Activity management documents SEUH Activity tech. staff | Thematic analysis based on themes and sub questions corresponding to each evaluation question. |
| | | What is your opinion about the appropriateness and efficiency of the SEUH Activity structure? | KII, FGD | UHEP staff at FMOH, SEUH Activity Tech. staff; Sectoral Offices; cluster coordinators; UHE-p; Educational institutions; UHE-p supervisors | Thematic analysis based on themes and sub questions corresponding to each evaluation question. |
| | Enabling environment | What did the activity do to create an enabling environment? How did this contribute for efficiency? | Document review; KII; FGD | FMOH and SEUH Activity documents; UHEP staff at FMOH, SEUH Activity Tech. staff; Sectoral Offices; cluster coordinators; UHE-p; Educational institutions; UHE-p supervisors; female community participants | Thematic analysis based on themes and sub questions corresponding to each evaluation question. |
| | | What factors facilitated or hampered the achievement or failure to achieve that enabling environment? | KII; FGD | FMOH and SEUH Activity documents; UHEP staff at FMOH, SEUH Activity Tech. staff; SEUH Activity AOR; Sectoral Offices; cluster coordinators; UHE-p; Educational | Thematic analysis based on themes and sub questions corresponding to each evaluation question. |

| Evaluation questions | Main themes | Potential questions | Data collection method (s) | Data Source/type of respondent | Data Analysis method |
|----------------------|--|--|----------------------------|---|--|
| | | | | institutions; UHE-p supervisors; female community participants | |
| | Adaptability to changes and barriers | What were the key changes that took place in the course of SEUH Activity implementation (government level, activity level)—Why those changes? What were the results of the changes | Document review; KII; FGD | FMOH and SEUH Activity documents; UHEP staff at FMOH, SEUH Activity Tech. staff; SEUH Activity AOR; Sectoral Offices; cluster coordinators; UHE-p; Educational institutions; UHE-p supervisors; female community participants | Thematic analysis based on themes and sub questions corresponding to each evaluation question. |
| | Efficiency in delivery of services/interventions | What did SEUH Activity do to improve the efficiency of the activity implementation? Were these changes effective in achieving the expected results? | Document review; KII; FGD | FMOH and SEUH Activity documents; UHEP staff at FMOH, SEUH Activity Tech. staff; Sectoral Offices; cluster coordinators; UHE-p; Educational institutions; UHE-p supervisors; female community participants | Thematic analysis based on themes and sub questions corresponding to each evaluation question. |
| | | How were the referrals coordinated between the health extension professionals and the health center? | Document review; KII; FGD | SEUH Activity documents; UHEP staff at FMOH, SEUH Activity Tech. staff; cluster coordinators; UHE-p; Educational institutions; UHE-p supervisors; female | Thematic analysis based on themes and sub questions corresponding to each evaluation question. |

| Evaluation questions | Main themes | Potential questions | Data collection method (s) | Data Source/type of respondent | Data Analysis method |
|--|-------------------------------|---|---|---|--|
| | | What system was put in place to monitor utilization of UHEP services? | Document review; KII; FGD | community participants SEUH Activity documents; UHEP staff at FMOH, SEUH Activity Tech. staff; cluster coordinators; UHE-p; Educational institutions; UHE-p supervisors; female community participants | Thematic analysis based on themes and sub questions corresponding to each evaluation question. |
| | | Lessons for strengthening the efficiency of implementation processes and strategies | KII; FGD | UHEP staff at FMOH, SEUH Activity Tech. staff; cluster coordinators; UHE-p; Educational institutions; UHE-p supervisors; female community participants | Thematic analysis based on themes and sub questions corresponding to each evaluation question. |
| EQ3. What are the main contributions of the Activity to strengthening of the GoE's UHEP | Core results of SEUH Activity | What were the main results of SEUH Activity? <ul style="list-style-type: none"> • Community mobilization • Service delivery • Intersectoral convergence • Uptake of services • Capacity building • Resource mobilization • Evidence generation and use | Document review, KII, FGD; secondary data analysis (monitoring and EDHS data) | SEUH Activity documents; FMOH documents; UHEP staff at FMOH, SEUH Activity Tech. staff; cluster coordinators; UHE-p; Educational institutions; UHE-p supervisors; female community participants | Thematic analysis based on themes and sub questions corresponding to each evaluation question. Descriptive analysis of monitoring and EDHS data |

| Evaluation questions | Main themes | Potential questions | Data collection method (s) | Data Source/type of respondent | Data Analysis method |
|---|--|---|----------------------------|---|--|
| | | <ul style="list-style-type: none"> Development and use of tools and guidelines | | | |
| | | Did SEUH Activity achieve other results outside of its contractual obligations? Which ones? | Document review; KII, FGD | SEUH Activity documents; FMOH documents; UHEP staff at FMOH, SEUH Activity Tech. staff; cluster coordinators; UHE-p; Educational institutions; UHE-p supervisors; female community participants | Thematic analysis based on themes and sub questions corresponding to each evaluation question. |
| | | What factors facilitated or hampered the achievement or failure to achieve these results? What could the activity have done differently to achieve greater results? | Document review; KII; FGD | UHEP staff at FMOH, SEUH Activity Tech. staff; cluster coordinators; UHE-p; Educational institutions; UHE-p supervisors; female community participants | Thematic analysis based on themes and sub questions corresponding to each evaluation question. |
| | | What gender issues did SEUH Activity address? How and what were the results related to gender? | Document review; KII; FGD | SEUH Activity documents; FMOH documents; UHEP staff at FMOH, SEUH Activity Tech. staff; cluster coordinators; UHE-p; Educational institutions; UHE-p supervisors; female community participants | Thematic analysis based on themes and sub questions corresponding to each evaluation question. |
| EQ4: To what extent are the SEUH Activity strategies and | Sustainability strategies adopted by SEUH Activity | What activities were undertaken to ensure | Document review; KII; FGD | SEUH Activity documents; FMOH documents; UHEP | Thematic analysis based on themes and sub questions |

| Evaluation questions | Main themes | Potential questions | Data collection method (s) | Data Source/type of respondent | Data Analysis method |
|----------------------------|---|---|----------------------------|---|--|
| interventions sustainable? | | sustainability of SEUH Activity results? | | staff at FMOH, SEUH Activity Tech. staff; cluster coordinators; UHE-p; Educational institutions; UHE-p supervisors; | corresponding to each evaluation question. |
| | Ownership creation at all levels | Which results/activities are likely to be sustainable after the closeout of SEUH Activity? Why? | Document review; KII; FGD | SEUH Activity documents; FMOH documents; UHEP staff at FMOH, SEUH Activity Tech. staff; cluster coordinators; UHE-p; Educational institutions; UHE-p supervisors; | Thematic analysis based on themes and sub questions corresponding to each evaluation question. |
| | Sustainability challenges faced in the implementation process | What challenges to sustainability can be foreseen from the implementation of SEUH Activity? | KII; FGD | UHEP staff at FMOH, SEUH Activity Tech. staff; cluster coordinators; UHE-p; Educational institutions; UHE-p supervisors; | Thematic analysis based on themes and sub questions corresponding to each evaluation question. |
| | Lessons learned during implementation | What were the main lessons learned in ensuring sustainability? | Document review; KII | UHEP staff at FMOH, SEUH Activity Tech. staff; cluster coordinators; UHE-p; Educational institutions; UHE-p supervisors; | Thematic analysis based on themes and sub questions corresponding to each evaluation question. |

ANNEX III: DATA COLLECTION INSTRUMENTS

Key Informant Consent Form

Title: Strengthening Ethiopia's Urban Health Program (SEUH) Activity—Final Performance Evaluation

Investigators: Francis O. Okello, Worku Ambelu; Danae Roumis; Yehualashet Tadesse; Andenet Haile; Lomi Yadeta; Fiseha Terefe

Sponsor: USAID/Ethiopia

Introduction

Hello, my name is----- . I am part of a team from Social Impact (SI) currently conducting an independent evaluation of the “**Ethiopia’s Urban Health (SEUH) Activity.**” SI is an international consulting company with its headquarters in Arlington Virginia, USA and with a Field Office in Addis Ababa, Ethiopia. SI works to improve development effectiveness around the world through evaluation, capacity building and strategic planning. SEUH Activity is a USAID-funded activity which supports the government of Ethiopia to deliver critical health services to the poor people living in urban areas of Ethiopia. SEUH Activity is implemented by a consortium led by John Snow International (JSI). This evaluation is intended to measure the achievements of this activity and to obtain opinions about how such an activity can be improved in the future.

I would like to request you to read (or have read to you) this Consent Form. This is to make sure that you are fully informed about this evaluation. After I have introduced this evaluation to you and have gone through what is expected of you, I will ask you to sign or use your thumbprint if you agree to participate. SI Internal Review Board has approved this evaluation. We will give you a copy of this form if you would like. This consent form might contain some words that are unfamiliar to you. Please ask us to explain anything you may not understand.

I want to be sure that you understand the purpose of this valuation and your responsibilities before you decide if you want to be in it or not. Please ask me to explain any words or information that you may not understand.

Information about the evaluation

If you agree to be part of this evaluation, we are going to ask you and other key informants about the interventions of SEUH Activity that you may know, such as capacity building, coordination and your perceptions of their results. We will also ask you about the successes and challenges SEUH Activity encountered and how the activity could be improved to achieve more significant results.

The information you share will be kept confidential and will not be disclosed to anyone in a way that can be linked to you. Although we will share the opinions you give us in a report to other entities outside of the evaluation team, all your answers will be treated with confidentiality and will be anonymized in the report. Additionally, your decision to participate or not to participate in this evaluation will in no way affect the services you currently receive or provide or the support you receive from SEUH Activity. You

have the right to refuse to answer any questions or to stop the interview at any time. Your participation in this evaluation will take about one hour. I will not write down your name on this form so that the answers you give cannot be linked to you. You have the right to tell whomever you choose about this evaluation. You may stop participating in this interview at any point during our discussion. Again, I want you to be aware that accepting to participate or ending your participation will not affect the services you provide or the support you may be receiving from SEUH Activity.

Possible risks

We do not anticipate any significant risks to you or your household or your organization because of your participation in this evaluation. However, please note that should you choose to participate in this study, you will be taking time away from your regular activities, which may affect your routine tasks. I wanted you to be aware of these possible aspects of the interview that might affect your feelings before accepting to participate in the discussion.

Possible benefits

The results of this evaluation are expected to inform USAID's planning and decision-making, assess the results of SEUH Activity, improve strategies for more significant public health impact and to guide broader inter-sectoral learning and collaboration. The evaluation findings could lead to continued and better delivery of Urban Health Extension services. Additionally, the results may be presented or disseminated at regional, national and international meetings to support planning aimed at mobilizing support for similar activities. The findings and recommendations from this evaluation will generate critical information that can be used by planners to determine and implement activities that support the delivery of health services to the urban poor. Your participation in this evaluation will therefore be essential to current and future similar programs. By participating in this evaluation, you will, however, get no immediate and direct personal benefit.

If you decide not to participate in this evaluation

You are free to decide if you want to participate in this evaluation or not. If you decide not to participate, we will accept your decision without holding anything against you. Your relationship with SEUH Activity or other organizations that provide similar services or will use the evaluation results will not be affected at all.

Confidentiality

We will protect information about you and your involvement in this evaluation to the best of our ability. We will not record your name in our data collection tools or notes, but only in this consent form, which we will keep separately from the notes and transcripts of this interview. We will also not indicate your name in any of the reports we prepare. We will not tell your peers, supervisors, family members, caretakers, or friends about your participation or about the information you give.

Leaving the interview

You may end your participation in the interview at any time. We will not hold anything against you should you choose to leave before the end of the interview.

Duration of interview

We anticipate that this interview will take no more than 1.5 hours.

If you have a question about the evaluation

If you have any questions about this evaluation, you may contact Biruk Belayneh via his BBelayneh@socialimpact.com or phone number 0912503019. You can also contact the Social Impact Internal Review Board. The contact person is Leslie Greene Hodel; Address is: 2300 Clarendon Blvd, Suite 1000, Arlington, VA 22201; phone number 703-465-1884; email address: irb@socialimpact.com.

VOLUNTARY AGREEMENT

I certify that the nature and purpose, the potential benefits, and the possible risks associated with participating in this research have been explained to me.

Signature of study participant

Date

Focus Group Discussion Informed Consent

Title: Strengthening Ethiopia’s Urban Health Program (SEUH) Activity—Final Performance Evaluation

Investigators: Francis O. Okello, Worku Ambelu, Danae Roumis, Yehualashet Tadesse, Andenet Haile, Lomi Yadeta, Fisheha Terefe

Sponsor: USAID/Ethiopia

Introduction: Hello, my name is------. I am part of a team from Social Impact (SI) currently conducting an independent evaluation of the **“Ethiopia’s Urban Health Program (SEUH) Activity.”** SI is an international consulting company with its headquarters in Arlington Virginia, USA and with a Filed Office in Addis Ababa, Ethiopia. SI works to improve development effectiveness around the world through evaluation, capacity building and strategic planning. SEUH Activity is a USAID-funded activity which supports the government of Ethiopia to deliver critical health services to the poor people living in urban areas of Ethiopia. SEUH Activity is implemented by a consortium led by John Snow International (JSI). This evaluation is intended to measure the achievements of this activity and to obtain opinions about how such an activity can be improved in the future.

I would like to request you to read (or have read to you) this Consent Form. This is to make sure that you are fully informed about this evaluation. After I have introduced this evaluation to you and have gone through what is expected of you, I will ask you to sign or use your thumbprint if you agree to participate. SI Internal Review Board has approved this evaluation. We will give you a copy of this form if you would like. This consent form might contain some words that are unfamiliar to you. Please ask us to explain anything you may not understand.

I want to be sure that you understand the purpose of this valuation and your responsibilities before you decide if you want to be in it or not. Please ask me to explain any words or information that you may not understand.

Information about the evaluation: You have been selected to participate in this evaluation because you have received services from a UHE-p in the past. If you agree to be part of this evaluation, we are going to ask you and other key informants about the interventions of SEUH Activity that you may know, such as capacity building, coordination and your perceptions of their results. We will also ask you about the successes and challenges SEUH Activity encountered and how the activity could be improved to achieve more significant results.

The information you share will be kept confidential and will not be disclosed to anyone in a way that can be linked to you. Although we will share the opinions you give us in a report to other entities outside of the evaluation team, all your answers will be treated with confidentiality and will be anonymized in the report. Additionally, your decision to participate or not to participate in this evaluation will in no way

affect the services you currently receive or provide or the support you receive from SEUH Activity. You have the right to refuse to answer any questions or to stop the interview at any time. Your participation in this evaluation will take about one hour. I will not write down your name on this form so that the answers you give cannot be linked to you. You have the right to tell whomever you choose about this evaluation. You may stop participating in this interview at any point during our discussion. Again, I want you to be aware that accepting to participate or ending your participation will not affect the services you provide or the support you may be receiving from SEUH Activity.

Possible risks: We do not anticipate any significant risks to you or your household or your organization because of your participation in this evaluation. However, please note that should you choose to participate in this study, you will be taking time away from your regular activities, which may affect your routine tasks. I wanted you to be aware of these possible aspects of the interview that might affect your feelings before accepting to participate in the discussion.

Possible benefits: The results of this evaluation are expected to inform USAID's planning and decision-making, assess the results of SEUH Activity, improve strategies for more significant public health impact and to guide broader inter-sectoral learning and collaboration. The evaluation findings could lead to continued and better delivery of Urban Health Extension services. Additionally, the results may be presented or disseminated at regional, national and international meetings to support planning aimed at mobilizing support for similar activities. The findings and recommendations from this evaluation will generate critical information that can be used by planners to determine and implement activities that support the delivery of health services to the urban poor. Your participation in this evaluation will therefore be essential to current and future similar programs. By participating in this evaluation, you will, however, get no immediate and direct personal benefit.

If you decide not to participate in this evaluation: You are free to decide if you want to participate in this evaluation or not. If you decide not to participate, we will accept your decision without holding anything against you. Your relationship with SEUH Activity or other organizations that provide similar services or will use the evaluation results will not be affected at all.

Confidentiality: We will protect information about you and your involvement in this evaluation to the best of our ability. We will not take down your name, nor indicate your name in the any of the reports we prepare. We will not tell your peers, supervisors, family members, caretakers, or friends about your participation or about the information you give.

Leaving the interview: You may end your participation in the interview at any time. We will not hold anything against you should you choose to leave before the end of the interview.

Duration of interview

We anticipate that this interview will take no more than 1.5-2 hours.

If you have a question about the evaluation

If you have any questions about this evaluation, you may contact Biruk Belayneh via his BBelayneh@socialimpact.com or phone number 0912503019. You can also contact the Social Impact Internal Review Board. The contact person is Leslie Greene Hodel; Address is: 2300 Clarendon Blvd, Suite 1000, Arlington, VA 22201; phone number 703-465-1884; email address: irb@socialimpact.com.

VOLUNTARY VERBAL CONSENT

Do you agree to participate in this focus group discussion?

Yes.....1

No.....2.

Date

Focus Group Discussion Guide Female Community Member FGD

Title: Strengthening Ethiopia’s Urban Health Program (SEUH) Activity—Final Performance Evaluation

Investigators: Francis O. Okello, Worku Ambelu, Danae Roumis, Yehualashet Tadesse, Andenet Haile, Lomi Yadeta, Fisheha Terefe

Sponsor: USAID/Ethiopia

DATE: _____ START TIME: _____

MODERATOR: _____ END TIME: _____

NOTE TAKER: _____ # PARTICIPANTS _____

MODERATOR INSTRUCTIONS:

- Check to make sure that the note takers got consent from everyone
- Register all consenting participants in a separate document from the discussions notebook

READ TO PARTICIPANTS: Thank you all for joining us for this discussion today. I am **[**your name**]** and these are my colleagues **[**names of note takers**]**. Before we begin our discussion, I’d like us all to agree to some ground rules so that everyone feels comfortable stating their opinion:

- Respect each other’s opinions even if different from your own;
- Do not cut people off; everyone will have a chance to speak;
- You may refuse to answer questions that make you uncomfortable;
- Maintain confidentiality about anything personal said during the discussion, by not discussing such things with others outside of this group;
- All cell phones and pagers should be turned off so we can give each other our full attention.

Can we all agree to these rules? Any other rules you want to suggest?

Before we begin I’d like to confirm that you have given your voluntary consent to participate in this focus group discussion.

- Does everyone agree freely?
- Does anyone have any questions?

OPENING: Let’s take a moment for everyone to introduce themselves. You don’t have to tell us your full name, just the name you’d like to be called by here today...

OK then, I’d like to begin.

DISCUSSION QUESTIONS

EQ1. How relevant and practical were the design and implementation approach of the USAID-supported SUHE Activity in relation to the Government of Ethiopia's UHEP?

Introductory Questions

- 1.1 What are the major health-related problems within your community?
- 1.2 Can you describe the different health services that are available to you within your community [*name of kebele*]? And which health services are available to you but are outside your community?
 - 1.1a. Please inform us about how you learned about these services.
 - 1.1b. What health services do you need or tried to access through the UHE-p but could not? Can you please give reasons that you know or think of for not being able to get those services?

Transition Questions

- 1.3. How did you come to know about the UHE-p? Please describe all sources

Key Questions

- 1.4. What types of interactions have you or other people in your community had with UHE-p in your health center/kebele?
 - 1.4a. Where do these interactions take place?
 - 1.4b. Thinking about the past year, can you please tell me about the frequency of interactions between the UHE-p and the community members?
 - 1.4c. What are the main reasons for these interactions with the health worker? If not mentioned, probe for: health seeking, community health education, social interactions beyond health needs
 - 1.4d. What are your opinions about the services of the UHE-p? **Probe for examples of positive and negative and ask for examples.**
 - 1.4e. In your opinion, do these services represent the main health needs of the urban poor? **Probe:** please explain.

EQ2. To what extent were the USAID-supported Urban Health Extension Activity's implementation processes and strategies efficient?

- 2.1. How easy or difficult is it for you to meet with UHE-p when you need assistance with your health needs? **Probe:** can you please explain the reasons?
- 2.2. What are your opinions about the way the UHE-p function in your community? **Probe for:**
 - a. What kinds of support do they get with their work? From who?
 - b. What challenges do you think they face in doing their work?
 - c. What recommendations would you give to improve the efficiency of their work?

EQ3. What are the main contributions of the Activity to strengthening of the GoE's UHEP?

Some of you were selected to participate in this FGD because you have at least one child who is less than five years old. Please try to recall your experience at the time you had your baby and respond to the following questions based on you own experience OR the experience of someone you know

- 3.1. What pregnancy-related services did you or someone you know receive from UHE-p?

- a. What health services did you or someone you know seek before getting pregnant? Who provided these services? Where did you get the services?
- b. What services did you or someone you know receive during pregnancy? Where did you get those services from?
- c. In what other ways did the UHE-p support you or someone you know during pregnancy?
- d. What health services did you or someone you know receive from UHE-p after delivery?

Note for the moderator -please explain the next questions we will discuss about health information given by UHE-p and other types of services that women receive from UHE-p

3.2. Think about the types of information shared by UHE-p in your community. Can you please describe what kinds of information they share with you? **Probe for:** Information about Immunization, information related to Pregnancy, information related to sanitation and hygiene, information on nutrition, communicable disease (HIV, Malaria...) Non-communicable disease.

- a. Which information have you found most useful? **Probe:** please explain the reasons that this information was useful or how it helped you?

3.3. Can you please give some examples of how you used this information and how it helped you?

- a. What other information did you receive from which you learnt something but did not act upon? Please explain why you were not able to apply what you learnt?

3.4. Do you or other women in your community receive family planning services or products from UHE-p?

- a. Please describe the services you or other women in your community receive: **Probe:** FP education, methods, follow-up, referrals
- b. What are your opinions/feelings about receiving FP services from UHE-p versus getting them from the health center?
- c. What is your overall impression about the FP information you received?
 - ✓ Which pieces of information did you find useful? Please explain why.
 - ✓ And which did you not find to be useful? Please explain why
 - ✓ Are there any pieces of information from which you learnt something but did not act upon? Which one and why?

3.5. What kind of medical examinations do the UHE-p conduct at the community level? **Probe for:** blood pressure measurement, mid upper arm circumference measurement for <5 children, physical examination

- a. Can you please describe your experiences or the experiences of other people in your community with the medical examinations conducted by the UHE-p? First, can you tell me about the positive experiences? And what issues have you or other people in your community experienced regarding the medical examinations by UHE-p?

3.6. Do the UHE-p conduct HIV counseling in your community? In your opinion, what are the main results of the HIV counseling that UHE-p conduct in your community? **Probe:**

- a. Have the people in your community responded by getting tested?

- b. Do you know someone in your community who has tested for HIV because of their interaction with UHE-p? Where do the majority in your community go to test for HIV?
 - c. Why do you think people would opt to get tested with the UHE-p? And why would they not want to get tested with the UHE-p?
- 3.7. What health services do the UHE-p provide for children under 5 in your community? **Probe for:** health education on prevention of childhood illnesses, detection of malnourished children, deworming of children, vitamin A distribution
- a. What is your opinion about the coverage of immunization of children in your community? Are most children immunized? If not, what do you think is the reason?
 - b. What role have the UHE-p played in increasing the immunization coverage in your community?
- 3.8. What procedures do the UHE-p follow when referring someone from the community to a health center? What services do they refer people for? **Probe for:** FP, ANC, HIV, Delivery, PNC, Emergency care.
- a. Can you please describe an experience that you or someone you know had with the referral? What service was the referral for? What was the experience at the health center?
 - b. If you could suggest ways to improve this referral process, what might you propose?
- EQ4. To what extent are the SEUH Activity strategies and interventions sustainable?**
- I.1. In what ways has the community contributed to support the work of the UHE-p?
 - I.2. Which services of SEUH Activity do you think will continue to benefit the community even after the completion of the Activity? Why do you think ... services will continue?
 - I.3. What do you think the health extension professionals should do better or differently to improve the health status of the poor people in your community?

We've now come to the end of our discussion. If anyone has any concluding remarks, please feel free to speak.

Thank you for your participation

In-Depth Interview Guide Men Beneficiaries

Title: Strengthening Ethiopia's Urban Health Program (SEUH) Activity—Final Performance Evaluation

Investigators: Francis O. Okello, Worku Ambelu, Danae Roumis, Yehualashet Tadesse, Andenet Haile, Lomi Yadeta, Fisheha Terefe

Sponsor: USAID/Ethiopia

| | |
|---------------------|--|
| Interviewee's Title | |
| Marital status | |
| Region | |

| | |
|-----------|--|
| Town/City | |
| Date | |

• **EQ1. How relevant and practical were the design and implementation approaches of the USAID- supported SUHE Activity in relation to the Government of Ethiopia’s UHEP?**

- I.1. What are the major health-related problems within your community?
- I.2. What health services are available in this community to you and other members of your household in this community? How do you get to know about these services? **If not mentioned, Probe for:**
 - a) Health Education
 - b) ANC/PNC
 - c) Home based care
 - d) Vitamin A and De-worming for children
 - e) GMP and screening of Malnourished children
 - f) Immunization services
 - g) RH service/Family Planning
 - h) HCT
 - i) Advice and follow up for patient on treatment
 - j) Screening and referral of TB suspect cases
 - k) Referral service
- I.3. Do you interact with UHE-p who provide services in your community? **If not mentioned probe: where do these interactions take place?**
 - a) Where do these interactions take place? (household, HC, community meeting)?
 - b) What are the main reasons for you or your household members to interact with the urban health professionals?
- I.4. What are your opinions about the services of the UHE-p? **Probe for positive and negative.** In your opinion, do these services represent the main health needs of the urban poor? **Probe:** please explain
- I.5. **Interviewer instructions: ASK THIS QUESTION ONLY IF NOT DISCUSSED IN** Are you satisfied with the services you receive from UHE-Ps? Why? Why not?

• **EQ2. To what extent were the USAID-supported Urban Health Extension Activity’s implementation processes and strategies efficient?**

- 2.3. Have you or your household member ever been referred to a health center by UHE professionals? **If yes, probe:**
 - a) Can you please describe the process followed by the UHE-p to refer you to a health center?
 - b) Please describe your experience or the experience of your family member about this referral?
- 2.4. How easy or difficult is it for you to meet with UHE-ps when you need assistance with your health needs? **Probe:** can you please explain the reasons?

- 2.5. What are your opinions about the way the UHE-ps function in your community?
- 2.6. Overall, what is your opinion on the health services provided by UHE-ps at community level?

• **EQ3. What are the main contributions of the Activity to strengthening of the GoE's UHEP?**

- 3.1. What type of services did you/your family receive from UHE-ps? **Interviewer instruction. If not mentioned, probe:**
 - a) Health Education (*what types of health education services did you/your family receive? On what topics? In what ways was the service provided?*)
 - b) ANC/PNC (*what types of ANC/PNC services did your family receive? In what ways was the service provided?*)
 - c) Home based care (*what types of home-based care services did you/your family receive? In what ways was the service provided?*)
 - d) Vitamin A and De-worming for children (*what types of Vitamin A and De-worming services did your children receive? In what ways was the service provided?*)
 - e) GMP and screening of Malnourished children (*In what ways was the service provided?*)
 - f) Immunization services (*what types of immunization services did your children receive? In what ways was the service provided?*)
 - g) RH service/Family Planning (*what types of RH/FP services did you/your family receive? In what ways was the service provided?*)
 - h) HCT (*what types of HCT services did you/your family receive? In what ways was the service provided?*)
 - i) Advice and follow up for patient on treatment (*what types of services did you/your family receive? In what ways was the service provided?*)
 - j) Screening and referral of TB suspect cases (*what types of services did you/your family receive? In what ways was the service provided?*)
 - k) Referral service (*what types of HCT services did you/your family receive? In what ways was the service provided?*)
- 3.2. Do you think the services provided by the urban health extension professionals contribute to improving access to and utilization of health services? In what ways?

• **EQ4. To what extent are the SEUHP Activity strategies and interventions sustainable?**

- 4.1. In what ways has the community contributed to support the work of the UHE-ps?
- 4.2. Have you personally made any contributions to support the work of the UHEPs? In what ways?
- 4.3. Which services of SEUH Activity do you think will continue to benefit the community even after the completion of the Activity?
- 4.4. What do you think the health extension professionals should do better or differently to improve the health status of your community?

Conclude

We've now come to the end of this discussion. But before I conclude, I'd like to ask if there is any additional information you'd like to share regarding the performance of SEUH Activity and of UHEP.

Thank you for your participation

Focus Group Discussion Guide UHE-p FGD

DATE: _____ START TIME: _____

MODERATOR: _____ END TIME: _____

NOTE TAKER: _____ # PARTICIPANTS _____

MODERATOR INSTRUCTIONS:

- Check to make sure that the note takers got consent from everyone.

READ TO PARTICIPANTS: Thank you all for joining us for this discussion today. I am **[**your name**]** and these are my colleagues **[**names of note takers**]**. Before we begin our discussion, I'd like us all to agree to some ground rules so that everyone feels comfortable stating their opinion:

- Respect each other's opinions even if different from your own;
- Do not cut people off; everyone will have a chance to speak;
- You may refuse to answer questions that make you uncomfortable;
- Maintain confidentiality about anything personal said during the discussion, by not discussing such things with others outside of this group;
- All cell phones and pagers should be turned off so we can give each other our full attention.

Can we all agree to these rules? Any other rules you want to suggest?

Before we begin I'd like to confirm that you have given your voluntary consent to participate in this focus group discussion.

- Does everyone agree freely?
- Does anyone have any questions?

OPENING: Let's take a moment for everyone to introduce themselves. You don't have to tell us your full name, just the name you'd like to be called by here today...

OK then, I'd like to begin.

DISCUSSION QUESTIONS

EQ1. How relevant and practical were the design and implementation approach of the USAID-supported SUHE Activity in relation to the Government of Ethiopia's UHEP?

Introductory Questions

I.3 What do you know about SEUH Activity? In what ways does it support UHEP?

I.4 Can you describe the different health services that are available to the poor and vulnerable households within your community [*name of kebele*]? Which health services are accessible, but the community members receive these services outside of their community?

Transition Questions

I.5 As a UHE-p, what are your major responsibilities? What other activities do you undertake but are not part of UHE-p responsibilities?

I.6 Which entities/groups or offices do you work with directly or indirectly within your community? [HC, Kebele, partners, sectors, stakeholders]?

a. Please describe how you work with these groups? In what ways do these groups support your work?

b. What are the main outcomes/results of your work with each of these offices/groups

Note for the interviewer – make sure the participants understand the activity name SEUH Activity.

Key Questions

I.7 Can you please describe the main characteristics of the people you serve? Probe for: income levels, what work they do, their living conditions, their needs

I.8 In your opinion, what needs of the of the poor and vulnerable urban populations in your community have met by UHEP? Which ones have not been met?

I.9 Approximately how many households are served by one UHE-p?

I.10. Can you please describe your experience and opinions about working with these households?

I.11. What are the main successes of the UHE-p? What aspects of your work was made possible because of the support from SEUH Activity

I.12. Thinking about the services that UHEP provides with support from SEUH Activity, what would you consider to be the main lessons learned with regard to the relevance and practicality of the implementation of the SEUH Activity. What changes were made based on the lessons learned

EQ2. To what extent were the USAID-supported Urban Health Extension Activity's implementation processes and strategies efficient?

2.1. What relationship/interactions exist between you and ... [the health center, SEUH Activity, other sectors in the district]? What are your general opinions about that relationship? *Interviewer instruction: please probe for potentially positive and negative views*

2.2. Do you receive any direct or indirect support from SEUH Activity?

a. What kind of support?

b. How is that support essential to meeting the needs of your work?

c. How often do you get that support?

d. Is there any support you need to better deliver UHEP services but do not have? Can you please state what that support is and how it could help you with your work?

2.3. From your own perspective, is the implementation of UHEP efficient? *Interviewer instruction: for any response, probe: HOW*

a. How does SEUH Activity assist the health center with improving the efficiency of UHEP implementation? Please provide examples.

- 2.4. Based on your personal experiences, what changes have you observed in the implementation approaches of the activity since you started working as a UHE-p? Why were those changes made?
- And what are some of the most important lessons you would recommend for strengthening the efficiency of this activity?

EQ3. What are the main contributions of the Activity to strengthening of the GoE's UHEP?

- 3.1. What support have you received from SEUH Activity in the following areas: Probe-Can you describe the specific assistance you receive from SUHEP for the following activities?
- Community mobilization?
 - Service delivery (including referrals and health education)?
 - Improving service uptake?
 - Building your capacity?
 - Service delivery logistics?
 - Documentation and reporting
 - Service delivery tools and guidelines?
- 3.2. Think about yourselves as UHE-p. What would you consider to be your main achievements from your work? How did SEUH Activity support you with your work?
- Imagine that you were not receiving any support from SEUH Activity. Can you please describe how your working conditions would have been?
- 3.3. Can you please describe the main results or achievements of UHEP and SEUH Activity in your community?
- Interviewer instruction: if not mentioned, probe for referrals?
- 3.4. Please describe the process that you follow to make a referral
- Do you make follow-ups on the referrals completion? How? What feedback do you get on referrals? Who provides that feedback
 - How are the referrals coordinated between UHE-p and the health center?
 - How do you document the referrals made by you?
- 3.5. What approaches and tools do you use to record patient information and service delivery? What do you do with the information you collect?
- 3.6. Do you prepare any reports? How often? Who do you send them to? Do you get feedback on these reports? Please give examples
- 3.7. Can you please give examples of any actions or decisions that have been made because of the information you collect or your reports to the HC?
- 3.8. How have you been supported by UHEP and SEUH Activity regarding implementing the community health information system?
- 3.9. How would you rate the program achievements with building a community information system?
- 3.10. From your personal experiences, what changes or adjustments have you observed in the approaches used by SEUH Activity to strengthen UHEP?
- What lessons could be drawn from those changes/adjustments in the Activity's approach towards strengthening the UHEP?

3.11. From your observations, what is the difference between kebele’s that are receiving support from UHE-p versus those that are not?

EQ4. To what extent are the SEUHP Activity strategies and interventions sustainable?

4.1. Apart from the support you receive from the HC, which other groups or individuals in your community support UHE-p? What forms of support do you receive from the community?

4.2. Of all the activities and results that you undertake as UHE-p, which ones do you feel can be sustained after the support from SEUH ends? Why? If not mentioned, probe for:

- ✓ Health services (education, referrals, FP, maternal and child health, HCT, WASH etc)
- ✓ Information system
- ✓ Production of tools and guidelines
- ✓ Referrals

a. And which ones are not likely to be sustained? Why?

4.3. Based on your experience as UHE-p, overall, what would you consider to be the main strengths of UHEP? And what have been the main strengths of SEUH Activity at the community level?

4.4. And, again, overall, what have been the main weaknesses of UHEP? And of SEUH Activity?

4.5. What do you like the most about your work as UHE-p? Why?

4.6. And what do you like the least about your work? Why?

4.7. What recommendations would you give to any future activity that seeks to support UHEP with delivery of health services to the poor and vulnerable populations living in urban areas?

4.8. As UHE-p, what would you consider to be the main lessons you’ve learnt with regard to the sustainability of SEUH Activity implementation approaches and results?

4.9. Overall, what, if anything, do you think should have been done differently by SEUH Activity? Can you provide suggestions for future improvement?

Conclude

We’ve now come to the end of this discussion. But before I conclude, I’d like to ask if there is any additional information you’d like to share regarding the performance of SEUH Activity and of UHEP.

Thank you for your participation.

KEY INFORMANT GUIDE

SEUH/JSI REPRESENTATIVES AND USAID

| | |
|--------------------------------------|--|
| Interviewee’s Title and Organization | |
| Position | |
| Region | |
| Town/City | |
| Years of Experience in this position | |

| | |
|------|--|
| Date | |
|------|--|

EQ 1: How relevant and practical were the design and implementation approach of the USAID-supported SEUH Activity to the Government of Ethiopia's UHEP

Interviewer instructions. Please note that in the process of answering these questions, the respondent may provide responses to other questions that come later. Please do not ask later questions if the respondent has already provided answers to such questions under EQ1.

- I.11. What role do you play concerning SEUH Activity or UHEP?
- I.12. Based on what you know, can you please describe the process that was used to design SEUH Activity? **Probe:**
- Which entities participated or were consulted during the design?
 - What was their contribution to the design?
- I.13. (a) Can you please provide examples of how the design of SEUH Activity is applicable to the core needs of UHEP?
- (b) Which of these UHEP needs have been supported by SEUH Activity? **Probe:**
- In what ways? Please give examples
 - What were the reasons for supporting these components?
- I.14. The components I am going to read out to you represent some of the critical results expected by USAID from SEUH Activity. Using examples, can you please tell me which of these were implemented by SEUH Activity and which ones were not? Why were not implemented?
- Read out each of the following result areas:**
- Capacity building—**probe for:** what kind of capacity building activities were undertaken? Who were the target groups? What was the outcome of that capacity building?
 - Sustainability—**Probe:** what did SEUH Activity do to ensure the sustainability of results?
 - Quality improvement: **Probe:** What did SEUH Activity do to improve quality of community-level urban health services?
 - Demand creation: **Probe:** What did SEUH Activity do to increase demand for services provided to the poor urban dwellers by UHEP? what were the main results of those demand creation activities
 - Regional platforms: **Probe:** did SEUH Activity create any forms of platforms at the regional level? Which ones?
 - Intersectoral convergence: **Probe:** What did SEUH Activity do to rally support for UHEP across various sectors? Which sectors did they bring together? What resulted from this intersectoral efforts?
 - Community information systems
- I.15. In your opinion, what were the main strengths of the SEUH Activity design? Also, what were the main limitations?
- a. Based on your knowledge of SEUH Activity design and implementation, what factors facilitated the design and implementation of SEUH Activity?
 - b. And what factors hampered the design and implementation of SEUH Activity?

- 1.16. Can you please describe any changes that were made to improve the design and implementation of SEUH Activity since its inception? **Probe:** What were the main reasons for making these adaptations? How did these adaptations support improvements in the SEUH Activity implementation?
- 1.17. In what ways did the SEUH Activity design address gender and vulnerable groups needs (urban poor, persons with disability, age, health status)?
- 1.18. What were the key lessons you've learned about the relevance and practicality of the implementation of the SEUH Activity. What changes were made based on the lessons learned?

EQ 2: To what extent were the USAID-supported Urban Health Extension Activity's implementation processes and strategies efficient?

Coordination

- 2.1. What would you consider to be the main achievements of SEUH Activity with regard to coordination of stakeholders to support the implementation of UHEP? **Probe:**
- 2.2. How did the coordination efforts contribute to improving the efficiency of SEUH Activity implementation? **Probe for efficiency in:**
- Improving the quality of community-level urban health services
 - Increasing demand for facility-level urban health services
 - Strengthening regional platforms for improved implementation of the urban health strategy
 - Improving sectoral convergence for urban sanitation and waste management
 - Other
- 2.3. From your own knowledge of other sectors working in this area, which other groups/stakeholders could SEUH Activity have coordinated with but did not? Why? How could such coordination have been beneficial to SEUH Activity?
- 2.4. What would you consider to be the main coordination challenges that SEUH Activity faced? **Probe for up to 3 challenges.** How did SEUH Activity deal with these challenges?
- 2.5. What would you consider to be the main strengths and lessons for strengthening the efficiency of a future activity similar to SEUH Activity in: coordination, structure and enabling environment?

Structure

- 2.6. How was SEUH Activity organized? **Probe for:**
- Staffing (office location and supervision)
 - Communication
 - Technical and logistical support
 - Reporting
- 2.7. In your opinion how did this structure contribute to the efficiency of SEUH Activity implementation?

Enabling Environment

2.8. What did SEUH Activity do to create an enabling environment? **Probe for enabling environment at the following levels:**

- National level, e.g., policy, guidelines
- Regional level
- Community level

2.9. Can you please describe some examples of how this enabling environment contributed to improving the efficiency of SEUH Activity implementation?

2.10. What would you consider to be the main lessons from the SEUH Activity that could be used to strengthen the efficiency of a future activity similar to SEUH Activity in: coordination, structuring or organization of support and enabling environment?

EQ 3. What are the main contributions of the Activity to the strengthening of the GOE's UHEP?

3.1. Based on what you know about SEUH Activity, what would you consider to be the main results of the Activity? *Allow respondents to answer freely before probes. Following this, Probe for areas they may not have mentioned. For any of the probes below, further probe for examples for why they say the Activity did or did not achieve certain results.*

- *Quality improvement*
 - a) Improving the knowledge/skills of UHE-p (training, service delivery toolkits and manuals)
 - b) Improving access to and use of UHEP services
 - c) Increasing referrals between the facility and non-facility health services
 - d) Client follow-up for routine services
- *Demand creation*
 - a) Community mobilization strategies and materials
 - b) Coordination between UHE-p, the community and health facilities
 - c) Health awareness of the urban poor
- *Strengthening regional platforms*
 - a) institutional and managerial capacity of urban health units at RHBs
 - b) Urban health data collection, analysis and utilization
 - c) Documentation, learning and adaptation
- *Sectoral convergence for urban sanitation and waste management*
 - a) Enhancing understanding of urban sanitation and waste management
 - b) Promoting inter-sectoral commitment to urban health within the government line offices
 - c) PPPs for urban sanitation and waste management
 - d) NGO Partner Capacity Building

3.2. From your own perspective, do you feel that the SEUH Activity support to the UHEP reached the target groups? Please explain.

- 3.3. Overall, what factors facilitated the achievement of SEUH Activity results? *Probe for examples. Also probe to understand whether those factors were within the control of SEUH Activity or not (e.g. contextual or unanticipated factors, or factors unrelated to the Activity itself)*
- 3.4. What factors affected or hindered the achievement of results? *Probe for examples. Also probe to understand whether those factors were within the control of SEUH Activity or not (e.g. contextual or unanticipated factors, or factors unrelated to the Activity itself)*
- 3.5. To the best of your knowledge, apart from the planned results, what, if any, unintended results were achieved by SEUH Activity beyond those that were stipulated in their plan?
- 3.6. What changes or adjustments has the SEUH Activity made over time in SEUH Activity approaches towards strengthening the government efforts under UHEP?
- a. What lessons could be drawn from those changes/adjustments in the Activity's approaches?

EQ 4: To what extent are the SUHEP activity strategies and interventions sustainable?

- 4.1. What strategies did SEUH Activity employ to ensure sustainability of its interventions and results?
Probe:
- a) In your opinion, are these strategies effective to ensure sustainability of SEUH Activity results?
- b) Which results and interventions are sustainable? Which ones are not? Please provide reasons.
- Probe for:**
- Service delivery and quality improvement
 - Demand creation
 - System strengthening (regional platform strengthening)
 - Sectoral convergence for sanitation and waste management
- 4.2. What has SEUH Activity done to strengthen the organizational capacity of partners **Probe for:**
- a. Planning
- b. Implementation and results monitoring
- 4.3. *Interviewer; PLEASE ASK THIS IF NOT MENTIONED IN 4.1:* What did SEUH Activity do to foster federal and regional government ownership of the strategies initiated by SEUH Activity? How, if at all, was the GOE involved in SEUH Activity planning for sustainability? In your opinion, are these strategies sustainable? Please tell me why you believe these strategies are sustainable/not sustainable.
- 4.4. Based on what you know about the SEUH Activity, what other recommendations would you give to groups that are interested in improving the results and ensuring sustainability of urban health initiatives targeted at the poor?
- 4.5. What would you consider to be the main lessons learned from the sustainability interventions of the SEUH Activity? What changes do you know of that were made during the course of implementation of the SEUH Activity to ensure sustainability of interventions and results?

Conclude

We've now come to the end of this discussion. But before I conclude, I'd like to ask if there is any additional information you'd like to share regarding the performance of SEUH Activity.

Thank you for your participation.

KEY INFORMANT GUIDE

FMOH, RHB AND C/THB AND CITY ADMINISTRATION REPRESENTATIVES

| | |
|--------------------------------------|--|
| Interviewee's Title and Organization | |
| Position | |
| Region | |
| Town/City | |
| Years of Experience on this position | |
| Date | |

EQ 1: How relevant and practical were the design and implementation approach of the USAID-supported SEUHP Activity in relation to the Government of Ethiopia's UHEP

- 1.1. What are your main roles that are related to the UHEP?
- 1.2. Can you please describe what you know about SEUHP?
- 1.3. Based on your own observations and knowledge, what would you consider to be the main health issues of the poor people living in the urban areas of..... (name of the town or city)
- 1.4. How does the UHEP support these needs?
- 1.5. Can you please describe how the SEUHP supports ... (Office Represented) with the delivery of UHEP services? **Probe for:**
 - a) Capacity building
 - b) Quality improvement
 - c) Demand creation
 - d) Service delivery...which services (hygiene and environmental sanitation, family health, NCDs, referrals)
 - e) Creating and coordinating regional platforms
 - f) Intersectoral engagement
 - g) Community information systems
- 1.6. In your opinion, which of these areas represent the priority needs of the UHEP? **Probe:** Please explain why you say...? And which of these would you consider not to be priority needs for UHEP? Please explain.
- 1.7. What is your opinion about the extent to which SEUHP has integrated and address the needs of - women and men; persons with disabilities; children and the elderly population?
- 1.8. Which of these support areas have been implemented by SEUHP? And which have not? **Probe:** can you please explain the reasons for non-implementation of these support areas?
- 1.9. What, if any, was the role of the FMOH during SEUHP design? **Probe:**
 - a) Which directorates/offices were consulted?
 - b) What was their contribution?
- 1.10. Based on what you know about SEUHP and the UHEP, what were the main strengths and weaknesses of the SEUHP design?
- 1.11. What factors facilitated the implementation approaches of SEUHP? And what factors hampered SEUHP implementation?

- 1.12. Since its inception, what changes have you observed in the way that SEUHP is implemented? **Probe:** What were the main reasons for those changes? What were the main outcomes from those changes?

EQ 2: To what extent were the USAID-supported Urban Health Extension Activity's implementation processes and strategies efficient?

Coordination

- 2.11. What would you consider to be the main achievements of SEUHP with regard to coordination of stakeholders to support the implementation of UHEP? **Probe:**
- a) Whom did they coordinate with?
 - b) What approaches did they use to facilitate coordination?
 - c) What were the main outcomes of that coordination?
- 2.12. How did the coordination efforts contribute to improving the efficiency of SEUHP implementation? **Moderator—of not mentioned, please ask:** Can you please give any examples for how SEUHP coordination may have contributed to: **Probe for efficiency in:**
- a) Improving the quality of community-level urban health services
 - b) Increasing demand for facility-level urban health services
 - c) Strengthening regional platforms for improved implementation of the urban health strategy
 - d) Improving sectoral convergence for urban sanitation and waste management
- 2.13. From your own knowledge of other sectors working in this area, which other groups/stakeholders could SEUHP have coordinated with but did not? Why? How could such coordination have been beneficial to SEUHP?
- 2.14. What would you consider to be the main three coordination challenges that SEUHP faced? **Probe for up to 3 challenges.** How did SEUHP deal with these challenges?

Structure/organization of support

- 2.15. How was the support you received from the SEUHP structured/organized? **Probe for:**
- a) Planning
 - b) Communication
 - c) Technical and logistical support
 - d) Reporting—did they share any periodic performance and research reports with you? Which ones? How did you use these reports?
- 2.16. In your opinion, how did this structure/organization of support contribute to the efficiency of SEUHP and UHEP implementation?

Enabling environment

2.17. What did SEUHP do to create an enabling environment? **Probe for enabling environment at the following levels:**

- a) National level, e.g., policy, guidelines
- b) Regional level
- c) Community level

2.18. Can you please describe some examples of how this enabling environment contributed to improving the efficiency of SEUHP implementation? **Probe for:**

- a) Improving the quality of community-level urban health services
- b) Increasing demand for facility-level urban health services
- c) Strengthening regional platforms for improved implementation of the urban health strategy
- d) Improving sectoral convergence for urban sanitation and waste management

2.19. What would you consider to be the main lessons for strengthening the efficiency of a future activity similar to SEUHP in: coordination, structuring or organization of support and enabling environment?

EQ 3. What are the main contributions of the Activity to strengthening of the GoE's UHEP?

3.7. Based on what you know about SEUHP, what would you consider to be their main results? **Probe for:**

- *Quality improvement*
 - e) Improving the knowledge/skills at the national and regional levels and health center levels e.g. training, service delivery toolkits and manuals
 - f) Improving access to and use of UHEP services
 - g) Increasing referrals between the facility and non-facility health services
 - h) Client follow-up for routine services
- *Demand creation*
 - a) Community mobilization strategies and materials
 - b) Coordination between UHE-P, the community and health facilities
 - c) Health awareness of the urban poor
- *Strengthening regional platforms*
 - a) institutional and managerial capacity of urban health units at RHBs
 - b) Urban health data collection, analysis and utilization
 - c) Documentation, learning and adaptation
- *Sectoral convergence for urban sanitation and waste management*
 - a) Enhancing understanding of urban sanitation and waste management
 - b) Promoting inter-sectoral commitment to urban health within the government line offices
 - c) PPPs for urban sanitation and waste management
 - d) NGO Partner Capacity Building

3.8. Overall, what factors facilitated the achievement of SEUHP results? Also, what factors affected or hindered the achievement of results?

3.9. To the best of your knowledge, apart from the planned results, what unintended results were achieved by SEUHP beyond those that were stipulated in their plan?

EQ 4: To what extent are the SUHEP activity strategies and interventions sustainable?

4.2. What strategies did SEUHP employ to ensure sustainability of its interventions and results? Probe:

- c) In your opinion, are these strategies effective to ensure sustainability of SEUHP results?
- d) Which results and interventions are sustainable? Which ones are not? Please provide reasons.

Probe for:

- Service delivery and quality improvement
- Demand creation
- System strengthening (regional platform strengthening)
- Sectoral convergence for sanitation and waste management

4.6. What has SEUHP done to strengthen the organizational capacity of partners **Probe for:**

- c. Planning
- d. Implementation and results monitoring
- e. Are the results achieved likely to continue after SEUHP closes down? Please give reasons

4.7. What did SEUHP do to foster federal and regional government ownership of the strategies initiated by SEUHP? In your opinion, are these strategies sustainable? Please tell me why you believe these strategies are sustainable/not sustainable.

4.8. Based on what you know about the SEUHP, what other recommendations would you give to groups that are interested in improving the results and ensure sustainability of urban health initiatives targeted at the poor?

Conclude

We’ve now come to the end of this discussion. But before I conclude, I’d like to ask if there is any additional information you’d like to share regarding the performance of SEUHP.

Thank you for your participation

KEY INFORMANT GUIDE

URBAN HEALTH EXTENSION PROFESSIONALS SUPERVISORS

Sponsor: USAID/Ethiopia

| | |
|--------------------------------------|--|
| Interviewee’s Title and Organization | |
|--------------------------------------|--|

| | |
|--------------------------------------|--|
| Position | |
| Region | |
| Town/City | |
| Years of Experience in this position | |
| Date | |

EQ 1: How relevant and practical were the design and implementation approach of the USAID-supported SEUH Activity in relation to the Government of Ethiopia’s UHEP?

- I.1. To begin with, can you please provide a brief description of your roles as a UHE-p supervisor?
- I.2. Think about the target groups of UHEP—the poor and vulnerable populations living in urban areas. What are their main health needs?
 - a. Which of these needs are addressed by UHEP? How?
 - b. Which are not? Why?
- I.3. As a UHE-p supervisor, what support do you receive from SEUH Activity? **If not mentioned, probe for the following:**
 - a. Capacity building—**probe:** in what areas? How has that capacity building helped you to perform better in the supervision of UHE-p?
 - b. Sustainability—**Probe:** what did SEUH Activity do to ensure the sustainability of results at the community level?
 - c. Quality improvement: **Probe:** What did SEUH Activity do to improve quality of community-level urban health services?
 - d. Demand creation: **Probe:** What did SEUH Activity do to increase demand for services provided to the poor urban dwellers by UHEP? what were the main results of those demand creation activities
 - e. Community information systems
- I.4. What were the key lessons you’ve learned, if any, about the relevance and practicality of the design and implementation of the SEUH Activity. What changes were made based on the lessons learned?
- I.5. In your view, what are the main successes of the UHE-p? What aspects of your work was made possible because of the support from SEUH Activity

EQ 2: To what extent were the USAID-supported Urban Health Extension Activity’s implementation processes and strategies efficient?

Coordination

- 2.1. Based on your knowledge, which groups, offices or institutions in your community coordinate with SEUH Activity?
- 2.2. On what areas does your office coordinate with SEUH Activity?
- 2.3. What is your perception of the support you receive from SEUH Activity on the following;
 - a. Supportive supervision, mentoring and coaching
 - b. Joint planning
 - c. Referral system
- Ensuring essential supplies
- 2.4. In your opinion, what are the main achievements of SEUH Activity on strengthening coordination of support for UHEP at the community level?

- a. The quality of community-level urban health services
- b. Demand for facility-level urban health services

2.5. Were the coordination approaches facilitated by SEUH Activity efficient? Please explain? **Probe for how the coordination approaches may have improved:**

- 2.6. (a) What would you consider to be the main coordination successes of SEUH Activity? Please provide examples
- (b) And what would you consider to be the main challenges to coordination faced by SEUH Activity at the community level? **Probe for up to 3 challenges.** How did SEUH Activity deal with these challenges?

Enabling Environment

- 2.4. What did SEUH Activity do to create an enabling environment for UHEP at the community level?
- 2.5. Can you please describe some examples of how this enabling environment contributed to improving the efficiency of SEUH Activity implementation in your community?
- 2.6. What would you consider to be the main lessons for strengthening the community-level efficiency of a future activity similar to SEUH Activity in: coordination and enabling environment?

General

- 2.7. Overall, what would you consider to be the main lessons from the SEUH Activity that could be used to strengthen the efficiency of a future activity similar to SEUH Activity in: coordination, structuring or organization of support and enabling environment?

EQ 3: What are the main contributions of the Activity to strengthening of the GoE's UHEP?

3.1. Can you please describe how SEUH Activity supported your Health Center with the items I'm going to read out to you? *Allow respondents to answer freely before probes. Following this, Probe for areas they may not have mentioned. For any of the probes below, further probe for examples for why they say the Activity did or did not achieve certain results.*

- *Quality improvement*
 - i) Improving the knowledge/skills of UHE-p (training, service delivery toolkits and manuals)
 - j) Improving access to and use of UHEP services
 - k) Increasing referrals between the facility and non-facility health services
 - l) Client follow-up for routine services
- *Demand creation*
 - a) Community mobilization strategies and materials
 - b) Coordination between UHE-P, the community and health facilities
 - c) Health awareness/education of the urban poor
- *Strengthening community-level coordination platforms*
 - a) Urban health data collection, analysis and utilization
 - b) Documentation, learning and adaptation

- 3.10. Overall, what factors facilitated the achievement of SEUH Activity results at the community level? *Probe for examples. Also probe to understand whether those factors were within the control of SEUH Activity or not (e.g. contextual or unanticipated factors, or factors unrelated to the Activity itself)*
- 3.11. What factors affected or hindered the achievement of the expected results? *Probe for examples. Also probe to understand whether those factors were within the control of SEUH Activity or not (e.g. contextual or unanticipated factors, or factors unrelated to the Activity itself)*
- 3.12. To the best of your knowledge, apart from the planned results, what, if any, unintended results were achieved by SEUH Activity beyond those that were stipulated in their plan?
- 3.13. From your observations, what is the difference between kebele's that are receiving support from UHE-p versus those that are not?
- 3.14. In your opinion, how can a future urban health program be improved to achieve greater results at the community level? Probe for:
- a) Community mobilization
 - b) Service quality improvement
 - c) Service delivery
 - d) Referral service
 - e) Community health information system
 - f) Viability of urban primary health care reform (family health team approach)
- 3.15. What changes or adjustments has the SEUH Activity made over time to its approaches towards strengthening the government efforts under UHEP?
- a. What lessons could be drawn from those changes/adjustments in the Activity's approaches?

EQ 4: To what extent are the SUHE Activity strategies and interventions sustainable?

- 4.1. What strategies did SEUH Activity employ to ensure sustainability of its interventions and results in your community? *If not mentioned, probe for: building local ownership by the Town Health Office/Health centers; infrastructure, tools and guidelines, local resource mobilization, others*
- e) In your opinion, are these strategies effective to ensure sustainability of the results achieved?
 - f) Which results, in your opinion, and interventions are sustainable? Which ones are not? Please provide reasons. **Probe for:**
 - Service delivery and quality improvement
 - Demand creation
- 4.9. Based on what you know about the SEUH Activity work in your community, what recommendations would you give to improve the implementation of future support to UHEP?
- 4.10. What were the main lessons learned in ensuring sustainability?
- 4.11. What would you consider to be the main lessons learned from the sustainability interventions of the SEUH Activity? What changes do you know of that were made during the course of implementation of the SEUH Activity to ensure sustainability of interventions and results?

Conclude

We've now come to the end of this discussion. But before I conclude, I'd like to ask if there is any additional information you'd like to share regarding the performance of SEUH Activity.

Thank you for your participation

KEY INFORMANT GUIDE
TRAINING INSTITUTIONS

| | | |
|--------------------------------------|-----------|--|
| Interviewee's Organization | Title and | |
| Position | | |
| Region | | |
| Town/City | | |
| Years of Experience in this position | | |
| Date | | |

EQ 1: How relevant and practical were the design and implementation approach of the USAID-supported SEUH Activity in relation to the Government of Ethiopia's UHEP?

- 1.1. To begin, can you please describe your role in this office in relation to UHEP? And in relation to SEUH Activity?
- 1.2. What are the main contributions of ... (institution name) to UHEP? And to UHE-p?
- 1.3. In your opinion, what were the key lessons learned, if any, about the relevance and practicality of the design and implementation of the SEUH Activity. What changes were made based on the lessons learned?

EQ 2: To what extent were the USAID-supported Urban Health Extension Activity's implementation processes and strategies efficient?

- 2.1. How are UHE-p trainees identified and enrolled?
- 2.2. Can you please describe how your institution coordinates with UHEP and with SEUH Activity on the training and placement of UHE-p?
- 2.3. Let's talk about your successes and challenges with the training of UHE-p
 - a. What would you consider to be the main successes of your institution in the establishment of a course and the training of UHE-ps
 - b. Have you faced any challenges? Please give examples. **if not mentioned, probe for:**
 - Motivation of trainees
 - High attrition of trainees
 - Curriculum and quality of the training related issues
 - Government future strategies on UHE-ps training
 - c. What changes/adaptations did your institution; SEUH Activity; UHEP make to address these challenges

Probe for:

- a) Capacity of the training institution
- b) Trainings quality related issues (e.g appropriateness of the curriculum)
- c) Challenges related to the training approach (including selection criteria)

- d) Government HRH strategy and policies
 - e) Motivation and retention related issues
 - f) Awareness of the community and trainees
- 2.4. In general, what approaches would you recommend for improving the training of UHE-p?
- 2.5. What would you consider to be the main lessons from the SEUH Activity that could be used to strengthen the efficiency of a future activity similar to SEUH Activity in: coordination, structuring or organization of support and enabling environment?

EQ 3. What are the main contributions of the Activity to strengthening of the GoE's UHEP?

- 3.1. Please think about the contributions of your institution to the UHEP and SEUH Activity. What would you consider to be your main contributions? **Probe:** Please give examples of the results from these contributions? **Probe for:**
- a) Recruitment and selection of trainees
 - b) Curriculum development/review
 - c) Capacity building of faculty members
 - d) Placement support
 - e) Others
- 3.2. What do you consider to be the main lessons learned in the process of training UHE-ps? What adjustments were made during implementation based such lessons?

EQ 4: To what extent are the SEUH Activity strategies and interventions sustainable?

- 4.1. In your view, what aspects of the work you did with UHEP and SEUH Activity are sustainable? Which ones are not?
- 4.2. How can the interventions and results of SEUH Activity and UHEP be sustained after the closeout of SEUH Activity?
- 4.3. What would you consider to be the main lessons learned from the sustainability interventions of the SEUH Activity? What changes do you know of that were made during the course of implementation of the SEUH Activity to ensure sustainability of interventions and results?

Conclude

We've now come to the end of this discussion. But before I conclude, I'd like to ask if there is any additional information you'd like to share regarding the performance of SEUH Activity.

Thank you for your participation.

KEY INFORMANT GUIDE

ADDIS ABABA UNIVERSITY AND URBAN HEALTH DEVELOPMENT CENTER REPRESENTATIVES

| | |
|--------------------------------------|--|
| Interviewee's Title and Organization | |
| Position | |
| Region | |
| Town/City | |
| Years of Experience in this position | |
| Date | |

EQ 1: How relevant and practical were the design and implementation approach of the USAID-supported SEUH Activity in relation to the Government of Ethiopia's UHEP

- 1.4. Can you please describe the role of your office in relation to UHEP? And what role does your office have with the implementation of SEUH Activity?
- 1.5. What would you consider to be the main health issues of the poor people living in the urban areas of Ethiopia?
- 1.6. How has SEUH Activity supported UHEP to address the health needs of the poor and vulnerable populations living in urban areas? (Office Represented) with the delivery of UHEP services?
Probe for:
 - h) Capacity building
 - i) Quality improvement
 - j) Demand creation
 - k) Service delivery...which services (hygiene and environmental sanitation, family health, NCDs, referrals)
 - l) Creating and coordinating regional platforms
 - m) Intersectoral engagement
 - n) Community information systems
- 1.7. What is the role of your office in supporting UHEP implementation? And in what areas has SEUH Activity worked with you?
- 1.8. Based on your knowledge of SEUH Activity and UHEP, would you consider the support from SEUH Activity to be addressing the priorities of UHEP?
 - a. Can you please provide examples of the UHEP priorities that SEUH Activity support?
 - b. What forms of support does SEUH Activity provide?
- 1.9. What is your opinion about the appropriateness of that support when compared with the priorities of UHEP and the needs of the urban poor and vulnerable populations?
- 1.10. Based on what you know about SEUH Activity and the needs of UHEP, what were the main strengths and weaknesses of the SEUH Activity design?
- 1.11. In your opinion, what were the key lessons learned, if any, about the relevance and practicality of the design and implementation of the SEUH Activity. What changes were made based on the lessons learned?

EQ 2: To what extent were the USAID-supported Urban Health Extension Activity's implementation processes and strategies efficient?

Coordination

- 2.1. What are the main areas of coordination between your institution/office and SEUH Activity?

2.2. Can you please describe, with examples, what the key outcomes of that coordination were?

2.3. How did the coordination efforts contribute to improving the efficiency of SEUH Activity implementation? **Probe for efficiency in:**

- a. Improving implementation of the urban health strategy
- b. Improving sectoral convergence for urban sanitation and waste management

2.4. What would you consider to be the main coordination strengths of SEUH Activity? **Probe up to 3 times and ask for some examples.**

2.5. And what would you consider to be the main challenges that SEUH Activity faced? **Probe up to 3 times.** How did SEUH Activity deal with these challenges?

2.6. Based on your work with SEUH Activity and UHEP, what lessons would you advance for strengthening the coordination and efficiency of a future activity similar to SEUH Activity?

Enabling Environment

2.7. What do you know of that SEUH Activity did to create an enabling environment? **Probe for enabling environment at the following levels:**

- National level, e.g., policy, guidelines
- Regional level
- Community level

2.8. Can you please describe some examples of how this enabling environment contributed to improving the efficiency of SEUH Activity implementation? Please provide examples

2.9. What would you consider to be the main lessons from the SEUH Activity that could be used to strengthen the efficiency of a future activity similar to SEUH Activity in: coordination, structuring or organization of support and enabling environment?

EQ 3. What are the main contributions of the Activity to strengthening of the GOE's UHEP

3.1. Based on what you know about SEUH Activity, what would you consider to be their main results? Probe for:

- *Quality improvement*
 - a) Improving the knowledge/skills of UHE-p (training, service delivery toolkits and manuals)
 - b) Improving access to and use of UHEP services
 - c) Increasing referrals between the facility and non-facility health services
 - d) Client follow-up for routine services
- *Demand creation*
 - a) Community mobilization strategies and materials
 - b) Coordination between UHE-P, the community and health facilities
 - c) Health awareness of the urban poor
- *Strengthening regional platforms*
 - a) institutional and managerial capacity of urban health units at RHBs
 - b) Urban health data collection, analysis and utilization

- c) Documentation, learning and adaptation
 - *Sectoral convergence for urban sanitation and waste management*
 - a) Enhancing understanding of urban sanitation and waste management
 - b) Promoting inter-sectoral commitment to urban health within the government line offices
 - c) PPPs for urban sanitation and waste management
 - d) NGO Partner Capacity Building

3.2. What did the urban health development center achieve in relation to the following areas:

- a) Promoting the impacts of urbanization on health and behavior
- b) Promoting trans disciplinary and collaborative research
- c) Serve as information center for urban health in Ethiopia
- d) Collecting and collating evidences on urban health
- e) Providing evidence to inform technical support to policies and programs
- f) Organizing dialogue forums on urban health
- g) a center for think tank group

3.16. Overall, what factors facilitated the achievement of SEUH Activity results? Also, what factors affected or hindered the achievement of results?

3.17. To the best of your knowledge, apart from the planned results, what unintended results were achieved by SEUH Activity beyond those that were stipulated in their plan?

3.18. What changes did SEUH Activity make during implementation to facilitate better achievement of expected results? What lessons can be drawn from those changes to inform future similar activities?

EQ 4: To what extent are the SUHEP activity strategies and interventions sustainable?

4.1. What strategies do you know of that SEUH Activity employed to ensure sustainability of its interventions and results? Probe:

- a) In your opinion, are these strategies effective to ensure sustainability of SEUH Activity results?
- b) Which results and interventions are sustainable? Which ones are not? Please provide reasons.

4.2. What do you know that SEUH Activity has done to strengthen the organizational capacity of partners in planning, implementation and monitoring of UHEP? Are the results achieved likely to continue after SEUH Activity closes? Please give reasons

What did SEUH Activity do to foster federal and regional government ownership of the strategies initiated by SEUH Activity? In your opinion, are these strategies sustainable? Please tell me why you believe these strategies are sustainable/not sustainable.

4.3. Based on what you know about the SEUH Activity, what recommendations would you give to groups that are interested in improving the results and ensure sustainability of urban health initiatives targeted at the poor?

Conclude

We've now come to the end of this discussion. But before I conclude, I'd like to ask if there is any additional information you'd like to share regarding the performance of SEUH Activity.

Thank you for your participation

KEY INFORMANT GUIDE

SECTOR OFFICES FOR SECTORAL CONVERGENCE ON SANITATION AND WASTE MANAGEMENT

| | |
|--------------------------------------|--|
| Interviewee's Title and Organization | |
| Position | |
| Region | |
| Town/City | |
| Years of Experience in this position | |
| Date | |

EQ 1: How relevant and practical were the design and implementation approach of the USAID-supported SEUH Activity in relation to the Government of Ethiopia's UHEP?

- 1.1. To begin, can you please describe your role in this office?
- 1.2. In just a few sentences what do you know about UHEP? What about SEUH Activity?
- 1.3. In what ways are you or your office involved with UHEP and SEUH Activity?
- 1.4. What platforms do you know of that SEUH Activity has created at the regional level and district levels?
- 1.5. What has SEUH Activity done to rally support for UHEP across various sectors? Which sectors did they bring together? What resulted from this intersectoral effort?
- 1.6. As you probably know, the UHEP was designed to support the GoE with meeting the health needs of the urban poor and vulnerable populations. Can you please share some examples, if you know of any, of how the approaches of SEUH are aligned with the priorities of UHEP? Please explain
- 1.7. In your opinion, what were the key lessons learned, if any, about the relevance and practicality of the design and implementation of the SEUH Activity. What changes were made based on the lessons learned?

EQ 2: To what extent were the USAID-supported Urban Health Extension Activity's implementation processes and strategies efficient?

Coordination

- 2.1. In what ways does your office coordinate with SEUH Activity?
- 2.2. Which other entities does SEUH Activity coordinate with in relation to the UHEP?
- 2.3. What are your general views or opinions about the ways in which SEUH Activity is coordinating with sector offices?
 - What approaches did they use to facilitate coordination?
 - What were the main outcomes of that coordination?
 - What were their coordination strengths and successes? Was the coordination efficient? Please give reasons
 - What weaknesses did you observe in their coordination efforts?
- 2.4. How did the coordination efforts contribute to improving the efficiency of SEUH Activity implementation? **Probe for efficiency in:**
 - Improving implementation of the urban health strategy
 - Improving sectoral convergence for urban sanitation and waste management

2.5. What would you consider to be the main three coordination challenges that SEUH Activity faced? **Probe for up to 3 challenges.** How did SEUH Activity deal with these challenges?

2.6. What would you consider to be the main lessons for strengthening the efficiency of a future activity similar to SEUH Activity in: coordination, structure and enabling environment?

EQ 3: What are the main contributions of the Activity to strengthening of the GoE's UHEP?

3.1. Regarding the interactions between SEUH Activity and your office, what would you consider to be their main results in strengthening sectoral collaboration for urban sanitation and waste management? *Allow respondents to answer freely before probes. Following this, Probe for areas they may not have mentioned. For any of the probes below, further probe for examples for why they say the Activity did or did not achieve certain results.* **Probe for:**

- b) Enhancing understanding of urban sanitation and waste management
- c) Promoting inter-sectoral commitment to urban health within the government line offices
- d) PPPs for urban sanitation and waste management
- e) NGO Partner Capacity Building
- f) Construction of communal and public toilets
- g) Resource mobilization for an endowment fund for Communal and public toilet construction
- h) Market-based mechanisms for public and communal toilets

3.2. Overall, what factors facilitated the achievement of SEUH Activity results? *Probe for examples. Also probe to understand whether those factors were within the control of SEUH Activity or not (e.g. contextual or unanticipated factors, or factors unrelated to the Activity itself)*

3.3. To the best of your knowledge, apart from the planned results, what, if any, unintended results were achieved by SEUH Activity beyond those that were stipulated in their plan?

3.4. What lessons, if any, can you draw from the SEUH Activity results to improve the outcomes of future efforts similar to the SEUH Activity?

EQ 4: To what extent are the SUHEP activity strategies and interventions sustainable?

4.3. What strategies did SEUH Activity employ to ensure sustainability of sectoral collaboration results on urban sanitation and waste management? **Probe:**

- In your opinion, are these strategies effective
- Would you consider these strategies to be sustainable? Why? Do you foresee that the sectors will continue working together? Please tell me why you believe the sectoral offices will continue/not continue working together.
- In your opinion do you foresee that all sectors will continue working together to improve urban sanitation and waste management in the future? How? Why?

4.12. In your opinion, what lessons could be learned from the sustainability approaches if the SEUH Activity?

4.13. What recommendations would you give to groups that are interested in strengthening sectoral collaboration to improve urban sanitation and waste management?

Conclude

We've now come to the end of this discussion. But before I conclude, I'd like to ask if there is any additional information you'd like to share regarding the performance of SEUH Activity.

Thank you for your participation.

KEY INFORMANT GUIDE
CLUSTER COORDINATORS

| | |
|--------------------------------------|--|
| Interviewee's Title and Organization | |
| Position | |
| Region | |
| Town/City | |
| Years of Experience in this position | |
| Date | |

EQ 1: How relevant and practical were the design and implementation approach of the USAID-supported SEUH Activity in relation to the Government of Ethiopia's UHEP?

- I.1. What is the role of a cluster coordinator? How does it support the implementation of SEUH Activity?
- I.2. In your opinion, to what extent is the design of SUHP aligned with the priorities of UHEP at the community level?
- I.3. The components I am going to read out to you represent some of the critical results included in the SEUH Activity design. Using examples, can you please tell me briefly which of these were implemented by SEUH Activity and which ones were not? Why were not implemented? **Read out each of the following result areas:**
 - a. Capacity building—**probe for:** what kind of capacity building activities were undertaken? Who were the target groups? What was the outcome of that capacity building?
 - b. Sustainability—**Probe:** what did SEUH Activity do to ensure the sustainability of results?
 - c. Quality improvement: **Probe:** What did SEUH Activity do to improve quality of community-level urban health services?
 - d. Demand creation: **Probe:** What did SEUH Activity do to increase demand for services provided to the poor urban dwellers by UHEP? what were the main results of those demand creation activities
 - e. Regional platforms: **Probe:** did SEUH Activity create any forms of platforms at the regional level? Which ones?
 - f. Intersectoral convergence: **Probe:** What did SEUH Activity do to rally support for UHEP across various sectors? Which sectors did they bring together? What resulted from this intersectoral effort?
 - g. Community information systems

- I.4. In what ways did the SEUH Activity design address gender and vulnerable groups needs (urban poor, persons with disability, age, health status)?
- I.5. In your opinion, what were the key lessons learned, if any, about the relevance and practicality of the design and implementation of the SEUH Activity. What changes were made based on the lessons learned?

EQ 2: To what extent were the USAID-supported Urban Health Extension Activity's implementation processes and strategies efficient?

Coordination

- 2.1. What would you consider to be the main achievements of SEUH Activity at the community level regarding coordination of stakeholders to support the implementation of UHEP? **Probe:**
 - a. Which groups/offices have been coordinated?
 - b. What approaches were used to facilitate coordination?
 - c. What were the main outcomes of that coordination?
- 2.2. How did the coordination efforts contribute to improving the efficiency of SEUH Activity implementation and achievement of results related to?
- 2.3. Which other groups/stakeholders could SEUH Activity have coordinated with but did not? How could such coordination have been beneficial?
- 2.4. What would you consider to be the main coordination successes of SEUH Activity at the community level? Please give examples. **Probe up to 3 times.**
- 2.5. And what would you consider to be the main challenges that SEUH Activity faced at the community-level? **Probe for up to 3 times.**
 - a. How did SEUH Activity deal with these challenges?

Enabling Environment

- 2.6. To the best of your knowledge, what did SEUH Activity do to create an enabling environment for UHEP at the community level? **Probe.** Can you please give some examples?
- 2.7. Can you please describe some examples of how this enabling environment contributed to improving the efficiency of SEUH Activity implementation?
- 2.8. What would you consider to be the main lessons for strengthening the efficiency of a future activity similar to SEUH Activity in: coordination and enabling environment?

EQ 3: What are the main contributions of the Activity to strengthening of the GoE's UHEP?

- 3.19. Based on what you know about SEUH Activity work in this town/city, what would you consider to be the main results of the Activity at the community level? Probe for:
 - *Quality improvement*
 - m) Improving the knowledge/skills of UHE-p (training, service delivery toolkits and manuals)
 - n) Improving access to and use of UHEP services
 - o) Increasing referrals between the facility and non-facility health services
 - p) Client follow-up for routine services

- *Demand creation*
 - q) Community mobilization strategies and materials
 - r) Coordination between UHE-P, the community and health facilities
 - s) Health awareness of the urban poor
- *Strengthening regional platforms*
 - a) institutional and managerial capacity of urban health units at RHBs
 - b) Urban health data collection, analysis and utilization
 - c) Documentation, learning and adaptation
- *Sectoral convergence for urban sanitation and waste management*
 - a) Enhancing understanding of urban sanitation and waste management
 - b) Promoting inter-sectoral commitment to urban health within the government line offices
 - c) PPPs for urban sanitation and waste management
 - d) NGO Partner Capacity Building

3.20. Overall, what factors facilitated the achievement of SEUH Activity results? Also, what factors affected or hindered the achievement of results?

3.21. To the best of your knowledge, apart from the planned results, what unintended results were achieved by SEUH Activity beyond those that were stipulated in their plan?

3.22. What lessons, if any, can you draw from the SEUH Activity results to improve the outcomes of future efforts similar to the SEUH Activity?

EQ 4: To what extent are the SUHEP Activity strategies and interventions sustainable?

4.1. What strategies do you know of that SEUH Activity employed to ensure sustainability of its interventions and results? Probe:

- a) In your opinion, are these strategies effective to ensure sustainability of SEUH Activity results?
- b) Which results and interventions are sustainable? Which ones are not? Please provide reasons. **Probe for:**
 - Service delivery and quality improvement
 - Demand creation
 - System strengthening (regional platform strengthening)
 - Sectoral convergence for sanitation and waste management

4.14. Based on your experience and the lessons from your work with the SEUH Activity and UHEP, what advice would you give to future projects of this kind that aim to work at the community level to improve the health of the poor and vulnerable urban populations?

Conclude

We've now come to the end of this discussion. But before I conclude, I'd like to ask if there is any additional information you'd like to share regarding the performance of SEUH Activity.

Thank you for your participation.

Observation questions/ checklist for PPP in SEUHP WASH activity

Instructions for the data collector:

The main purpose of this tool is to support supplemental data collection during observation. Please note the following:

- a. Observe all rooms and services offered at this site
- b. Take photos of each service/rooms at the public toilet and its vicinity
- c. Write notes about your observations
- d. Ask the questions below to relevant people involved with the operation of the public toilet as relevant. Note that some questions may be applicable only to the people involved in the management of the toilets

Supplemental questions to ask the attendants.

1. Can you please describe the process that was followed to establish a public-private partnership between ... and ... for the establishment of the public toilets?
 - a. Where did the idea come from?
 - b. Why was it necessary to establish the public toilets?
 - c. Which institutions were involved?
 - d. Who constructed the latrines and the associated rooms?
 - e. Where did the funding come from?
2. What services are provided at this public toilet?
 - a. Latrines?
 - b. Showers?
 - c. Other public services operating within the public toilet vicinity
3. Since its establishment, how has this public toilet benefited the people of this town?
4. How is the public toilet managed? **Probe for:**
 - a. Which office or group is responsible, and the position of the person responsible
 - b. Who cleans the toilets and how are they paid? Ask also how much they earn and how many they are
 - c. What is the cost for each service offered at this public toilet?
 - d. Approximately how much money is generated from this public toilet in a month?
 - e. How is this money collected and remitted? Which office is responsible for collecting and receiving the money?
 - f. Giving examples, can you describe how this money is used?
 - g. What is the system for documenting the operations of this public toilet?
 - h. What are your opinions about the management of the public toilet?
5. What type of business operate at this site? (**Observe and also ask people running the businesses. Also take photos**)
 - a. Who owns these businesses (individuals or groups—not names)?
 - b. What is the procedure for establishing a business here?
 - c. What are the contributions of these businesses to this town?

6. Can you please give examples of the changes that have happened in this community because of this public toilet?
 - a. What are the main challenges with the management and operations of this toilet?
 - b. How have these challenges been addressed?
7. In your opinion, is the operation of this public toilet sustainable with the revenue generated from the users? Please explain why it is sustainable/not sustainable

8. What recommendations can you give to strengthen the functioning of this public toilet?

Thank you.

ANNEX IV: INFORMATION SOURCES

Key Informant Interviews

| S.No. | Name of office/organization |
|-------|---|
| 1. | Federal Ministry of Health |
| 2. | USAID/Ethiopia |
| 3. | Addis Ababa Region Health Bureau |
| 4. | Yeka Sub-city Health Office |
| 5. | Nefas Silk Lafto Sub-city Health Office |
| 6. | Addis Ababa Urban Development Center |
| 7. | Health Center in Nefas Lafto Sub-city |
| 8. | Amhara Region Health Bureau |
| 9. | Tigray Region Health Bureau |
| 10. | Oromia Region Health Bureau |
| 11. | SNNP Regional Health Bureau |
| 12. | Harari Region Health Bureau |
| 13. | A Health Center in Harari |
| 14. | Dire Dawa City administration Health Bureau |
| 15. | Dire Dawa Town Beautification and Sanitation office |
| 16. | A Health Center in Dire Dawa |
| 17. | John Snow Inc., Strengthening Ethiopia's Urban Health, Head Office |
| 18. | John Snow Inc., Strengthening Ethiopia's Urban Health, Amhara Regional Office |
| 19. | John Snow Inc., Strengthening Ethiopia's Urban Health, Tigray Regional Bureau |
| 20. | John Snow Inc., Strengthening Ethiopia's Urban Health, Oromia Regional Office |
| 21. | John Snow Inc., Strengthening Ethiopia's Urban Health, SNNP Regional Office |
| 22. | John Snow Inc. Strengthening Ethiopia's Urban Health, Dire Dawa office |
| 23. | John Snow Inc. Strengthening Ethiopia's Urban Health, Harari Office |
| 24. | John Snow Inc., Data Utilization Partnership |
| 25. | Michew Town Health Office |
| 26. | Michew Water and Sanitation Office |
| 27. | Mekelle Town Health Office |
| 28. | Mekelle Health Center |
| 29. | Emanuel Development Association |
| 30. | Dire Dawa City Beautification Office |
| 31. | Harar Solid Waste Management/Beautification Office. |
| 32. | Injibara Town Health Office |
| 33. | Injibara Health Center |
| 34. | Bahir Dar Town Health Office |
| 35. | Amhara Region, Environmental Sanitation and Hygiene Bureau |
| 36. | Bahir Dar Health Center |
| 37. | Miychech Health Center |
| 38. | Mekelle Mayor Office |

| | |
|-----|---|
| 39. | Michew Municipality Office |
| 40. | Halaba Town Municipality office |
| 41. | Halaba Town Education Office |
| 42. | Halaba Town Health Office |
| 43. | Halaba Health Center |
| 44. | Hawassa City Mayor Office |
| 45. | Hawassa Town Health Office |
| 46. | Millennium Health Center in Hawassa |
| 47. | Hawassa Regional Health Science College |
| 48. | Assela Town Water Office |
| 49. | Ambo Town Greenery Office |
| 50. | Halaba Education Office |
| 51. | Addis Ababa University |
| 52. | Minilik Hospital Training Center |
| 53. | Adama Town Water Office |
| 54. | Adama Town Environmental Protection Office |
| 55. | Dembela Health Center in Adama |
| 56. | Kemissie Town Water Office (As part of the PPT in Kemissie) |
| 57. | Kemissie Town Sanitation and Beautification Office (As part of the PPT in Kemissie) |
| 58. | Kemissie Town Health Office (As part of the PPT in Kemissie) |
| 59. | Kemissie Small Scale Enterprise office (As part of the PPT in Kemissie) |

UHE-p and beneficiaries FGDs

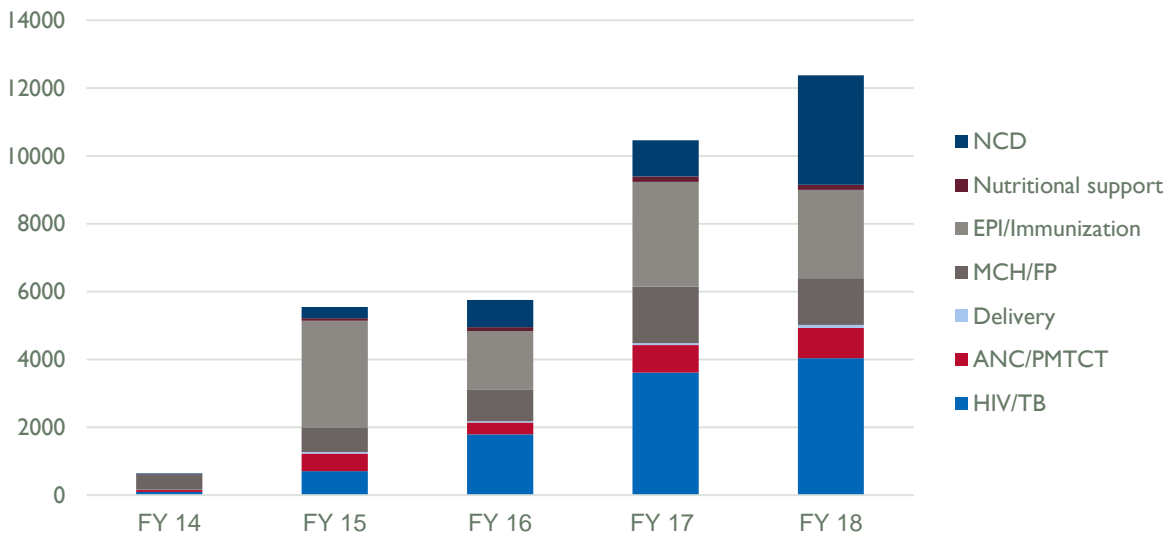
| | |
|----|---|
| 1 | Nefas Silk, Lafto sub city, Addis ABaba |
| 2 | Yeka sub-city, Addis Ababa |
| 3 | Bahir Dar, Amhara region |
| 4 | Injibara, Amhara region |
| 5 | Mekelle, Tigray region |
| 6 | Maichaw, Tigray region |
| 7 | Hawassa, SNNP region |
| 8 | Assella, Oromia Region |
| 9 | Ambo, Oromia Region |
| 10 | Adama, Oromia region |
| 11 | Halaba, SNNP region |

Observations

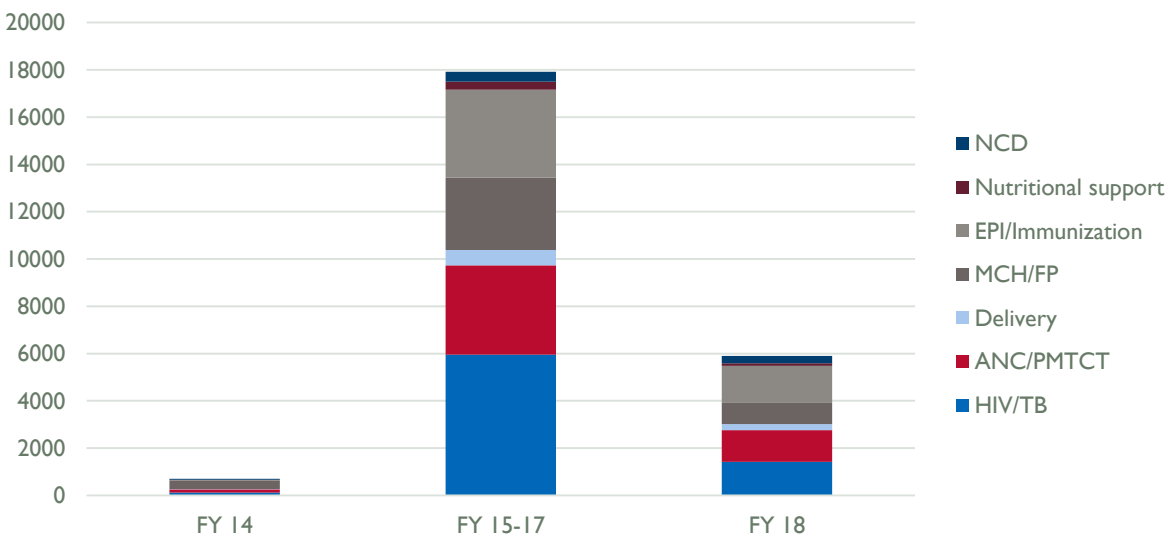
Public toilets were observed in Kemissie, Amhara region and Mekelle, Tigray regio. A school was observed in Hawassa for WASH initiatives. An Urban health post was observed in Adama, Oromia region. Observations were also conducted in all towns on solid and liquid waste.

ANNEX V: ADDITIONAL TABLES AND FIGURES

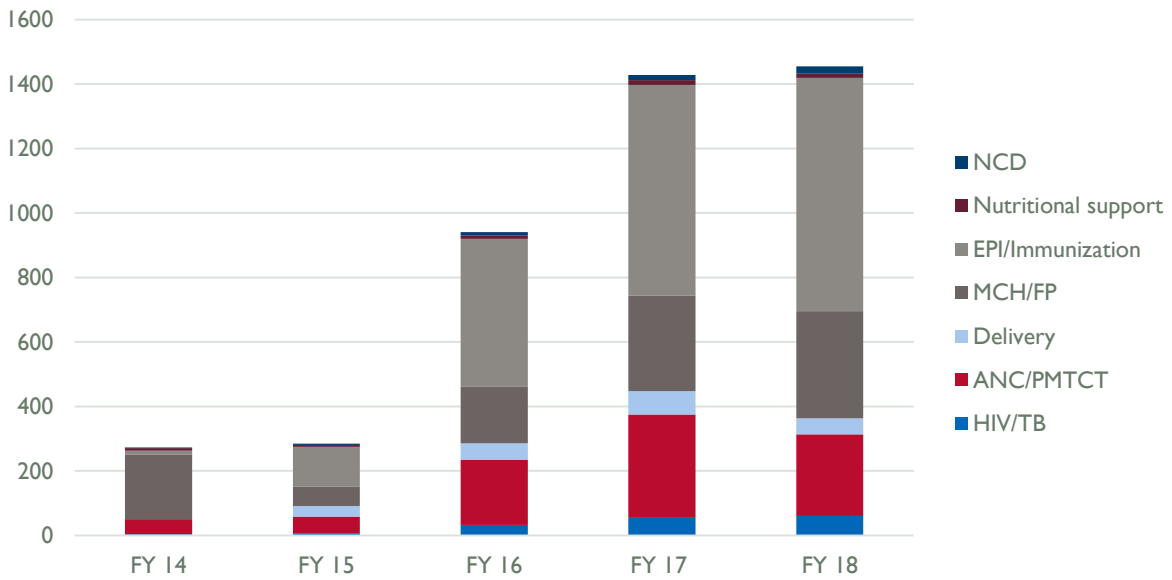
ADDIS



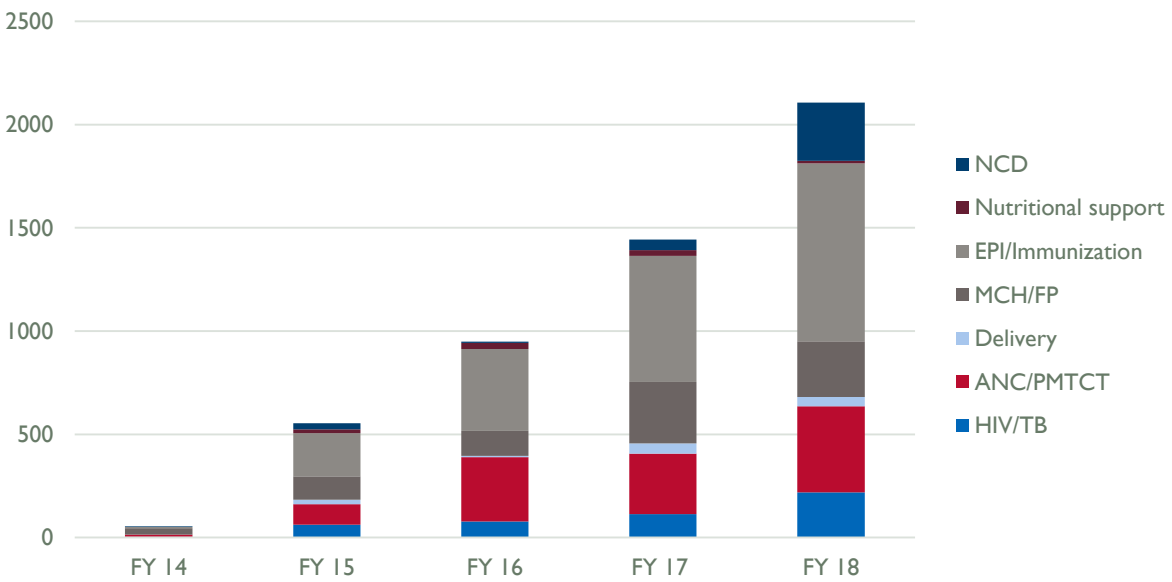
AMHARA



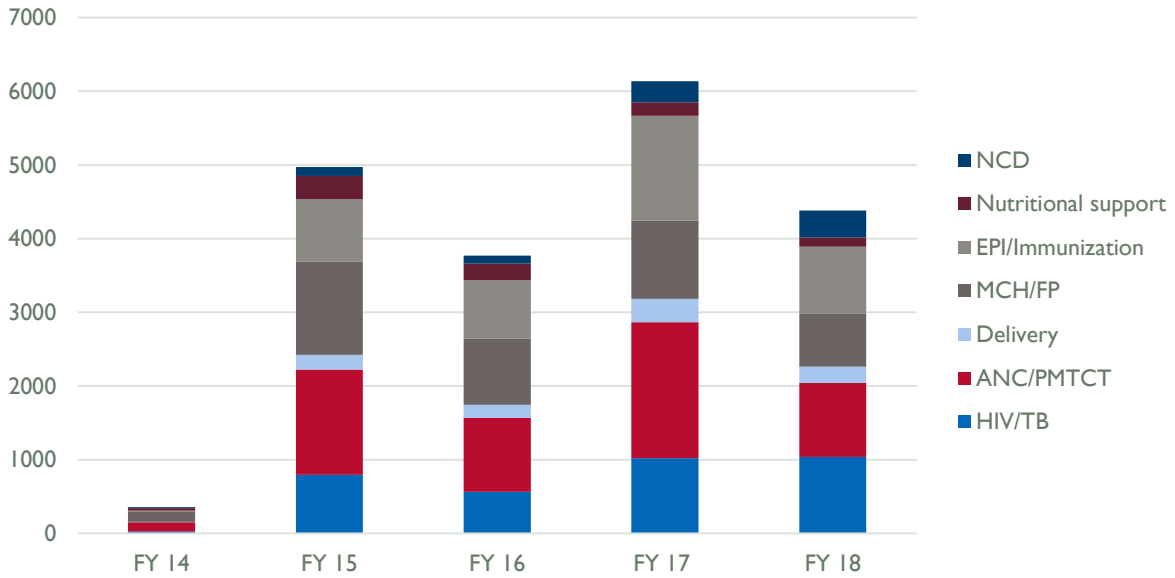
DIRE DAWA



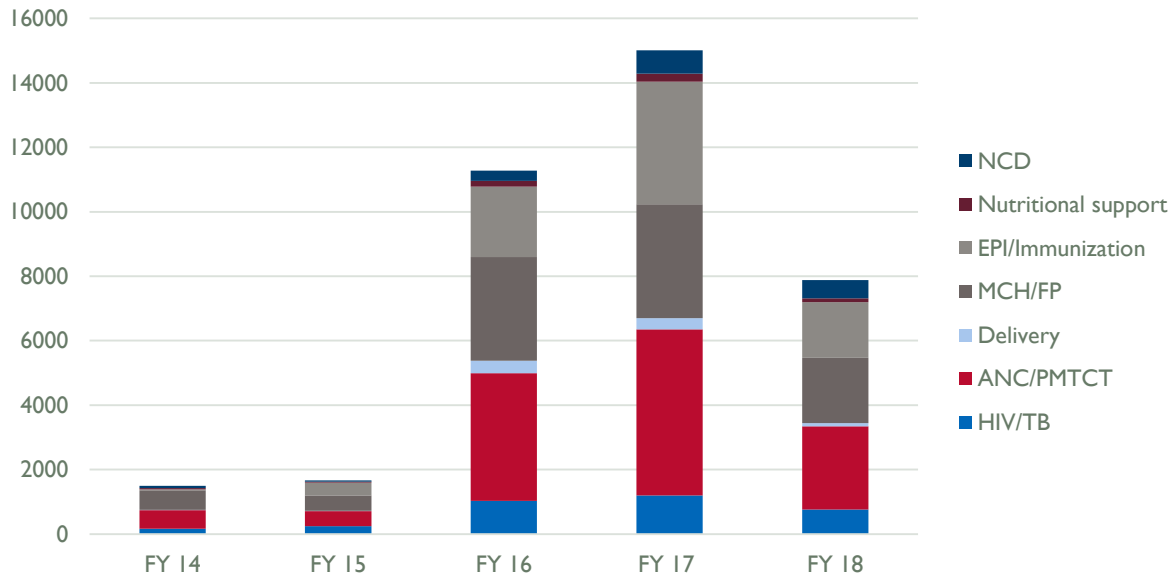
HARARI



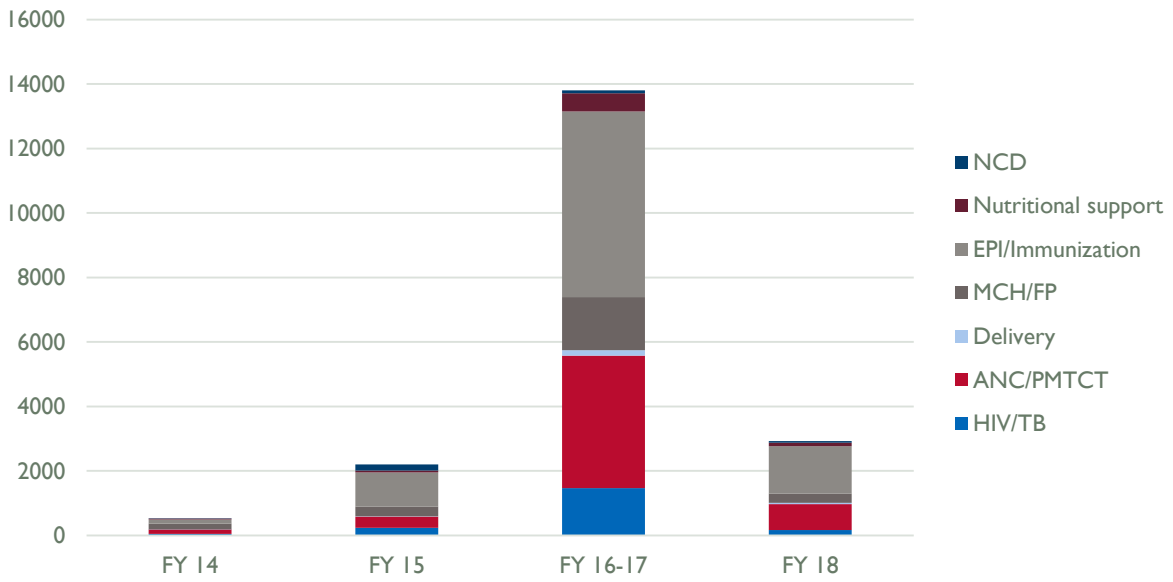
OROMIA



SNNPR



TIGRAY



Total achievement, disaggregated by region

| Region | Individuals referred to facilities for services | Number of defaulters identified & linked to health facilities | Individuals received HIV T&C and received test result |
|--------------|---|---|---|
| Addis | 28,395 | 354 | 283 |
| Amhara | 24,526 | 516 | 8,314 |
| Dire Dawa | 4,382 | 90 | 2,610 |
| Harari | 5,107 | 406 | 1,291 |
| Oromia | 19,616 | 865 | 16,381 |
| SNNPR | 37,335 | 1,177 | 8,519 |
| Tigray | 19,458 | 356 | 2,459 |
| Total | 138,819 | 3,764 | 39,857 |

Percentage of sexually active non-pregnant urban women using specific family planning methods by region

| FP method used | Year | Region | | | | | | | | | | | | | | | |
|---------------------|--------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|-------------|------------|------------|------------|------------|------------|
| | | Tigray | | Amhara | | Oromia | | SNNPR | | Harari | | Addis Adaba | | Dire Dawa | | Total | |
| | | 2011 | 2016 | 2011 | 2016 | 2011 | 2016 | 2011 | 2016 | 2011 | 2016 | 2011 | 2016 | 2011 | 2016 | 2011 | 2016 |
| None | Estimate (%) | 51.0 | 47.8 | 45.5 | 36.8 | 37.6 | 41.3 | 46.4 | 42.6 | 43.1 | 45.8 | 31.7 | 40.0 | 45.3 | 56.6 | 41.0 | 41.0 |
| | SE (%) | 2.9 | 6.0 | 5.4 | 6.0 | 3.9 | 5.9 | 9.6 | 5.4 | 2.6 | 3.9 | 2.2 | 1.9 | 4.6 | 4.5 | 2.6 | 2.4 |
| | 95% Lower | 45.3 | 36.2 | 35.1 | 25.9 | 30.3 | 30.3 | 28.7 | 32.4 | 38.0 | 38.2 | 27.4 | 36.3 | 36.5 | 47.7 | 36.0 | 36.4 |
| | CI Upper | 56.6 | 59.6 | 56.2 | 49.2 | 45.5 | 53.1 | 65.0 | 53.5 | 48.3 | 53.5 | 36.3 | 43.8 | 54.4 | 65.2 | 46.1 | 45.7 |
| LARC | Estimate (%) | 2.8 | 11.2 | 6.2 | 16.8 | 4.6 | 14.3 | 4.6 | 20.9 | 5.9 | 19.8 | 5.9 | 24.2 | 14.5 | 20.8 | 5.3 | 18.1 |
| | SE (%) | 1.3 | 2.3 | 2.0 | 3.9 | 2.1 | 3.8 | 3.0 | 4.2 | 1.3 | 3.4 | 0.9 | 2.0 | 2.8 | 3.9 | 1.0 | 1.6 |
| | 95% Lower | 1.1 | 7.5 | 3.2 | 10.4 | 1.8 | 8.2 | 1.3 | 13.8 | 3.8 | 14.0 | 4.4 | 20.4 | 9.8 | 14.1 | 3.7 | 15.1 |
| | CI Upper | 7.0 | 16.5 | 11.5 | 26.1 | 10.9 | 23.6 | 15.7 | 30.5 | 9.0 | 27.3 | 7.9 | 28.5 | 20.9 | 29.6 | 7.6 | 21.5 |
| Short acting method | Estimate (%) | 42.2 | 35.9 | 43.1 | 44.7 | 54.0 | 42.0 | 45.8 | 35.5 | 45.4 | 33.4 | 53.2 | 28.3 | 35.6 | 20.3 | 48.4 | 37.5 |
| | SE (%) | 3.8 | 5.9 | 5.8 | 5.4 | 3.8 | 5.5 | 11.9 | 9.1 | 2.6 | 4.0 | 2.7 | 2.1 | 3.3 | 1.9 | 2.9 | 2.5 |
| | 95% Lower | 34.8 | 25.3 | 32.1 | 34.4 | 46.5 | 31.6 | 24.8 | 20.1 | 40.4 | 26.1 | 47.9 | 24.3 | 29.4 | 16.9 | 42.7 | 32.8 |
| | CI Upper | 49.9 | 48.1 | 54.8 | 55.5 | 61.2 | 53.1 | 68.5 | 54.6 | 50.5 | 41.6 | 58.4 | 32.6 | 42.4 | 24.3 | 54.2 | 42.5 |
| Permanent method | Estimate (%) | 1.5 | 0.7 | 1.8 | 0.0 | 1.3 | 1.1 | 1.9 | 0.0 | 0.3 | 0.0 | 2.5 | 0.6 | 0.4 | 0.0 | 1.7 | 0.5 |
| | SE (%) | 1.5 | 0.7 | 1.3 | 0.0 | 0.8 | 0.8 | 1.2 | 0.0 | 0.3 | 0.0 | 0.7 | 0.3 | 0.4 | 0.0 | 0.5 | 0.2 |
| | 95% Lower | 0.2 | 0.1 | 0.4 | 0.0 | 0.4 | 0.2 | 0.5 | 0.0 | 0.0 | 0.0 | 1.4 | 0.2 | 0.1 | 0.0 | 1.0 | 0.2 |
| | CI Upper | 9.8 | 4.4 | 7.2 | 0.0 | 4.3 | 4.9 | 6.3 | 0.0 | 2.3 | 0.0 | 4.4 | 1.5 | 2.8 | 0.0 | 3.1 | 1.2 |
| Other method | Estimate (%) | 2.5 | 4.4 | 3.5 | 1.7 | 2.6 | 1.4 | 1.3 | 1.0 | 5.4 | 1.0 | 6.7 | 6.9 | 4.2 | 2.2 | 3.6 | 3.0 |
| | SE (%) | 1.2 | 2.2 | 3.1 | 1.2 | 1.5 | 1.0 | 1.3 | 1.0 | 1.6 | 0.7 | 1.3 | 1.1 | 1.2 | 0.8 | 1.0 | 0.6 |
| | 95% Lower | 1.0 | 1.6 | 0.6 | 0.4 | 0.8 | 0.3 | 0.2 | 0.1 | 2.9 | 0.2 | 4.6 | 5.0 | 2.3 | 1.1 | 2.0 | 2.0 |
| | CI Upper | 6.4 | 11.3 | 17.8 | 6.4 | 7.8 | 5.7 | 8.6 | 7.0 | 9.7 | 3.9 | 9.7 | 9.5 | 7.3 | 4.6 | 6.3 | 4.3 |
| Total | (%) | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 |

Percent distribution urban women by place of delivery of the most recent child born in the last five years and by region

| Place of delivery | Year | Region | | | | | | | | | | | | | | | |
|--------------------------|---------------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|-------------|------------|------------|------------|------------|------------|
| | | Tigray | | Amhara | | Oromia | | SNNPR | | Harari | | Addis Adaba | | Dire Dawa | | Total | |
| | | 2011 | 2016 | 2011 | 2016 | 2011 | 2016 | 2011 | 2016 | 2011 | 2016 | 2011 | 2016 | 2011 | 2016 | 2011 | 2016 |
| Own or other home | Estimate (%) | 44.0 | 7.4 | 55.4 | 20.0 | 51.3 | 6.4 | 46.0 | 33.1 | 19.2 | 8.1 | 15.2 | 3.7 | 14.6 | 10.5 | 44.2 | 13.6 |
| | SE (%) | 11.5 | 2.5 | 6.2 | 3.9 | 8.1 | 2.5 | 13.2 | 15.1 | 5.6 | 2.4 | 3.5 | 0.9 | 4.4 | 2.9 | 4.1 | 3.3 |
| | 95% Lower | 23.8 | 3.8 | 43.1 | 13.4 | 35.7 | 3.0 | 23.0 | 11.4 | 10.4 | 4.4 | 9.4 | 2.2 | 7.8 | 6.0 | 36.3 | 8.4 |
| | CI Upper | 66.5 | 14.1 | 67.1 | 28.8 | 66.7 | 13.4 | 70.8 | 65.5 | 32.7 | 14.4 | 23.5 | 6.0 | 25.7 | 17.6 | 52.4 | 21.5 |
| Government hospital | Estimate (%) | 39.2 | 40.1 | 21.4 | 28.8 | 13.3 | 43.6 | 20.7 | 23.8 | 63.5 | 63.7 | 30.1 | 34.3 | 53.0 | 35.0 | 22.5 | 34.3 |
| | SE (%) | 10.4 | 9.2 | 9.1 | 3.9 | 6.0 | 10.7 | 4.9 | 7.5 | 4.4 | 4.5 | 3.3 | 3.5 | 6.1 | 5.5 | 3.4 | 3.4 |
| | 95% Lower | 21.5 | 24.0 | 8.5 | 21.7 | 5.2 | 24.7 | 12.6 | 12.0 | 54.5 | 54.5 | 24.0 | 27.7 | 41.0 | 25.1 | 16.4 | 28.0 |
| | CI Upper | 60.4 | 58.8 | 44.2 | 37.1 | 30.2 | 64.6 | 32.1 | 41.5 | 71.7 | 72.0 | 36.9 | 41.6 | 64.7 | 46.5 | 30.0 | 41.2 |
| Government health center | Estimate (%) | 7.1 | 48.0 | 19.3 | 47.4 | 27.2 | 44.6 | 26.0 | 38.6 | 2.6 | 8.3 | 34.1 | 36.6 | 22.1 | 40.7 | 24.1 | 42.5 |
| | SE (%) | 1.9 | 7.9 | 9.7 | 4.2 | 5.9 | 9.9 | 8.2 | 8.9 | 1.3 | 2.4 | 2.1 | 3.0 | 5.2 | 5.4 | 3.9 | 3.2 |
| | 95% Lower | 4.1 | 33.0 | 6.5 | 39.3 | 17.2 | 26.7 | 13.1 | 23.1 | 1.0 | 4.6 | 30.0 | 30.9 | 13.6 | 30.6 | 17.3 | 36.4 |
| | CI Upper | 12.0 | 63.3 | 44.9 | 55.6 | 40.2 | 63.9 | 45.0 | 56.9 | 6.7 | 14.5 | 38.4 | 42.6 | 34.0 | 51.6 | 32.5 | 48.9 |
| Other public facility | Estimate (%) | 2.4 | 1.5 | 1.5 | 1.7 | 1.0 | 0.0 | 2.3 | 1.8 | 0.0 | 0.0 | 0.0 | 0.3 | 0.0 | 0.6 | 1.2 | 0.9 |
| | SE (%) | 1.4 | 1.0 | 1.5 | 1.7 | 1.0 | 0.0 | 2.3 | 1.9 | 0.0 | 0.0 | 0.0 | 0.3 | 0.0 | 0.6 | 0.6 | 0.5 |
| | 95% Lower | 0.8 | 0.4 | 0.2 | 0.2 | 0.1 | 0.0 | 0.3 | 0.2 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.1 | 0.5 | 0.3 |
| | CI Upper | 7.2 | 5.7 | 10.4 | 11.1 | 7.2 | 0.0 | 14.8 | 13.2 | 0.0 | 0.0 | 0.0 | 2.3 | 0.0 | 4.5 | 3.4 | 2.8 |
| Other place | Estimate (%) | 7.2 | 3.0 | 2.5 | 2.2 | 7.1 | 5.4 | 5.0 | 2.7 | 14.7 | 20.0 | 20.7 | 25.1 | 10.2 | 13.2 | 8.0 | 8.5 |
| | SE (%) | 4.5 | 1.2 | 2.7 | 1.7 | 3.0 | 3.1 | 5.2 | 2.8 | 3.2 | 4.8 | 2.9 | 2.9 | 3.0 | 2.8 | 1.7 | 1.3 |
| | 95% Lower | 2.0 | 1.3 | 0.3 | 0.4 | 3.1 | 1.7 | 0.6 | 0.3 | 9.3 | 12.1 | 15.5 | 19.8 | 5.6 | 8.6 | 5.2 | 6.3 |
| | CI Upper | 22.9 | 6.5 | 18.6 | 10.0 | 15.7 | 15.7 | 31.4 | 19.1 | 22.3 | 31.1 | 27.0 | 31.3 | 18.0 | 19.7 | 12.1 | 11.5 |
| Total | Estimate (%) | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 |

Percent distribution urban women who have given birth in the past five years by place of delivery of the second most recent child and by region

| Place of delivery | Year | Region | | | | | | | | | | | | | | | |
|--------------------------|---------------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|-------------|------------|------------|------------|------------|------------|
| | | Tigray | | Amhara | | Oromia | | SNNPR | | Harari | | Addis Adaba | | Dire Dawa | | Total | |
| | | 2011 | 2016 | 2011 | 2016 | 2011 | 2016 | 2011 | 2016 | 2011 | 2016 | 2011 | 2016 | 2011 | 2016 | 2011 | 2016 |
| Own or other home | Estimate (%) | 66.2 | 10.8 | 51.1 | 39.4 | 61.6 | 46.1 | 58.9 | 64.0 | 35.1 | 13.1 | 12.4 | 0.0 | 30.6 | 26.3 | 52.6 | 32.9 |
| | SE (%) | 11.3 | 7.0 | 13.1 | 11.3 | 14.9 | 28.5 | 10.8 | 18.2 | 9.6 | 6.9 | 5.2 | 0.0 | 7.5 | 7.3 | 7.0 | 9.4 |
| | 95% Lower | 41.8 | 2.8 | 27.0 | 20.3 | 31.5 | 8.2 | 37.2 | 27.1 | 19.0 | 4.3 | 5.2 | 0.0 | 18.0 | 14.5 | 39.0 | 17.5 |
| | CI Upper | 84.2 | 33.7 | 74.7 | 62.4 | 84.8 | 89.2 | 77.7 | 89.5 | 55.4 | 33.4 | 26.6 | 0.0 | 46.9 | 42.9 | 65.8 | 53.1 |
| Government hospital | Estimate (%) | 24.9 | 40.9 | 18.1 | 25.5 | 19.4 | 35.8 | 12.4 | 23.7 | 56.0 | 41.6 | 30.9 | 36.4 | 58.0 | 20.9 | 20.6 | 31.7 |
| | SE (%) | 9.2 | 13.2 | 8.9 | 12.4 | 9.6 | 19.6 | 9.8 | 17.3 | 8.9 | 9.8 | 6.7 | 7.9 | 8.3 | 7.6 | 4.7 | 7.0 |
| | 95% Lower | 11.1 | 19.0 | 6.4 | 8.6 | 6.7 | 9.3 | 2.3 | 4.5 | 38.4 | 24.3 | 19.4 | 22.6 | 41.3 | 9.7 | 12.8 | 19.7 |
| | CI Upper | 46.8 | 67.1 | 41.9 | 55.5 | 44.7 | 75.1 | 45.5 | 67.2 | 72.3 | 61.3 | 45.4 | 52.9 | 73.1 | 39.5 | 31.4 | 46.7 |
| Government health center | Estimate (%) | 8.9 | 44.8 | 23.5 | 35.0 | 13.8 | 14.4 | 20.5 | 12.3 | 0.0 | 13.9 | 35.5 | 34.0 | 3.6 | 33.5 | 19.2 | 26.8 |
| | SE (%) | 5.4 | 13.8 | 16.0 | 13.0 | 5.6 | 10.1 | 13.2 | 4.7 | 0.0 | 5.6 | 7.2 | 8.1 | 2.6 | 7.4 | 5.0 | 4.5 |
| | 95% Lower | 2.5 | 21.2 | 5.0 | 14.9 | 5.9 | 3.2 | 4.9 | 5.5 | 0.0 | 6.0 | 22.8 | 20.2 | 0.9 | 20.8 | 11.1 | 18.9 |
| | CI Upper | 26.8 | 71.0 | 64.1 | 62.4 | 29.0 | 46.0 | 56.0 | 25.1 | 0.0 | 29.0 | 50.7 | 51.3 | 14.2 | 49.1 | 31.0 | 36.6 |
| Other public facility | Estimate (%) | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 8.2 | 0.0 | 0.0 | 0.0 | 0.0 | 1.6 | 0.0 | 1.2 | 1.2 | 0.4 |
| | SE (%) | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 6.2 | 0.0 | 0.0 | 0.0 | 0.0 | 1.6 | 0.0 | 1.2 | 1.2 | 0.4 |
| | 95% Lower | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 1.7 | 0.0 | 0.0 | 0.0 | 0.0 | 0.2 | 0.0 | 0.2 | 0.2 | 0.1 |
| | CI Upper | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 31.3 | 0.0 | 0.0 | 0.0 | 0.0 | 10.8 | 0.0 | 8.2 | 7.8 | 2.5 |
| Other place | Estimate (%) | 0.0 | 3.6 | 7.3 | 0.0 | 5.2 | 3.7 | 0.0 | 0.0 | 8.9 | 31.4 | 21.2 | 28.0 | 7.7 | 18.2 | 6.5 | 8.2 |
| | SE (%) | 0.0 | 3.3 | 8.1 | 0.0 | 3.5 | 4.2 | 0.0 | 0.0 | 6.5 | 11.1 | 6.6 | 6.0 | 4.4 | 7.5 | 2.5 | 2.1 |
| | 95% Lower | 0.0 | 0.6 | 0.7 | 0.0 | 1.3 | 0.4 | 0.0 | 0.0 | 2.0 | 14.2 | 11.0 | 17.7 | 2.4 | 7.5 | 2.9 | 4.9 |
| | CI Upper | 0.0 | 19.6 | 45.3 | 0.0 | 18.1 | 28.1 | 0.0 | 0.0 | 32.0 | 55.9 | 36.9 | 41.3 | 22.3 | 37.6 | 13.7 | 13.5 |
| Total | Estimate (%) | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 |

Percent distribution of household water sources reported by urban women by region

| Water source | Region | | | | | | | | | | | | | | | | |
|------------------------------|--------------|--------|------|--------|------|--------|------|-------|------|--------|------|-------------|------|-----------|------|-------|------|
| | Year | Tigray | | Amhara | | Oromia | | SNNPR | | Harari | | Addis Adaba | | Dire Dawa | | Total | |
| | | 2011 | 2016 | 2011 | 2016 | 2011 | 2016 | 2011 | 2016 | 2011 | 2016 | 2011 | 2016 | 2011 | 2016 | 2011 | 2016 |
| Piped to dwelling | Estimate (%) | 6.3 | 4.8 | 8.1 | 0.5 | 4.1 | 4.3 | 8.5 | 0.3 | 0.3 | 7.2 | 3.9 | 8.4 | 4.7 | 6.2 | 6.0 | 4.2 |
| | SE (%) | 2.2 | 2.4 | 3.2 | 0.5 | 1.8 | 1.1 | 8.4 | 0.3 | 0.3 | 1.4 | 1.1 | 2.8 | 1.4 | 1.6 | 1.6 | 0.9 |
| | 95% Lower | 3.1 | 1.7 | 3.7 | 0.1 | 1.8 | 2.6 | 1.1 | 0.0 | 0.0 | 4.8 | 2.2 | 4.3 | 2.6 | 3.8 | 3.4 | 2.8 |
| | CI Upper | 12.4 | 12.6 | 17.0 | 3.7 | 9.4 | 7.0 | 43.9 | 2.6 | 2.4 | 10.6 | 6.8 | 15.7 | 8.3 | 10.1 | 10.1 | 6.3 |
| Piped to neighbor/public tap | Estimate (%) | 81.6 | 85.1 | 68.5 | 80.8 | 83.2 | 94.1 | 76.0 | 58.6 | 89.6 | 89.7 | 94.5 | 84.8 | 92.4 | 83.5 | 80.2 | 83.0 |
| | SE (%) | 4.4 | 5.2 | 9.5 | 8.3 | 4.6 | 1.4 | 7.2 | 18.5 | 4.0 | 1.8 | 1.2 | 3.0 | 1.9 | 1.9 | 3.4 | 3.2 |
| | 95% Lower | 71.4 | 71.7 | 47.7 | 59.4 | 72.1 | 90.5 | 59.3 | 23.9 | 78.8 | 85.6 | 91.6 | 77.8 | 87.7 | 79.5 | 72.6 | 75.9 |
| | CI Upper | 88.7 | 92.8 | 83.8 | 92.3 | 90.5 | 96.4 | 87.4 | 86.5 | 95%3 | 92.8 | 96.4 | 89.9 | 95%3 | 86.9 | 86.1 | 88.4 |
| Borehole | Estimate (%) | 0.0 | 1.1 | 4.1 | 8.6 | 0.0 | 0.0 | 1.2 | 5.0 | 0.4 | 0.0 | 0.0 | 0.1 | 0.0 | 1.1 | 1.4 | 2.6 |
| | SE (%) | 0.0 | 0.7 | 4.2 | 7.6 | 0.0 | 0.0 | 1.2 | 4.3 | 0.4 | 0.0 | 0.0 | 0.1 | 0.0 | 0.9 | 1.2 | 1.7 |
| | 95% Lower | 0.0 | 0.3 | 0.5 | 1.4 | 0.0 | 0.0 | 0.2 | 0.9 | 0.1 | 0.0 | 0.0 | 0.0 | 0.0 | 0.2 | 0.2 | 0.7 |
| | CI Upper | 0.0 | 3.6 | 25.9 | 39.0 | 0.0 | 0.0 | 8.2 | 24.0 | 2.9 | 0.0 | 0.0 | 0.4 | 0.0 | 5.2 | 7.6 | 9.4 |
| Protected well/spring | Estimate (%) | 3.2 | 2.7 | 9.4 | 2.8 | 1.7 | 0.0 | 11.2 | 30.8 | 1.1 | 0.0 | 0.0 | 0.3 | 0.5 | 0.0 | 5.0 | 4.9 |
| | SE (%) | 2.4 | 1.8 | 5.1 | 1.9 | 1.3 | 0.0 | 4.6 | 15.2 | 0.6 | 0.0 | 0.0 | 0.2 | 0.5 | 0.0 | 1.6 | 2.1 |
| | 95% Lower | 0.7 | 0.7 | 3.1 | 0.7 | 0.4 | 0.0 | 4.8 | 9.8 | 0.4 | 0.0 | 0.0 | 0.1 | 0.1 | 0.0 | 2.6 | 2.1 |
| | CI Upper | 13.1 | 9.5 | 25.2 | 10.5 | 7.2 | 0.0 | 23.8 | 64.6 | 3.3 | 0.0 | 0.0 | 1.4 | 3.5 | 0.0 | 9.4 | 11.0 |
| Unprotected well/spring | Estimate (%) | 1.8 | 1.2 | 4.6 | 4.1 | 9.3 | 0.0 | 3.1 | 4.3 | 0.0 | 0.0 | 0.0 | 0.3 | 0.5 | 0.0 | 4.6 | 1.6 |
| | SE (%) | 1.2 | 0.9 | 2.2 | 2.0 | 5.5 | 0.0 | 2.0 | 3.0 | 0.0 | 0.0 | 0.0 | 0.2 | 0.5 | 0.0 | 1.8 | 0.6 |
| | 95% Lower | 0.5 | 0.3 | 1.8 | 1.6 | 2.8 | 0.0 | 0.9 | 1.0 | 0.0 | 0.0 | 0.0 | 0.1 | 0.1 | 0.0 | 2.1 | 0.8 |
| | CI Upper | 6.8 | 5.2 | 11.7 | 10.3 | 27.0 | 0.0 | 10.6 | 16.2 | 0.0 | 0.0 | 0.0 | 1.4 | 3.5 | 0.0 | 9.6 | 3.4 |
| Other | Estimate (%) | 7.0 | 5.1 | 5.3 | 3.1 | 1.6 | 1.6 | 0.0 | 1.0 | 8.5 | 3.1 | 1.6 | 6.1 | 2.0 | 9.2 | 2.9 | 3.6 |
| | SE (%) | 2.2 | 1.6 | 1.4 | 1.3 | 0.9 | 1.1 | 0.0 | 0.9 | 3.7 | 0.8 | 0.5 | 0.8 | 0.9 | 1.5 | 0.6 | 0.5 |
| | 95% Lower | 3.7 | 2.7 | 3.1 | 1.4 | 0.5 | 0.4 | 0.0 | 0.2 | 3.5 | 1.8 | 0.9 | 4.8 | 0.8 | 6.7 | 2.0 | 2.8 |
| | CI Upper | 12.7 | 9.5 | 8.8 | 6.9 | 4.7 | 6.3 | 0.0 | 5.9 | 19.1 | 5.3 | 3.0 | 7.8 | 4.8 | 12.6 | 4.3 | 4.7 |
| Total | Estimate (%) | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 |

Percent distribution of toilet types used by households by region

| Toilet type | Region | | | | | | | | | | | | | | | | | |
|--------------------------|---------------------|-------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|-------------|------------|------------|------------|------------|------------|
| | | | Tigray | | Amhara | | Oromia | | SNNPR | | Harari | | Addis Adaba | | Dire Dawa | | Total | |
| | | | 2011 | 2016 | 2011 | 2016 | 2011 | 2016 | 2011 | 2016 | 2011 | 2016 | 2011 | 2016 | 2011 | 2016 | 2011 | 2016 |
| Flush toilet | Estimate (%) | | 35.2 | 33.5 | 4.5 | 3.6 | 0.7 | 3.4 | 13.2 | 2.6 | 4.9 | 10.7 | 10.2 | 31.1 | 11.3 | 8.4 | 7.9 | 13.8 |
| | SE (%) | | 11.4 | 5.4 | 2.9 | 1.7 | 0.7 | 1.7 | 13.0 | 1.8 | 1.3 | 3.6 | 1.8 | 3.4 | 2.9 | 1.8 | 2.3 | 1.5 |
| | 95% | Lower | 16.8 | 23.8 | 1.2 | 1.4 | 0.1 | 1.2 | 1.6 | 0.6 | 2.9 | 5.4 | 7.1 | 24.8 | 6.7 | 5.4 | 4.4 | 11.1 |
| | CI | Upper | 59.4 | 44.8 | 15.3 | 9.0 | 4.6 | 8.9 | 59.0 | 9.9 | 8.1 | 20.1 | 14.5 | 38.3 | 18.4 | 12.7 | 13.8 | 17.1 |
| VIP | Estimate (%) | | 1.6 | 0.6 | 2.9 | 0.5 | 0.9 | 1.8 | 1.2 | 0.0 | 4.6 | 3.2 | 2.9 | 3.2 | 6.5 | 1.4 | 2.1 | 1.6 |
| | SE (%) | | 1.2 | 0.4 | 1.9 | 0.4 | 0.7 | 1.1 | 1.2 | 0.0 | 1.8 | 1.2 | 0.9 | 0.8 | 1.8 | 0.6 | 0.6 | 0.4 |
| | 95% | Lower | 0.4 | 0.2 | 0.8 | 0.1 | 0.2 | 0.5 | 0.2 | 0.0 | 2.1 | 1.5 | 1.6 | 2.0 | 3.8 | 0.6 | 1.2 | 1.0 |
| | CI | Upper | 6.9 | 2.1 | 10.2 | 2.2 | 3.9 | 6.0 | 8.2 | 0.0 | 9.8 | 6.7 | 5.5 | 5.2 | 11.0 | 3.4 | 3.7 | 2.5 |
| Pit with or without slab | Estimate (%) | | 38.1 | 50.5 | 47.2 | 75.9 | 82.1 | 89.7 | 77.2 | 91.3 | 76.6 | 78.6 | 76.8 | 57.9 | 65.3 | 83.3 | 66.7 | 74.4 |
| | SE (%) | | 8.4 | 4.5 | 11.2 | 5.0 | 4.2 | 2.4 | 11.9 | 3.5 | 4.6 | 3.6 | 2.7 | 3.4 | 5.1 | 2.4 | 5.2 | 2.0 |
| | 95% | Lower | 23.4 | 41.7 | 26.8 | 64.8 | 72.1 | 83.9 | 47.0 | 81.6 | 66.5 | 70.6 | 71.1 | 51.1 | 54.7 | 78.0 | 55.9 | 70.3 |
| | CI | Upper | 55.4 | 59.2 | 68.6 | 84.3 | 89.0 | 93.6 | 92.8 | 96.1 | 84.4 | 84.9 | 81.6 | 64.4 | 74.6 | 87.6 | 76.1 | 78.2 |
| No facility | Estimate (%) | | 17.6 | 11.7 | 36.3 | 15.2 | 13.0 | 1.6 | 3.1 | 3.1 | 10.7 | 5.9 | 5.5 | 1.4 | 12.9 | 3.1 | 17.4 | 5.6 |
| | SE (%) | | 5.7 | 5.7 | 13.8 | 5.5 | 4.8 | 0.6 | 2.0 | 1.4 | 3.7 | 2.2 | 2.2 | 0.4 | 5.9 | 1.4 | 5.8 | 1.4 |
| | 95% | Lower | 9.0 | 4.3 | 14.9 | 7.2 | 6.1 | 0.8 | 0.9 | 1.2 | 5.2 | 2.7 | 2.4 | 0.8 | 4.9 | 1.3 | 8.7 | 3.4 |
| | CI | Upper | 31.7 | 28.1 | 65.0 | 29.5 | 25.6 | 3.5 | 10.6 | 7.4 | 20.5 | 12.2 | 11.8 | 2.6 | 29.6 | 7.2 | 31.8 | 9.1 |
| Other | Estimate (%) | | 7.4 | 3.8 | 9.1 | 4.8 | 3.3 | 3.5 | 5.3 | 3.1 | 3.2 | 1.6 | 4.7 | 6.3 | 4.0 | 3.7 | 5.8 | 4.5 |
| | SE (%) | | 3.1 | 1.0 | 2.4 | 1.7 | 1.1 | 1.2 | 3.5 | 1.4 | 0.9 | 0.7 | 0.9 | 1.3 | 1.1 | 0.8 | 0.9 | 0.7 |
| | 95% | Lower | 3.1 | 2.3 | 5.3 | 2.3 | 1.7 | 1.7 | 1.4 | 1.2 | 1.8 | 0.7 | 3.2 | 4.2 | 2.3 | 2.4 | 4.3 | 3.4 |
| | CI | Upper | 16.5 | 6.3 | 15.1 | 9.6 | 6.4 | 7.0 | 18.5 | 7.4 | 5.6 | 3.6 | 6.8 | 9.5 | 6.8 | 5.8 | 7.9 | 6.0 |
| Total | Estimate (%) | | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 |

Percent of urban women who have tested for HIV by region

| Ever been tested for HIV? | Year | Region | | | | | | | | | | | | | | | | |
|---------------------------|---------------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|------------|-------------|------------|------------|------------|------------|------------|------|
| | | Tigray | | Amhara | | Oromia | | SNNPR | | Harari | | Addis Adaba | | Dire Dawa | | Total | | |
| | | 2011 | 2016 | 2011 | 2016 | 2011 | 2016 | 2011 | 2016 | 2011 | 2016 | 2011 | 2016 | 2011 | 2016 | 2011 | 2016 | |
| No | Estimate (%) | 13.4 | 19.5 | 27.7 | 21.8 | 32.1 | 37.1 | 23.7 | 33.8 | 14.7 | 23.5 | 15.6 | 26.8 | 11.7 | 25.5 | 24.7 | 28.7 | |
| | SE (%) | 2.8 | 1.9 | 4.9 | 3.3 | 7.1 | 5 | 7.9 | 4.5 | 1.6 | 1.9 | 1.5 | 1.3 | 2.2 | 2.9 | 2.7 | 1.6 | |
| | 95% CI | Lower | 8.9 | 16.1 | 19.1 | 15.9 | 19.9 | 27.8 | 11.5 | 25.5 | 11.7 | 19.9 | 12.8 | 24.3 | 7.9 | 20.2 | 19.7 | 25.6 |
| | | Upper | 19.9 | 23.4 | 38.2 | 29.1 | 47.3 | 47.4 | 42.5 | 43.3 | 18.1 | 27.6 | 18.8 | 29.5 | 16.9 | 31.7 | 30.5 | 31.9 |
| Yes | Estimate (%) | 86.6 | 80.5 | 72.3 | 78.2 | 67.9 | 62.9 | 76.3 | 66.2 | 85.3 | 76.5 | 84.4 | 73.2 | 88.3 | 74.5 | 75.3 | 71.3 | |
| | SE (%) | 2.8 | 1.9 | 4.9 | 3.3 | 7.1 | 5 | 7.9 | 4.5 | 1.6 | 1.9 | 1.5 | 1.3 | 2.2 | 2.9 | 2.7 | 1.6 | |
| | 95% CI | Lower | 80.1 | 76.6 | 61.8 | 70.9 | 52.7 | 52.6 | 57.5 | 56.7 | 81.9 | 72.4 | 81.2 | 70.5 | 83.1 | 68.3 | 69.5 | 68.1 |
| | | Upper | 91.1 | 83.9 | 80.9 | 84.1 | 80.1 | 72.2 | 88.5 | 74.5 | 88.3 | 80.1 | 87.2 | 75.7 | 92.1 | 79.8 | 80.3 | 74.4 |
| Total | Estimate (%) | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 | |

ANNEX VI: POST-EVALUATION ACTION PLAN

This Post-evaluation Action Plan is developed to create an opportunity to openly discuss evaluation findings, conclusions, and recommendations within the Mission, in collaboration with MEL technical working group and Evaluation Contractor, and plan for use/ adoption of findings.

The below two tables are adapted from the USAID Post-Evaluation Plan templates for this exercise, and the following are the principles (The P6) the Mission needs to follow to execute the Post-evaluation Action Plan.

PRINCIPLE ONE: After an evaluation is completed, the COR or the Program Office at large and the Evaluation Contractor (as appropriate) shall seek the overall impression of the relevant Office/s within the Mission about the quality of the evaluation.

PRINCIPLE TWO: After the evaluation report is approved, the evaluation COR or the Program Office at large and the Evaluation Contractor (as appropriate) shall sit together with the relevant office/s within the Mission to identify relevant/doable and non-doable recommendations (*this is a completion to Table 1.*)

PRINCIPLE THREE: The evaluation COR or the Program Office at large and the Evaluation Contractor (as appropriate) shall discuss with the relevant Office/s within the Mission to plan how evaluation findings/recommendations shall be used, the responsible person to follow-up on that and also the timeline for adoption (*this is a partial completion to Table 2.*)

PRINCIPLE FOUR: Actions completed under PRINCIPLES ONE, TWO and THREE shall be part of the Annexes of the Final Evaluation Report by the Evaluation Contractor.

PRINCIPLE FIVE: Tables 1 and 2 shall be shared, for instances as google sheet, with the wider Mission community to promote transparency and learning.

PRINCIPLE SIX: The evaluation COR or the Program Office at large and the Evaluation Contractor (as appropriate) shall keep track of the plan and update the status on a quarterly basis by following up on the actions with the technical team (*this is a completion to Table 2.*)

| Evaluation Recommendation | USAID Response : <i>Accepted/Partially Accepted/Rejected</i> | If not accepted or partially accepted, provide more information why it was not ACCEPTED or PARTIALLY ACCEPTED? |
|--|---|--|
| Recommendations on relevance and practicality of the design and implementation approaches | | |
| 1. | SEUH is the only implementer supporting UHEP. Considering the plurality and diversity of health needs of urban poor populations and the large number of urban poor inhabitants, more stakeholders should be recruited by the GoE to support UHEP. The needs around NCDs and WASH are particularly inadequately addressed and call for significant government and donor support. FMOH considers interventions against NCDs a priority; accordingly, USAID's limited focus on NCDs should be revisited. An activity such as the SEUH should also be designed to allow space for balancing between emerging government needs and activity priorities. | |
| 2. | The large population of homeless urban poor presents substantial health care needs that have been exacerbated by the political instability that Ethiopia experienced during SEUH implementation. The designs of future initiatives for urban health should include strategies for improving access to health care by the urban homeless poor. Future urban health activities should also support the government with developing a policy that defines the roles of line ministries in WASH implementation, including requirements for allocating resources for WASH activities and logistics. Apart from FMOH, support for WASH sectoral convergence among line ministries is weak due to the lack of supporting government policy. Also, given the resource limitations in the Activity-supported areas, more attention (including resource allocation) should be directed at material support (such as the construction of WASH facilities). This can be achieved by increasing the engagement and contribution of line ministries and expanding the sources of donor support for WASH | |
| Recommendations on Activity's implementation processes and strategies efficiency | | |
| 3. | SEUH results demonstrate the viability of activities that work to build the leadership capacity of the government offices. By supporting system strengthening and government priorities and letting the government take the lead role, SEUH gained a strong relationship with FMO and the RHBs, C/THOs, and health centers. Future activities should continue to strengthen the capacity of government offices to lead UHEP implementation. Also, evaluation findings show that alignment of implementation priorities and strategies with GoE and using participatory implementation approaches, which engage all stakeholders in the planning and execution of activities, increases the efficiency of implementation. For example, working within the GoE UHEP strategy motivated FMOH and RHB participation, and bolstering their capacity to lead the implementation of their own strategy fostered sustainability through the commitment of FMOH and RHB resources. Furthermore, by co-locating SEUH staff within the RHBs, their engagement with the regional staff on local planning and implementation was influenced. Future activities should therefore, as much as possible, ensure design and implementation alignment with GoE strategies and priorities to promote government ownership and to increase prospects for sustainability of development initiatives and results. | |
| 4. | The lack of a guiding policy for intersectoral work is a significant threat to success. For activities such as WASH, a government-level strategy or policy directive could lay the foundation for better participation in WASH activities. | |
| Recommendations on Activity's contribution to the strengthening of the GoE's UHEP | | |
| 5. | SEUH helped to create reliable systems for data collection, reporting, and use, which have taken effect in UHEP. SEUH played the lead role in analyzing and facilitating discussions on the UHEP monitoring data. Future activities should strengthen the capacity of specific government offices at the RHB and C/THO to analyze, convene and lead the dissemination and data utilization efforts. Intersectoral convergence is a challenging task that requires higher-level government involvement | |
| 6. | While the SEUH could undertake advocacy efforts, the GoE should develop formal guidelines for intersectoral engagement in urban WASH initiatives. Related to PPP, the model applied by SEUH with media entities was a success. Future activities should map UHEP priorities against the private sector companies in the implementation locations and identify possible non-cash contributions of such companies to UHEP results. | |
| Recommendations on Sustainability | | |

| Evaluation Recommendation | USAID Response : <i>Accepted/Partially Accepted/Rejected</i> | If not accepted or partially accepted, provide more information why it was not ACCEPTED or PARTIALLY ACCEPTED? |
|--------------------------------|--|--|
| 7. | The evaluation team recommends that future initiative should continue to support timely and efficient supply distribution of commodities to work toward sustainability of SEUH results. Donor support is essential to the continued viability of UHEP initiatives; otherwise, UHEP will not be able to match the growing demand for urban health services | |
| 8. | A future activity should support the government with increasing the understanding of the roles of different sectors in urban WASH initiatives and establishing policy guidelines and resource commitments to support urban WASH priorities in support of intersectoral coordination. Furthermore, because the support for system-level improvements appears promising—given evidenced government ownership of initiatives such as IRT—future initiatives should continue supporting system improvements. | |
| Overall recommendations | | |
| 9. | USAID is the only donor that has supported the GoE UHEP. The multiple and diverse needs of urban poor populations require a greater engagement of other donors. Although the USAID assistance through SEUH has significantly responded to UHEP priorities around CDs, future programs, projects, and activities should also include resources for addressing the rising rates of NCDs among the urban poor. | |
| 10 | UHEP and SEUH have effectively reached the urban poor living in home settings but have not put in place a systematic approach for reaching the homeless poor. The government should spearhead consultations with regional actors, donors, and IPs to devise strategies for reaching the urban homeless poor. The mobile nature of these populations and their greater exposure to health risks, however, make them a difficult group to target. | |
| 11 | UHEP and SEUH have effectively reached the urban poor living in home settings but have not put in place a systematic approach for reaching the homeless poor. The government should spearhead consultations with regional actors, donors, and IPs to devise strategies for reaching the urban homeless poor. The mobile nature of these populations and their greater exposure to health risks, however, make them a difficult group to target. | |
| 12 | SEUH and UHEP created a system for targeting poor households in urban areas, but the lifestyles of the better-off urban populations have implications for the health of the urban poor. Inclusive approaches based on well-defined root cause analyses are needed to comprehensively address the health needs of urban populations. | |
| 13 | The government strategy to establish industrial parks in the regions will continue to attract the rural poor searching for employment both within the parks and also as domestic workers. This trend will continue to increase. Deliberate interventions in UHEP should target the low-salaried workers from within the parks through PPP, with the companies running the parks | |
| 14 | The SEUH results cast a big shadow on the viability of intersectoral convergence initiatives. Unless the government issues clear formal guidelines to line ministries to support FMoH with the implementation of UHEP initiatives, mobilization of intersectoral support will not succeed. The evaluation team recommends that future activities offer targeted support to FMoH to work with the other ministries to craft policy guidance defining material and technical support contributions of the line ministries to UHEP. | |
| 15 | The urban WASH initiatives are in very high demand among the urban poor, but SEUH's capacity to meet those needs is limited. Future donor funding should either establish a separate procurement for urban WASH or ensure that UHEP support establishes formal coordination links with existing WASH initiatives. A successful example observed by the evaluation team exists in Harar city administration, where the town obtained support from the World Bank to produce solid waste bins using the design that was developed by SEUH. These bins were installed in several locations in the city. | |
| 16 | The SEUH evaluation results have demonstrated that working within the government's priorities and strengthening the leadership capacity of government officials increase the chances of success in activities that target public health systems to deliver development initiatives. Supporting system strengthening and direct government priorities and letting the government take the lead role is a pathway to sustainability, particularly when the government starts to invest their own resources. | |

| | | |
|----------------------------------|--|---|
| Evaluation Recommendation | USAID Response : <i>Accepted/Partially Accepted/Rejected</i> | If not accepted or partially accepted, provide more information why it was not ACCEPTED or PARTIALLY ACCEPTED? |
| 17 | SEUH helped to create reliable systems for data collection, reporting, and use, which have taken effect in UHEP, but this system needs to be reviewed and linked with the HMIS so that it will benefit from government HMIS funding. | |

Evaluation Title: Strengthening Ethiopia's Urban Health Activity

Evaluation Completion Date:


| Recommendations fully or partially accepted | Adoption plan | | | | Follow-up | |
|---|--------------------|------------------------------|---|---|--------------------------------|-------------|
| | USAID Focal Office | USAID Focal Person and Title | How will the Office use/adopt the recommendation? | When is the expected time for use/adoption? | Status of Actions (as of date) | Any remarks |
| 1. | | | | | | |
| 2. | | | | | | |
| 3. | | | | | | |
| 4. | | | | | | |
| 5. | | | | | | |
| 6. | | | | | | |
| 7. | | | | | | |
| 8. | | | | | | |

ANNEX VII: DISCLOSURES OF CONFLICT OF INTEREST

Disclosure of Conflict of Interest for USAID Evaluation Team Members

| | |
|--|--|
| Name | Francis Ogojo Okelo |
| Title | |
| Organization | |
| Evaluation Position? | <input checked="" type="checkbox"/> Team Leader <input type="checkbox"/> Team member |
| Evaluation Award Number (contract or other instrument) | AID-663-C-16-00010 |
| USAID Project(s) Evaluated (Include project name(s), implementer name(s) and award number(s), if applicable) | Strengthening Ethiopia's Urban Health Extension Activity. Implemented by John Snow International, Inc. (JSI) with partners: Addis Ababa University (AAU), and Emmanuel Development Association (EDA) |
| I have real or potential conflicts of interest to disclose. | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| If yes answered above, I disclose the following facts: <i>Real or potential conflicts of interest may include, but are not limited to:</i> <ol style="list-style-type: none"> 1. Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated. 2. Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation. 3. Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project. 4. Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated. 5. Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated. 6. Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation. | |

I certify (1) that I have completed this disclosure form fully and to the best of my ability and (2) that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.

| | |
|------------------|---|
| Signature |  |
| Date | 08/07/2018 |

Disclosure of Conflict of Interest for USAID Evaluation Team Members

| | |
|--|--|
| Name | ADDENET HAILE |
| Title | LOCAL CONSULTANT |
| Organization | |
| Evaluation Position | <input type="checkbox"/> Team Leader <input checked="" type="checkbox"/> Team member |
| Evaluation Award Number (contract or other instrument) | |
| USAID Project(s) Evaluated (Include project name(s), implementer name(s) and award number(s), if applicable) | |
| I have real or potential conflicts of interest to disclose. | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| <p>If yes answered above, I disclose the following facts: <i>Real or potential conflicts of interest may include, but are not limited to:</i></p> <ol style="list-style-type: none"> 1. Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated. 2. Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation. 3. Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project. 4. Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated. 5. Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated. 6. Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation. | |

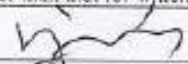
I certify (1) that I have completed this disclosure form fully and to the best of my ability and (2) that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.

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| Signature | AKS |
| Date | July 17/2018 |

Disclosure of Conflict of Interest for USAID Evaluation Team Members

| | |
|--|--|
| Name | Fiseha Tereze |
| Title | Local Consultant |
| Organization | SI |
| Evaluation Position | <input type="checkbox"/> Team Leader <input checked="" type="checkbox"/> Team member |
| Evaluation Award Number (contract or other instrument) | |
| USAID Project(s) Evaluated (include project name(s), implementer name(s) and award number(s), if applicable) | |
| I have real or potential conflicts of interest to disclose. | <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| <p>If yes answered above, I disclose the following facts: <i>Real or potential conflicts of interest may include, but are not limited to:</i></p> <ol style="list-style-type: none"> 1. Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated. 2. Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation. 3. Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project. 4. Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated. 5. Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated. 6. Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation. | |

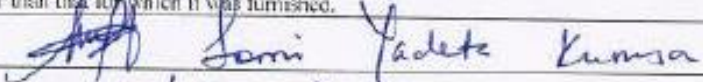
I certify (1) that I have completed this disclosure form fully and to the best of my ability and (2) that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.

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|-----------|---|
| Signature |  |
| Date | July 17, 2018 |

Disclosure of Conflict of Interest for USAID Evaluation Team Members

| | |
|---|---|
| Name | Sami Yadeza Kumsa |
| Title | Local Consultant/ Technical Specialist |
| Organization | |
| Evaluation Position | <input type="checkbox"/> Team Leader <input type="checkbox"/> Team member |
| Evaluation Award Number (contract or other instrument) | |
| USAID Project(s) Evaluated (include project name(s), implementer name(s) and award number(s), if applicable) | |
| I have real or potential conflicts of interest to disclose. | <input type="checkbox"/> Yes No <input checked="" type="checkbox"/> |
| <p>If yes answered above, I disclose the following facts:</p> <p>Real or potential conflicts of interest may include, but are not limited to:</p> <ol style="list-style-type: none"> 1. Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated. 2. Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation. 3. Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project. 4. Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated. 5. Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated. 6. Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation. | |

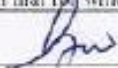
I certify (1) that I have completed this disclosure form fully and to the best of my ability and (2) that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.

| | |
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| Signature |  |
| Date | July 17 th , 2018 |

Disclosure of Conflict of Interest for USAID Evaluation Team Members

| | |
|---|--|
| Name | Yehualamech Tadesse |
| Title | Dr. |
| Organization | Social Impact |
| Evaluation Position | <input type="checkbox"/> Team Leader <input checked="" type="checkbox"/> Team member |
| Evaluation Award Number (contract or other instrument) | |
| USAID Project(s) Evaluated (include project name(s), implementer name(s) and award number(s), if applicable) | |
| I have real or potential conflicts of interest to disclose. | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| <p>If yes answered above, I disclose the following facts:</p> <p>Real or potential conflicts of interest may include, but are not limited to:</p> <ol style="list-style-type: none"> 1. Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated. 2. Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation. 3. Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project. 4. Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated. 5. Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated. 6. Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation. | |

I certify (1) that I have completed this disclosure form fully and to the best of my ability and (2) that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.

| | |
|-----------|---|
| Signature |  |
| Date | 17 - Jun - 2018 |

ANNEX VIII: EVALUATION TEAM MEMBER PROFILES

Francis Ogojo Okello, Team Leader, has 20 years' experience in research, monitoring and evaluation (RM&E), and management of health projects in family planning, HIV, malaria, health financing and hypertension. Before serving as EPMES Chief of Party, Mr. Okello served as the Deputy Research Director, SHOPS project at Abt Associates. He previously worked for FHI 360-Ethiopia as Chief of Party for the PROGRESS project, Deputy Country Director/COP PROGRESS Project, and Country Director/COP PROGRESS project. He has also previously worked in RM&E and management for various companies and organizations in his past career. The PROGRESS project/Ethiopia provided technical assistance to Ethiopia's Federal Ministry of Health (FMoH) to build capacity for research and M&E of family planning interventions. Mr. Okello assisted the FMoH to strengthen M&E systems at the national, regional, district and facility levels and conducted critical research on family planning initiatives. He participated in the national Family Planning and the prevention of mother-to-child (PMTCT) transmission of HIV working groups and contributed to the development of national guidelines on these two areas. As Deputy Country Director and later Country Director for FHI 360/Ethiopia, Mr. Okello also provided leadership to the Highly Vulnerable Children (HVC) project, an HIV prevention workplace program, and conducted an impact evaluation of the home and community-based HIV program. Mr. Okello's past career also includes work for Chemonics International (USA) as Director for Project Planning and Monitoring, Populations Services International (Uganda) as the country Research Manager and Research International East Africa Limited as the Country Manager for the Uganda office. He has extensive technical and managerial experience in RM&E, program implementation and management, capacity building in RM&E at the national and community levels and technical assistance related to RM&E. He has excellent relationship building skills at local and international levels and is experienced in new business development. His country experience spans sub-Saharan Africa and Asia countries.

Andenet Haile Godana, Team Member, has more than 15 years of proven knowledge, skill and experience in coordinating and managing Sexual Reproductive Health, Family Planning, Maternal, Newborn and Child Health(MNCH) and Nutrition projects and programs implemented by International NGOs and funded by USAID, Department for International Development (DFID), Bill AND Melinda gates Foundation and the Ethiopian Government. Over the years Andenet has led, coordinated, managed and conducted several consultancy services for various international organizations as well as bilateral and multilateral donor organizations in Ethiopia. For the last 10 years, Andenet has worked as a team leader, lead consultant co-investigator in several baseline surveys, midterm evaluations, end term/terminal evaluations as well as training and other capacity building on health, nutrition and child protection issues.

Academically, Andenet holds M Phil degree in Psychology and behavioral development from the University of Oslo, Norway and is currently a final year PhD candidate at the Department of Psychology, University of South Africa (UNISA), Ethiopia Center. Andenet is the founder and managing director of Deep Dive Research and Consulting PLC, which is currently a fast growing and dependable consulting firm in Ethiopia.

Fiseha Terefe Yinesu, Team Member, holds a postgraduate degree in Public Health. Fiseha has over ten years of experience in research, clinical trial and program management, monitoring and

evaluation in the area of communicable & non-communicable diseases in general, Sexual and Reproductive Health, Family Planning, HIV/AIDS, Maternal, Newborn and Child Health, nutrition and other development issues in Ethiopia. For the last seven years Fiseha has been actively engaged in providing technical assistance and consultancy services for various local and international organizations especially in conducting regional and national surveys including clinical trial, baseline assessments, midterm and end term evaluations of both longitudinal and cross-sectional study designs employing qualitative and quantitative approach. Additionally, Fiseha have hands on Experience in monitoring project and preparing organizational strategic plan and framework. He has knowledge on Ethiopian health care system, policy, strategies and public health priorities of the country including the National Nutrition Program II, Urban Safety net program/policies and other new initiatives that are currently undertaking in the Country.

Lomi Yadeta Kumsa, Team Member, is an evaluation specialist with more than 15 years of rich experience conducting evaluations, developing project monitoring systems, performance monitoring frameworks and research in Ethiopia. She furthermore has substantial experience in local capacity building, primarily through her time spent conducted trainings on qualitative evaluation methods. Mrs. Lomi served as the technical lead for monitoring and evaluation of CDC Ethiopia programs for four years, assuming different positions progressively. There she led the outcome evaluation of Modeling and Reinforcement to Combat HIV/AIDS Project (MARCH). Mrs. Lomi also served as Strategic Information Liaison for US government (USG) funding for HIV program in Ethiopia. She successfully coordinated Strategic Information Partners including local and international Universities along FMOH, and the UN family. She served in the National Advisory Committee (NAC) representing USG Monitoring and Evaluation Technical Working Group.

Ms. Lomi for five consecutive years served as Evaluation and Special Studies Department Head for Tulane University's technical assistance program in Ethiopia. There she was responsible for program monitoring and evaluation, including survey design, data management and evaluations, as well as providing technical leadership for evaluation teams. Currently, she is the technical consultant for the Impact Evaluation of the CRADLE 3 (Community Blood Pressure Measurement in Rural Africa and Asia: the detection of Underlying Pre-eclampsia and Shock) in Ethiopia. She is proficient using different statistical packages (SPSS, STATA) and GIS software packages, and holds a masters in Regional and Local Development Studies from Addis Ababa University. She has also attended international evaluation certification program with The Evaluators Institutes at George Washington University and certified in project management.

Yehualashet Tadesse Wondimu, Team Member, holds an MD from Jimma University and a Master's in Public Health with a specialty in epidemiology from the International School of Global Health and Epidemiology at Umeå University in Sweden. Dr. Yehualashet has significant experience as a Research Consultant, an Impact Evaluation Team Leader, and as a Monitoring & Evaluation Advisor, with regional expertise throughout Ethiopia. Dr. Yehualashet's experience also includes development project evaluation design, specifically with regard to public health projects based in Ethiopia. Dr. Yehualashet speaks, reads, and writes fluently in both Amharic and English.

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