



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

## FINAL PERFORMANCE EVALUATION OF TRANSFORM HEALTH IN DEVELOPING REGIONS (HDR) ACTIVITY

Submission Date: August 19, 2022  
Revised Version: September 22, 2022  
Final Version: November 1, 2022

Submitted to:  
USAID/Ethiopia  
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Contract Number: OAA-I-15-00028 Task Order No.: AID-663-TO-17-00001  
Transform: MELA Activity, Addis Ababa, Ethiopia

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

ACTIVITY INFORMATION

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

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## ACRONYMS AND ABBREVIATIONS

ANC	Antenatal Care
BEmONC	Basic Emergency Obstetric and Neonatal Care
CBHI	Community-based Health Insurance
COR	Contracting Officer’s Representatives
DID	Difference in Differences
DRS	Developing the Regional States
EQs	Evaluation Questions
ESOG	Ethiopian Society of Obstetricians and Gynecologists
GOE	Government of Ethiopia
Gott	Amharic: Neighborhood
HC	Health Center
HDR	Health in Developing Regions
HF	Health Facility
HH	Household
HLM	High Level Monitoring
HMIS	Health Management Information System
HP	Health Post
HSTP	Health Sector Transformation Plan
KPIs	Key Performance Indicators
IFA	Iron and Folic Acid
IP	Implementing Partner
ISS	Integrated Supportive Supervision
Kebele	Amharic: Ward
KI	Key Informant
KII	Key Informant Interview
LAFP	Long-Acting Family Planning
LMG	Leadership, Management, and Governance
LOA	Life of Activity
MCPR	Modern Contraceptive Prevalence Rate
MCVI	Measles Containing Vaccine First Dose

MELA	Monitoring, Evaluation, Learning, and Adapting
M&E	Monitoring and Evaluation
MNCH/FP	Maternal, Newborn, Child Health and Family Planning
MOH	Federal Ministry of Health
PCMD	Preventing Child and Maternal Deaths
PHCU	Primary Health Care Unit
RH	Reproductive Health
RHB	Regional Health Bureau
RMNCH	Reproductive, Maternal, Newborn, and Child Health
SBCC	Social and Behavior Change Communication
SNNP	Southern Nations, Nationalities, and People
TMG	The Mitchell Group, Inc.
USAID	United States Agency for International Development
USG	United States Government
WHO	World Health Organization
Woreda	Amharic: District
WorHO	Woreda Health Office
ZHD	Zonal Health Department

## **ABSTRACT**

This final performance evaluation of USAID/Ethiopia's Health in Developing Regions (HDR) Activity was conducted by The Mitchell Group, Inc. as part of USAID/Ethiopia's Transform Monitoring, Evaluation, Learning, and Adapting (Transform: MELA) Activity. Transform: MELA conducted this final performance evaluation to measure the progress made towards achievements of results by the activity towards improving maternal, newborn, child health, and family planning (MNCH/FP). Results are presented in terms of effectiveness in improving MNCH/FP outcomes; contributions to local ownership and sustainability and coherence with the existing health system; gender dynamics in design and implementation; and learning and use of evidence. Compared to the baseline, the evaluation confirmed that Transform HDR contributed to improvement in essential newborn care and early initiation of breastfeeding, measles coverage, Vitamin A supplementation and ARI and diarrhea treatment. However, performance on most MNCH/FP key performance indicators (KPI) declined by the endline, despite progress at the midterm. For almost three quarters of the KPIs, at endline performance in Transform HDR intervention areas descended below the respective baseline values. Despite these obstacles, Transform HDR intervention areas had better performance at endline compared to the non-Transform intervention areas.

The evaluation also reviews the ways in which Transform HDR facilitated local ownership and sustainability, adopted a gender focus; and was coherent with Ministry of Health objectives. Findings were that Transform HDR: 1) adopted participatory approaches and worked in alignment with the existing health system to ensure ownership; 2) considered gender in most of its activities including supporting traditional women-only community structures; 3) was flexible and adaptive in addressing the changing needs of the health system and dynamic contexts. The report ends with recommendations for future programming in developing regions with specific recommendations for the Ministry of Health and USAID/Ethiopia.

## **1) EXECUTIVE SUMMARY**

### **Background**

In 2017, USAID/Ethiopia launched the Transform Program, a five-year integrated reproductive, maternal, newborn, and child health (RMNCH) program to reduce preventable maternal and child morbidity and mortality in Ethiopia. The Transform health in developing regions (HDR) is one of the three Activities implemented under the umbrella of the Transform program. Transform HDR targeted sixty woredas (districts) in four regions – Afar, Benishangul-Gumuz, Gambella, and Somali – that have had historically poorly performing health systems and high maternal, perinatal, and child mortality relative to other regions. USAID/Ethiopia awarded a contract to The Mitchell Group, Inc. to implement the Transform: MELA Activity, which was tasked to provide high quality monitoring and evaluation (M&E) information that guided programmatic decision making by USAID/Ethiopia, implementing partners, (IPs) and Ministry of Health (MOH) of Ethiopia. Transform: MELA conducted this final performance evaluation to measure the progress made by the Transform HDR towards improving MNCH/FP outcomes. This report, therefore, details the

evaluation questions, methods used, findings, conclusions, and recommendations for improving future MNCH/FP programming in Ethiopia.

### Evaluation objectives

The final performance evaluation was intended to measure the effectiveness of Transform HDR interventions in contributing to improving MNCH/FP outcomes, in facilitating local ownership, sustainability and coherence, in considering gender dynamics in its design and implementation, and in adapting interventions based on learning and available evidence.

### Methodology

The evaluation used a mixed methods pre-post cross-sectional design using quantitative and qualitative data from primary and secondary sources. The evaluation collected data in fifty-two woredas, from 3,210 households and 158 health facilities in both Transform HDR and non-Transform intervention areas. Qualitative data were also obtained from twenty-two in-depth key informant interviews (KIIs) with USAID/Ethiopia staff, Transform implementing partners, and individuals at different levels of the health system. The evaluation also included a review of Transform HDR's progress reports, annual work plans, MEL plans, assessments conducted by the IP, and other secondary documents.

The evaluation used a three staged cluster sampling to select households from woredas in Transform HDR and non-Transform HDR intervention areas that met predefined inclusion and exclusion criteria. Health posts that were found within the selected kebeles and health centers and primary hospitals that had a reporting relationship respectively were considered for the health facility survey. The evaluation used Transform HDR's results framework and associated key indicators to measure Activity performance. Analysis of quantitative data involved computation of values of the select set of key performance indicators, comparing values between/across periods, woreda categories (Transform HDR and non-Transform intervention), and regions. Thematic analysis was used to summarize and present the qualitative data.

### FINDINGS

Results are summarized below based on the following evaluation questions:

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

### MNCH/FP Outcomes

This section first provides a summary of MNCH/FP outcomes in the following thematic areas: family planning, maternal health, newborn health, and child health. Effectiveness of the approaches, as measured by triangulating quantitative and qualitative data, are briefly summarized below and describe in greater detail in the body of this report.

### Family Planning

- Performance for all family planning KPIs had positive progress at the midpoint of Activity implementation but dropped at the endline. Midterm performance exceeded the target set for 2020, but at the endline the Activity achieved only 37% of the life of activity (LOA) target.
- In Transform intervention areas, modern contraceptive prevalence rate (MCPR), and postpartum family planning (PPFP) counseling and use declined significantly ( $P < 0.001$ ). However long-acting family planning (LAFP) uptake remained the same.
- Performance for family planning KPIs declined in both Transform HDR and non-Transform intervention areas, except LAFP use in Transform HDR intervention areas. However, performance in Transform HDR areas was found to be higher in all cases.
- At the endline, MCPR and LAFP use between Transform HDR, and non-Transform intervention areas were statistically different ( $p < 0.05$ ).

### Maternal Health

- Maternal health outcomes declined in both Transform HDR and non-Transform intervention areas. At the baseline, non-Transform intervention areas had better performance on maternal health indicators. However, at the endline, the performance for all maternal health KPIs was better in Transform HDR intervention areas than in non-Transform HDR areas.
- Although a steep decline was observed on performance of all the KPIs at endline, the performance trend for all maternal health KPIs was positive at midterm, apart from IFA which showed a steady decline over both periods.
- In Transform HDR intervention areas, maternal health indicators declined; these declines were statistically significant ( $p < 0.001$ ) except for early ANC and PNC. Iron and folic acid (IFA) supplementation and essential ANC coverages were the KPIs that underwent major declines.
- At the endline, LOA targets set for ANC4+ and SBA were not achieved.

### Newborn Health

- Essential newborn care showed a sharp increase from its midterm status. However, performance for early PNC and early initiation of breastfeeding dropped despite the progress made at midterm.
- In Transform HDR intervention areas, essential newborn care and early initiation of breastfeeding significantly improved ( $p < 0.001$ ) when compared to baseline status.
- At the endline, early PNC coverage showed a non-significant drop below its baseline. However, Transform achieved only 45% of its LOA target.

- Essential newborn care and early initiation of breastfeeding improved in both Transform HDR and non-Transform intervention areas, whereas early PNC declined in both. At the endline, Transform HDR intervention areas performed better than non-Transform HDR intervention areas.

#### Preventive Child Health Service Components

- Performance trends for all preventive child health KPIs showed a decline despite gains at midterm. However, Transform HDR campaigns played a role in improvements in preventative child health. Measles coverage refers to MCV1 which is mainly provided as part of routine immunization service although some measles vaccine received through campaigns are also included. Vitamin A supplementation can be linked to services provided through campaigns as well as through routine modalities. In Transform HDR intervention areas, measles coverage among children who received the vaccine any time before the survey and vitamin A supplementation improved significantly ( $p < 0.05$ ).
- Penta 3 and full immunization coverages declined significantly ( $p < 0.001$ ).
- Transform HDR supported areas were only able to attain less than 30% of the LOA targets set for Penta 3 and full immunization. Conversely, the LOA target for Vitamin A supplementation was overachieved.
- Penta 3 and full immunization coverage and exclusive breastfeeding practices dropped in both Transform HDR and non-Transform intervention areas. At the endline, Transform HDR areas had higher performance for all KPIs than the non-Transform intervention areas.

#### Curative Child Health Service Components

- Transform HDR areas outperformed non-Transform intervention areas for all key performance indicators (KPI) except deworming. At endline, diarrhea treatment showed an increase from its lowest point at midterm. ARI treatment and deworming declined sharply from their respective highest points at midterm.
- Treatment of acute respiratory infection (ARI) and diarrhea increased from the baseline, although the difference is statistically significant only for ARI treatment ( $p = 0.001$ ). However, deworming and the practice of seeking treatment for children within 24 hours of onset of fever declined significantly ( $p < 0.001$ ).
- LOA targets for ARI, diarrhea and fever treatments were not met.

#### Effectiveness in Increasing the Demand for High-Impact MNCH/FP Services

- Women who heard/saw specific messages on reproductive health and family planning declined from baseline in both Transform HDR and non-Transform intervention areas, whereas the proportion of women who were exposed to maternal, neonatal, and child health (MNCH) specific messages increased from baseline.
- Overall, women's participation in health care decision making and men accompanying their spouses during antenatal care (ANC) and delivery declined significantly ( $p < 0.001$ ).

#### More Effective and Less Effective Approaches

Key informants (KI) were asked to describe what they considered to be the most effective approaches that should be sustained or scaled up. The approaches most often cited as effective included: provision of the mobile ultrasound devices, and capacity building including training, clinical mentoring, coaching and post training follow-ups. In terms of less effective approaches, some KIs identified provision of youth friendly services, community level intervention, male engagement in family planning, and woreda transformation as interventions that were not adequately implemented. As an example, although the Activity provided training to health education workers and associated structures in the community, there was a lack of follow-up. KIs also mentioned the mismatch between the scope of Transform HDR and the resources available to implement the associated activities as a limiting factor. KIs also provided input on the Activity's work to promote local ownership and sustainability, its coherence with the health system, gender dynamics in design and implementation, and learning and the use of evidence. These are detailed below.

#### Local Ownership, Sustainability, and Coherence

This section applies to approaches that were introduced by Transform HDR and those that were government-driven and strengthened because of support from Transform HDR. It therefore describes the strategies that were implemented by THDR to ensure institutionalization of interventions introduced by the Activity and to strengthen the existing health system interventions.

- A majority of KIs indicated that the approach of Transform HDR was highly participatory, and the activity worked in full alignment with the existing health system ensuring ownership at all levels. As an example, the activity participated in review meetings with health officials and other development actors to foster partnership and harmonize activities. The Activity worked jointly with decentralized MOH agencies, through joint planning, alignment, performance review exercises, integrated supportive supervision (ISS), post-training follow up, clinical mentoring, and coaching.
- KIs acknowledged Transform HDR's effort in creating a pool of certified master trainers at regional level. They viewed this as a valuable contribution in ensuring continuity of capacity building activities for sustainability.
- Transform HDR supported community engagement initiatives implemented by the government to improve health seeking behavior and ensure social accountability. These included supported a government-driven community score card initiative including capacity building for client councils and community awareness raising; support for traditional community structures to improve health seeking behavior (create demand) and ensure social accountability; training for women's development groups, social mobilization committee, clan, and religious leaders to increase demand; and support for pregnant mothers' conferences, forums where pregnant women gather regularly to discuss health and health related issues during pregnancy.

- According to some KIs, factors such as conflict, staff turnover, a lack of commitment at some local levels, and the need for more financial resources for some of the interventions may limit sustainability of interventions supported by Transform HDR.

#### Gender Dynamics in Activity Design and Implementation

- Transform HDR considered gender in most of its activities, such as health worker training, social and behavior change communication (SBCC), leadership training, and school programs.
- The Activity supported traditional women-only community structures in the Somali region called *Umulgargar*, whose work was complemented by *Abugargar* groups for men. These were identified as potential models for scale-up for addressing gender issues in pastoralist communities with distinct traditions and cultures.
- The one-stop GBV service center established in the Afar Region was successful in pulling together different resources in the community to support GBV survivors.

#### Adaptation of Transform HDR interventions based on Learning and Generated Evidence

- Transform HDR was flexible and adaptive to address the changing needs in the health system and dynamic contexts. **As one example, based on evidence generated by the activity, it supported the establishment of one-stop center for GBV survivors.**
- In response to gaps identified in Transform: MELA's midterm evaluation and high-level monitoring (HLM), Transform HDR focused more of its development interventions in twenty "learning woredas." Based on findings from these reports, the Activity also revitalized relevant interventions in antenatal care, strengthening of woreda coordination mechanisms, and improvement of data quality and information use practices in these twenty woredas. Moreover, the decision to use traditional birth attendants to strengthen different community health components such as disease surveillance and linkage to health facilities was stirred by findings from operational research conducted by Transform HDR and the HLM.

#### CONCLUSIONS

- Performance on most MNCH/FP KPIs in Transform HDR intervention areas declined by the endline, despite progress at the midterm. For almost three quarters of the KPIs, performance at endline descended below the respective baseline values.
- The performance declines are likely attributable to the recurrent security problems, protracted drought, flooding, and the massive internal displacement that followed these shocks which affected the demand for or access to healthcare. In addition, disease outbreaks (the COVID-19 pandemic, measles, cholera) affected the supply and demand side of the health service.
- Despite these obstacles, at endline, Transform HDR intervention areas had better performance in terms of exhibiting lesser declines compared to the non-Transform intervention areas, clearly showing the contributions of Transform HDR Activity in preventing deterioration in most of the MNCH/FP outcome measures.

- Transform HDR capacity building interventions, integration to the health system, and efforts made to engage regional, zonal and woreda level experts to share experiences in health system planning, capacity building, and monitoring activities is believed to enable sustainability of MNCH/FP services and results achieved.
- Transform HDR integrated gender in the design and implementation of most of its interventions. It also enabled accessibility of post-GBV services in many health facilities.
- There were good practices in the use of evidence generated from Transform HDR-led studies/assessments and those that were conducted by Transform MELA, to inform activity planning, the design of new initiatives and implementation.

## RECOMMENDATIONS

The report includes recommendations for the Ministry of Health and for USAID/Ethiopia for future interventions in developing regions. These are briefly summarized below.

### Recommendations to the Ministry of Health

- Develop and implement context specific MNCH/FP intervention strategies for each of the developing regions.
- Develop and implement innovative, tailored and context appropriate facility and community based SBCC approaches for sustained behavioral change in MNCH/FP practices.
- Strengthen male engagement in adolescent and youth services and in family planning.
- Reinforce coordination of development partners to effectively implement HSTP II.
- Commit earmarked resources in the future as part of co-design exercise with USAID investments to ensure sustainability of promising interventions.
- Develop and implement health performance-based standards and budgeting for woredas.
- Continue the support of quality improvement initiatives.
- Improve use of monitoring data for decision making at health facilities.
- Strengthen and standardize mobile health service delivery to expand access to MNCH/FP services for pastoralist communities.
- Institute mobile services policy and guidelines for developing regions.
- Implement innovative health approaches when designing programs to pastoralist communities.
- Assign more female providers, especially for childbirth services.
- Integrate FP counseling across all contacts in the continuum of care.
- Ensure availability of family planning services at health posts.
- Develop a national HR database to track participation in continuous education programs funded by donors, and support context specific MNCH/FP health workforce and leadership development and retention strategies.

## Recommendations to USAID

- The design of future activities should be performance-based and include a revised target setting and monitoring methodology and assumptions.
- The design of future activities should also have a plan to mitigate potential crisis/shocks in the developing regions.
- The design of future activities should consider selection of intervention sites that have a mix of performance levels – high, moderate, and low.
- The design of future activities should employ performance-based support that can also be complemented with allocation of a matching fund from government.
- Develop and implement context specific MNCH/FP intervention strategies for each of the developing regions.
- Develop and implement innovative, tailored and context appropriate facility and community based SBCC approaches for sustained behavioral change in MNCH/FP practices.
- Strengthen male engagement in adolescent and youth services and in family planning.
- Support operational research agendas that identify causes of service bottlenecks and explore the underlying factors contributing to the decline in performance of selected KPIs.
- Support ethnographic and health studies on pastoralist lifestyles for activity planning.
- Investment in developing regions should focus on anchoring capacity-building and SBCC to primary health care institutions.
- Investment in developing regions should integrate essential health systems strengthening (HSS) interventions.

## 2) BACKGROUND AND CONTEXT

### Background to the Evaluation

In 2017, USAID/Ethiopia launched the Transform Program, a five-year (2017–2021) integrated reproductive, maternal, newborn, and child health (RMNCH) and water, sanitation, and hygiene (WASH) program to reduce preventable maternal and child morbidity and mortality in Ethiopia. The Transform Program operates across ten<sup>1</sup> regions in Ethiopia and comprises three Activities: primary health care (PHC), health in developing regions (HDR), and water, sanitation, and hygiene (WASH).

USAID/Ethiopia awarded a contract to The Mitchell Group, Inc. (TMG) to implement the Transform: MELA Activity. Overall, Transform: MELA provides and synthesizes high-quality M&E data for USAID/Ethiopia and guides the United States Government (USG) and the Government of Ethiopia (GOE)/ Ministry of Health (MOH) in learning and adaptive health system management. As part of its contract, USAID/Ethiopia and the MOH have commissioned Transform: MELA to conduct the final performance evaluation of the Transform: PHC and Transform HDR Activities,

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

the Transform Program Impact Evaluation in 2022. The performance reports also include short vignettes of selected case studies to document important lessons learned that highlight the contribution of the Transform program. The WASH activity was not included in these evaluations.

This final performance evaluation of the Transform HDR Activity presents a brief background and details the evaluation objectives, methodology, findings, conclusions, and recommendations.

### Activity Background

Transform Health in Developing Regions (Transform HDR) is one of USAID’s flagship investments. The activity was implemented by Amref Health Africa with consortium partners Project Hope, IntraHealth, and General Electric. Transform HDR aimed to contribute to preventing child and maternal deaths (PCMD) through supporting the implementation of the GOE’s Health Sector Transformation Plan (HSTP) at different levels of the health system in Ethiopia’s developing regions. Through supporting the GOE’s strategic initiatives, Transform HDR aimed to achieve four high-level intermediate results (IR):

- IR1: Increased access to integrated, quality high-impact maternal, neo-natal, and child health/family planning (MNCH/FP) services at health facility and community levels
- IR2: Strengthened health systems to provide quality MNCH/FP services
- IR3: Increased demand for high-impact MNCH/FP services
- IR4: Improved strategic information for evidence-based decision making and program learning

Transform HDR targeted four developing regions – Afar, Benishangul-Gumuz, Gambella, and Somali – that have had historically poorly performing health systems and health outcomes such as high maternal, perinatal and child mortality, relative to other regions. Some of these regions, such as Somali, contain large pastoralist communities that are scattered over a large landmass. People living in developing regions are faced with underdeveloped infrastructure, recurrent manmade and natural disasters, and weak health systems. In focusing on these pastoralist regions and hard-to-reach communities, the Activity aimed to address geographic inequity observed in maternal and child health outcomes in the country. Over a five-year Activity lifespan, Transform HDR supported a total of 60 woredas<sup>2</sup> which functioned at lower performance levels compared to the other woredas in each of the targeted regions. Table 1 presents the coverage of the Activity in each of the targeted regions.

**Table 1.** Coverage of Transform HDR Activity by Region

Regions	Intervention Woredas	Total Woredas in Region	Percent covered by Transform HDR
Afar	17	39	44%

<sup>2</sup> Districts, or woreda (Amharic: ወረዳ), are the third-level administrative divisions of Ethiopia. Districts are further subdivided into wards (kebele), or neighborhood associations, which are the smallest unit of local government in Ethiopia. As a result of Transform: MELA findings and recommendations at mid-term, the Activity placed a stronger focus of 20 of these 60 woredas, which were termed “learning woredas.”

Regions	Intervention Woredas	Total Woredas in Region	Percent covered by Transform HDR
Benishangul-Gumuz	10	23	43%
Gambella	6	12	50%
Somali	27	99	27%
Total	60	173	35%

Transform: HDR implements interventions through strategic approaches which include the provision of medical equipment, building capacities of the health workforce, supporting woreda health offices (WorHO) with the organization of comprehensive mobile outreach services, strengthening the provision of one-stop service to victims of gender-based violence (GBV), use of performance improvement interventions, and strengthening implementation of health management information systems (HMIS).

### 3) EVALUATION PURPOSE AND EVALUATION QUESTIONS

#### EVALUATION PURPOSE

The final performance evaluation of the Transform HDR Activity was to assess performance of Transform HDR with the intention of informing USAID/Ethiopia’s decisions related to future investment in supporting MNCH/FP interventions in developing regions. The purpose of the evaluation was to measure achievements of Transform HDR in terms its Activity-level results framework (see Results Framework in Annex 2), and to explore associated underlying reasons for achievement and/or non-achievement of anticipated results as well as reviewing intervention approaches used by the implementing partner (IP). The evaluation also assessed the degree to which the IP proactively adapted to contextual changes during the intervention period. In addition, the evaluation documents lessons learned and best practices—incorporating illustrative vignettes on selected case studies based on field visits—to inform the future programming of similar program activities by USAID/Ethiopia.

This final performance evaluation assessed factors that contributed to the observed results and those which may have inhibited achievement. To do so, it examined the following key areas:

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

## EVALUATION QUESTIONS

The performance evaluation answered the following evaluation questions (EQs) related to Activity performance:

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

Sub-questions were identified under each key evaluation question (EQ) as presented in Annex I.

## AUDIENCE AND INTENDED USES

The audiences of the final evaluation report are USAID/Ethiopia, specifically its Health Office; MOH authorities and its regional health bureaus (RHB); public healthcare providers at the regional, zonal, and woreda levels; and other country-level IPs. In this report, the evaluators also documented evidence of the lessons learned and best practices that can inform new policies and MNCH/FP programs.

## **4) EVALUATION METHODS, ETHICAL CONSIDERATIONS AND LIMITATIONS**

The final performance evaluation covers all regions where the Transform HDR Activity operates. Site visits and/or face-to-face interviews were not conducted in conflict-affected areas or areas with active conflict. The performance evaluation of Transform HDR employed a cross-sectional evaluation design in the intervention areas to measure effective achievement of HDR IRs in comparison to baseline and midline achievements, and life of project targets. Data from non-intervention areas were collected and analyzed separately as part of the Transform Program Impact Evaluation. A mixed-methods approach, with both quantitative and qualitative methods, was used to gather and analyze data to answer the performance EQs.

#### 4.1. Sampling of Woredas

Simple random sampling was used to select woredas in the Transform HDR targeted regions with five or fewer interventions by other development partners. Woredas with security problems and no development partner information were excluded. A total of 36 and 16 woredas were selected for the performance evaluation from Transform HDR and non-Transform intervention areas respectively. Regional distribution of woredas sampled from Transform HDR intervention areas are shown in Table 2.

**Table 2. Distribution of Transform HDR sampled woredas**

Region	Eligible Woredas	Sampled Woredas
Afar	12	9
Benishangul-Gumuz	2	2
Gambella	6	4
Somali	25	21
Total	45	36

#### 4.2. Sampling of Households

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

The third stage of the sampling was a selection of HHs from the randomly selected Gotts. A list of households from each selected Gott served as a frame from which to select 30 HHs per kebele. The key eligibility criterion for selecting the HHs was the availability of a woman aged 15-49 in the HH, regardless of marital status, who had residential status there for at least 6 months prior to the data collection. When more than one such eligible respondent was found in a selected household, the enumerator randomly selected one respondent from among the eligible women. A total of 2,548 and 662 households were selected from Transform HDR and non-Transform intervention woredas, respectively (Table 3).

**Table 3. Distribution of households surveyed in Transform HDR and non-Transform intervention woredas**

Woreda Category	Number of woredas surveyed	Total HHs surveyed
Transform HDR intervention	36	2548
Non-Transform intervention	16	662

### 4.3. Sampling for Health Facility Survey

All the primary health care facilities designated to serve the population of the sampled kebeles - health posts (HPs), health centers (HCs), and primary hospitals - were identified and included in the final performance evaluations. That is, the health post serving the population in the sampled kebele was automatically included in the study, and the catchment HC to which the selected health post was linked was also included. Similarly, if a primary hospital was attached to the selected HC, it too was included. Health posts were part of the health facility (HF) survey in sampled kebeles if they did not exist or were not functional.

As a result, 52 HCs and 65 HPs from Transform intervention woredas were selected. The impact evaluation also included 17 HC and 19 HPs from non-Transform intervention woredas. Moreover, primary hospitals were included whenever such facilities existed in the selected woredas (Table 4).

**Table 4: Table 4. Distribution of health facilities surveyed in Transform HDR and non-Transform intervention woredas**

Woreda Category	Health posts	Health centers	Primary Hospitals
Transform HDR intervention	65	52	5
Non-Transform intervention	19	17	0

### 4.4. Selection of Key Informants

Interviewees for key informant interviews (KIIs) were selected using purposive sampling. Gender balance was considered in the selection process, as was representation of various stakeholder groups: USAID, central and regional IPs, relevant directorates at MOH, Regional Health Bureaus (RHBs), and selected WorHOs. A total of 22 KIIs were conducted as part of the performance evaluation (Table 5).

**Table 5. Distribution of KIIs**

Stakeholders	
USAID/Ethiopia	Interview with USAID AOR
Ministry of Health	Interview with MOH Directorates Health System Special Support Health Extension Program and Primary Health Care Policy, Planning, Monitoring and Evaluation
IPs central office	KIs Transform HDR management and technical team (2)
IP's regional offices	Interview with Transform HDR four regional project coordination team
Regional Health Bureaus – MCH unit	KIIs (1 KII per region) MNCH Department
Woreda health offices	Transform Intervention woredas (4): 7 KIs – Heads of Woreda Health Offices and/or MNCH officers

Stakeholders	
	Non-Transform Intervention woredas (2): 2 KIs – Heads of Woreda Health Offices or MNCH officers
Total	22 KIIs

## 4.5. Data Collection Methods

### 4.5.1. Data Sources

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

### 4.5.2. Data Collection Tools

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

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

Household and HF surveys were conducted using pre-tested structured questionnaires that were uploaded to smartphones, generating electronically collected HH and HF data. Moreover, some open-ended questions were used to collect relevant data from KIs at health facilities. In addition, Gott listing, HH listing,<sup>3</sup> enumerator assignment and follow-up tools were used to guide the sampling and the data collection process.

The household survey tool included sections on:

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

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<sup>3</sup> Lists were prepared by using already available HH records at a health post or kebele, which were validated and updated with information sought from kebele guides. In some instances, when enumerators could not locate available records, HH lists were prepared afresh with the help of kebele guides.

The health facility survey tool enabled collection of data on:

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

#### *4.5.3. Data Collectors' Training and Quality Assurance*

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

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

Before traveling to each of the selected woreda, supervisors and coordinators communicated with regional and local leaders about the evaluation. To ensure the quality of collected data, supervisors conducted spot-checks and reinterviewing, especially at the beginning (the first 3 days) of data collection. Moreover, supervisors reviewed a sampling of completed questionnaires daily before uploading them to the server. All KIIs were audio-recorded and transcribed and translated into English. Five percent of the transcriptions were checked against the audio file for accuracy. In addition to the KIIs, Transform: MELA conducted limited interviews for nested case study vignettes on topics relevant to program goals of reducing preventable maternal and child morbidity and mortality.

#### **4.6. Data Analysis**

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

#### 4.6.1. Quantitative Data Analysis:

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

#### 4.6.2. Outcome Measures

The evaluation used the results framework of Transform HDR and its KPIs to measure performance. A result-indicator matrix (Annex 2) linked the KPIs to measures for the IRs identified in the results frameworks of Transform HDR. Some of the KPIs considered in this analysis were: family planning indicators (modern contraceptive prevalence rate (MCPR), long-acting family planning (LAFP) use, postpartum family planning (PPFP) counseling and use), maternal health indicators (antenatal care (ANC), skilled birth attendance (SBA), early postnatal care (PNC), iron-folic acid (IFA) supplementation, neonatal health indicators (early PNC, essential newborn care and early initiation of breastfeeding), child health indicators (Penta3 coverage, measles coverage (MCV1), exclusive breastfeeding, vitamin A supplementation, deworming, ARI treatment with antibiotics, diarrhea treatment with ORS and Zinc, and fever treatment within 24 hours of onset) and cross cutting indicators (access to basic sanitation, spouse accompany to ANC, spouse accompany to delivery, and women participation in decisions regarding their health). These KPIs were used in the measurement of achievement of intermediate results of the Transform HDR Activity.

#### 4.6.3. Qualitative Data Analysis

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

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

### 4.7 Ethical Considerations

The evaluation received institutional review board (IRB) approval from the Ethiopian Public Health Institute (EPHI) at the outset of research, and all data collectors and supervisors were trained in research ethics. Key informants (KIs) were asked for their consent to be interviewed and for the interview to be recorded, and interview notes and recordings were coded to protect respondent confidentiality. Survey respondents were also asked for their informed consent; during that

process, they were informed about choices regarding participation, responding or not to specific questions, and their right to request termination of the survey at any time. Informed consent also covered the privacy and confidentiality of participants—respondent names were not captured; instead, coding was used to conceal their identity. All interviews were conducted privately, ensuring that information collected remained confidential. For women under the age of 18, additional parental permission and participant assent was obtained before data collection.

#### 4.8 Limitations

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

Resource availability was an important factor that was considered when determining sample size and the decision to use a ratio of 4:1 households for THDR intervention areas and non-Transform intervention areas respectively. This ratio provides adequate statistical power at the Transform program level but is not adequate for determining statistical significance for regional level comparisons. The design also allows for approximation of the effects of other MNCH/FP-focused development partners intervening in the non-intervention areas. However, there are limited data available on the level of financial investments that these other development partners made in both Transform-intervention woredas and non-Transform intervention woredas. Thus, measuring the actual effects of other partner investments remains a challenge.

In terms of triangulation with other data sources such as IP monitoring data, the evaluation recognizes that there can be methodological difference with these sources. For this reason, comparisons of these data sources with the Transform evaluation data, particularly with the quantitative data obtained through household and facility surveys, may demonstrate divergent results. Furthermore, because the qualitative data depends on the views and comments of those persons that made themselves available to be interviewed, selection and desirability bias can result. However, the careful selection and training of highly qualified qualitative data collectors and analysts helped to mitigate data quality bias to a large extent. Data from various sources were carefully triangulated to confirm the evidence and to mitigate recall bias as well as potential social desirability bias, whereby respondents give favorable or positive answers to please the interviewer.

**Security and logistics.** Security issues in Benishangul-Gumuz and Gambella limited access to many woredas. For this reason, results from these regions should be interpreted with caution as they may over- or under-estimate the outcome of interest in the entirety of those regions. Moreover, survey data collection took longer than initially anticipated because of security and logistical issues, which required adjustments to the survey and interview schedules in all regions.

In addition to impacting schedules, this also had important cost implications in regions such as Somali, due to the need for changed itineraries and the unavailability of gasoline at fixed market prices. Despite these challenges, security and logistical issues were mitigated; evaluators were able to interview selected informants, visit facilities, and collect sampled data.

## 5) FINDINGS

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

### 5.1 HOW EFFECTIVE WERE THE TRANSFORM HDR ACTIVITY APPROACHES IN CONTRIBUTING TO IMPROVING MNCH/FP OUTCOMES?

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

Transform HDR was implemented with the objectives of increasing the number of healthy mothers with successful birth outcomes, expanding access and uptake of family planning, increasing numbers of healthy newborns, and sustaining gains in preventing child and maternal deaths. According to key informants, most Activity implementation in targeted regions went as planned, with some exceptions in areas where implementation was interrupted or ceased because of security problems.

Conflict interrupted Transform HDR activities in some regions such as Benishangul-Gumuz. Respondents there reported that although the program had been implemented as planned for the first three years, interventions were largely interrupted over the last two years due to the security problem in the area. When explaining how security problems affected the program activities, a Transform regional manager in Benishangul region described the challenges:

*"Transform HDR was able to implement its activities in ten targeted woredas only during the first two and a half years. Later, due to the local security problem, the project couldn't continue to operate in eight woredas and was obliged to withdraw its support totally. It has therefore restricted itself to supporting only the remaining two woredas over the last two years."*

In addition, key informants (KIs) described several challenges in implementing the T-HDR program. Developing regions have fragile health systems, where the number of trained and capable health professionals are limited. In addition to that, the turnover of trained individuals during the intervention period was common. As one example, a scarcity of midwives in the Gambella region was a challenge in promoting maternal health service. In addition, there was high turnover and gaps in levels of commitment of regional and woreda health sector leaders and local government. In sum, the activity met targets set for more than half of the key performance indicators. However, it did not meet 16 of the 34 performance indicators in the MEL plan in the Activity 2021 Annual Report.<sup>4</sup>

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<sup>4</sup> USAID Transform Health in Developing Regions, FY 2021 Annual Progress Report.

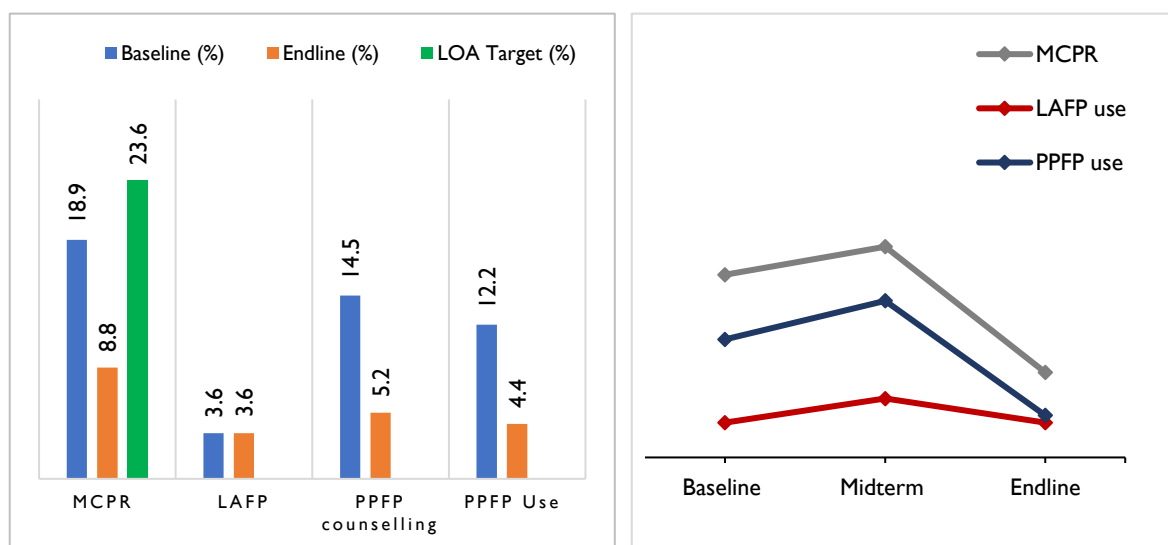
To what extent did the activity improve MNCH/FP outcomes and reduce inequities in different groups and intervention areas?

### Family planning outcomes

As shown in Figure 1, in Transform HDR intervention areas, MCPR among currently married women, PFP counseling and PFP use declined significantly ( $p < 0.001$ ) compared to their baseline values, except for LAFP, which remained the same. Although at midterm the Activity was close to meeting targets for MPCR, the Activity achieved only 37% of the LOA target at the endline. Performance for all family planning KPIs had positive progress at the midpoint of Activity implementation, although dropped at endline (Figure 1). Frequently mentioned reasons by the surveyed women for not ever or not currently using family planning methods included in rank order: religious restrictions, the need for children, having no partner, partner/spouse refusal, and fear of side effects or infertility.

Performance for all family planning KPIs had positive progress at the midpoint of Activity implementation but dropped at the endline. At midterm, the Activity close to meeting targets for MPCR but at the endline, the Activity achieved only 37% of the LOA target.

Figure 1. Performance for family planning KPIs at baseline, endline and against LOA target (left) and Performance trend (right) in Transform HDR intervention areas



Most family planning KPIs declined in all regions except LAFP use in Afar, Benishangul-Gumuz and Gambella, and PFP use in Benishangul-Gumuz. Somali region had the lowest performance for all family planning indicators (Table 6). Family planning commodity stockout was a problem in 60% of the surveyed facilities, where at least one type of FP commodity was reported as being out of stock in the last three months. Family planning commodities that were out of stock in one out of five of the facilities included: combined oral contraceptives, condoms, progesterone-only injectables (Depo-Provera), and Jadelle. Moreover, findings of the health facility survey showed that nearly half of the health posts (50.8%) in Transform HDR intervention areas were not providing modern family planning methods, which is higher than non-Transform intervention areas (42.1%).

**Table 6. Performance for family planning KPIs at baseline and endline in Transform HDR intervention areas by region**

Indicator	Period	Afar	B/Gumuz	Gambella	Somali
MCPR	Baseline	5.1	41.7	21.6	6.2
	Endline	4.2	41.9	14.0	1.5
LAFP	Baseline	0.2	12.2	0.8	0.9
	Endline	0.9	20.2	2.3	0.6
PPFP counselling	Baseline	11.8	25.8	11.7	8.4
	Endline	6.9	22.9	8.7	0.5
PPFP Use	Baseline	6.4	30.5	9.6	3.1
	Endline	1.5	35.7	2.2	0.3

Performance for all family planning KPIs declined in both Transform HDR and non-Transform intervention areas, apart from LAFP use which remained the same in Transform HDR intervention areas (Figure 2). Although both areas have shown declines in performance for all the indicators at the endline, performance in Transform HDR areas was higher than non-Transform areas. However, statistically significant differences were detected on performance between Transform HDR and non-Transform intervention areas only for MCPR and LAFP use ( $p < 0.05$ ).

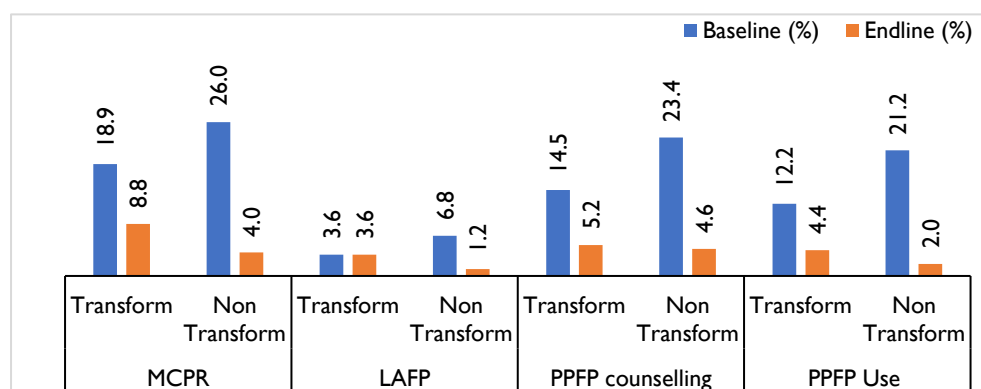


Figure 2. Performance for family planning KPIs at baseline and endline by Transform and non-Transform intervention areas

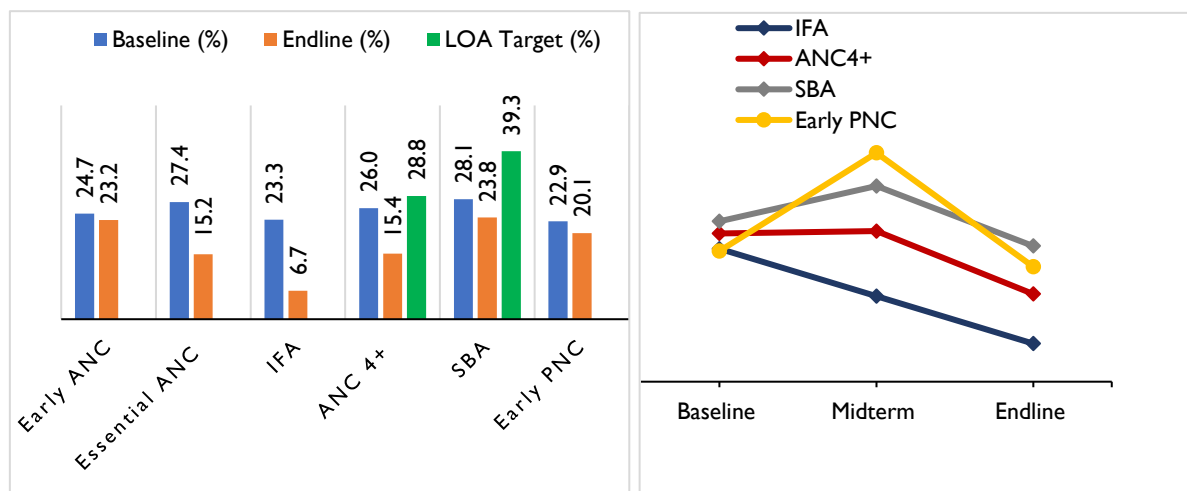
### Maternal Health Outcomes

As shown in Figure 3, Maternal health outcomes declined in both Transform HDR and non-Transform intervention areas. At the baseline, non-Transform intervention areas had better performance on maternal

Maternal health outcomes declined in both Transform HDR and non-Transform intervention areas. At the baseline, non-Transform intervention areas had better performance on maternal health indicators. However, at the endline, the performance for all maternal health KPIs was better in Transform HDR intervention areas than in non-Transform HDR areas. Although a steep decline was observed on performance of all the KPIs at endline, the performance trend for all maternal health KPIs was positive at midterm, apart from IFA which showed a steady decline over both periods.

health indicators. However, at the endline, the performance for all maternal health KPIs was better in Transform HDR intervention areas than in non-Transform HDR areas. For Transform HDR areas, these declines were statistically significant ( $p < 0.001$ ) except for early ANC and PNC. The most affected outcomes are IFA supplementation and essential ANC components which declined by 71.2% and 44.5%, respectively. At the endline, the Activity has achieved 53.4% and 60.6% of the LOA targets set for ANC4+ and SBA, respectively.

Figure 3. Performance for maternal health KPIs at baseline, endline and against LOA target (left) and Performance trend (right) in Transform HDR intervention areas



Although a steep decline was observed on performance of all the KPIs at endline, the performance trend for all maternal health KPIs was positive at midterm, apart from IFA which showed a steady decline over these periods. Despite significant declines in the reported essential components of ANC and IFA use, more than 84% of the surveyed facilities in Transform HDR intervention areas provided essential components of ANC and all provided IFA supplementation.<sup>5</sup> Conversely, essential components of ANC were available in fewer facilities in non-Transform intervention areas. For example, syphilis testing was available in 47% of the surveyed facilities.

The most frequently mentioned reasons for not having any ANC contact (in rank order) include long distance to a facility, no observed problems during pregnancy, the unavailability of transportation, perceived poor service quality, not knowing where to get the service, absence of female service providers, and partner refusal. The Activity implemented targeted SBCC interventions using existing community structures. Supporting the organization of pregnant women conferences and use of mothers group that facilitated education and referral of women for ANC, delivery, and other maternal and child health services, were identified as mechanisms used address the knowledge and attitudinal issues. Similarly, the quality improvement interventions at facilities were used to address service delivery gaps.

Similarly, long distance to a facility, not thinking it as necessary, the service being not customary in the community, lack of transportation, perceived poor service quality, facility closure at the time and absence of female service provider at the facility were the most frequently mentioned reasons for not having the last birth at a health facility. Generally, geographic, behavioral, and

<sup>5</sup> The evaluation did not assess reasons for the declines in utilization of the specific services despite the observed availability in the surveyed facilities. This is noted as an area for future research in the recommendations.

organizational (health facility) factors played a substantial role in limiting the access of women to ANC and SBA services. Despite the intervention, this problem continues to persist.

As shown in Table 7, performance for maternal health KPIs varied by region. Between baseline and endline, all regions had improved performance for early ANC and PNC, except Somali, exacerbating inequalities in that region compared with other THDR regions. All maternal health KPIs improved in B/Gumuz, except IFA intake. IFA intake for at least 90 days declined in all regions. In Gambella, there was an increase in ANC4+ uptake despite a slight decrease in SBA. In contrast, in Afar, SBA service uptake improved by close to 50% from baseline value, unlike ANC4+ uptake, which dropped by more than a quarter.

**Table 7. Performance for maternal health KPIs at baseline and endline in Transform HDR intervention areas by region**

Indicator	Period	Afar	B/Gumuz	Gambella	Somali
Early ANC	Baseline	15.8	30.2	34.5	24.6
	Endline	21.6	71.4	54.4	11.1
Essential components of ANC	Baseline	40.7	22.7	21.7	16.9
	Endline	15.7	55.7	15.2	7.3
IFA supplement for at least 90 days	Baseline	17.7	36.5	11.8	5.9
	Endline	7.4	30.0	10.9	1.4
ANC 4+	Baseline	16.5	49.7	23.7	16.9
	Endline	11.8	78.6	26.1	4.1
SBA	Baseline	17.7	31.8	50.9	21.4
	Endline	26.0	81.4	47.8	8.7
Early PNC for mothers	Baseline	10.5	37.1	34.2	17.6
	Endline	20.1	78.6	34.8	7.3

Maternal health outcomes generally declined in both Transform HDR and non-Transform intervention areas. However, at the endline, Transform HDR intervention performance for all maternal health KPIs was better than non-Transform HDR areas (Figure 4), although the

performance difference between them was observed to be statistically significant only for ANC4+ ( $p < 0.05$ ).

Figure 4. Performance for maternal health KPIs at baseline and endline by Transform and non- Transform intervention areas

Box 1: Case Study Vignette: Maternal / Perinatal Death Surveillance and Response

The MOH began surveillance of maternal deaths in 2013, later adding surveillance of perinatal deaths. However, expansion of the surveillance system and use of the information to prevent deaths has been slow. According to the 2016 Ethiopia Demographic and Health Survey (DHS), only 1,025 maternal deaths were recorded at the time of data collection, representing only approximately 8% of expected maternal deaths and 0.4% of expected perinatal deaths. To address the lack of MPDSR in the four developing regions in which it operated, Transform HDR facilitated MPDSR implementation beginning with the training of 198 healthcare workers on MPDSR use, following this up with training of an additional 161 health workers. Importantly, the Activity performed follow-up visits assisted with the implementation of the system and with making decisions based on surveillance data to improve service delivery and address the last two of the three sources of delays that are generally associated with preventable maternal and perinatal deaths: 1) Delay in recognizing the complication, and subsequently seeking professional care; 2) Delay at the primary level in referring the patient for treatment at secondary level; 3) Delay in providing appropriate treatment at the secondary level.

Interviewees in Karamara Hospital in Somali and Dupti Hospital in Afar reported monthly meetings on MPDSR, reporting marked reduction in maternal deaths and progress in reducing perinatal deaths. At Karamara Hospital, MPDSR teams worked closely with facility-based quality Improvement Teams to set up a neonatal intensive care unit. Respondents also pointed to related contributions of Transform, such as a mini blood bank that has enabled them to successfully treat maternal hemorrhage, a common cause of death. Transform-supported skills labs and CEmONC mentoring were also cited as contributing to improved emergency maternal health services. In Afar, recent improved performance at Dupti Hospital has motivated changes in other facilities in that region. However, in both regions, high staff turnover and fear of accountability issues following a death audit or review remain challenges to MPDSR sustainability.

Transform HDR has successfully revitalized MPDSR in selected facilities. This intervention led to further quality improvements and linkages with other programs such as the hospital's Quality Improvement Team, the CEmONC, Kangaroo Mother Care (KMC) program, the creation of Neonatal Intensive Care Units (NICU) and the installation of Mini Blood Banks.

### Newborn Health Outcomes

Essential newborn care and early initiation of breastfeeding significantly improved ( $p < 0.001$ ) compared to baseline status. At endline, early PNC coverage dropped below its baseline, although not statistically significant, and reached only 45% of its LOA target. Essential newborn care showed a sharp increase from its midterm status. However, performance for the remaining KPIs dropped despite the progress made at midterm (Figure 5).

Essential newborn care showed a sharp increase from its midterm status. However, performance for early PNC and early initiation of breastfeeding dropped despite the progress made at midterm.

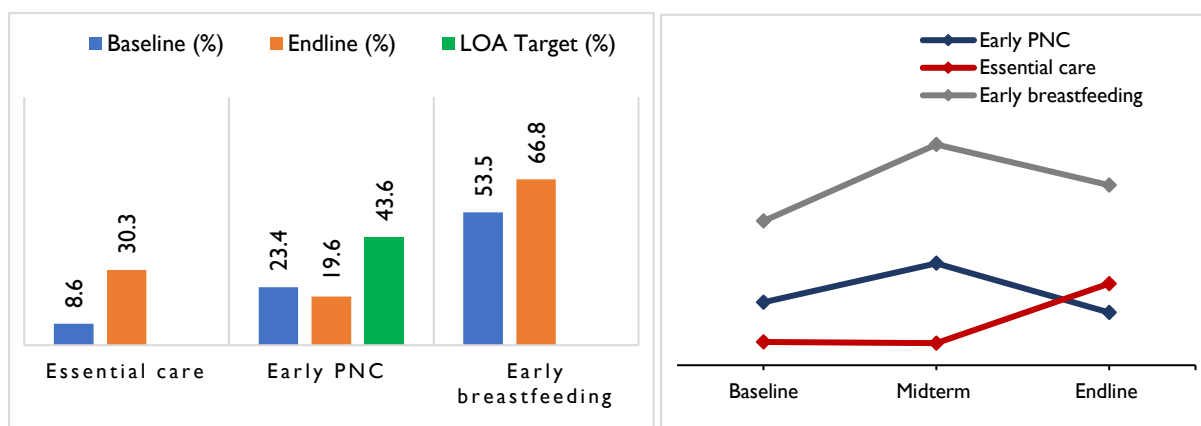


Figure 5. Performance for newborn health KPIs at baseline, endline and against LOA target (left) and Performance trend (right) in Transform HDR intervention areas

Compared to the baseline, performance for essential newborn care improved in all regions. Similarly, early PNC uptake increased in all regions, except in Somali, where it dropped by 14.5 percentage points and was the cause for the overall decline in Transform HDR regions. Unlike the marginal decline observed in Gambella, the practice of initiating breastfeeding within one hour of childbirth improved in all regions (Table 8).

**Table 8. Performance for newborn health KPIs at baseline and endline in Transform HDR intervention areas by region**

Indicator	Period	Afar	B/Gumuz	Gambella	Somali
Essential Newborn Care	Baseline	0.0	0.0	13.3	25.0
	Endline	14.8	42.1	22.7	40.6
Early PNC for newborn (2 days)	Baseline	12.3	30.5	36.8	22.1
	Endline	20.1	70.0	37.0	7.6
Early initiation of breastfeeding	Baseline	52.3	48.8	82.6	35.4
	Endline	65.2	84.3	80.4	62.7

Essential newborn care and early initiation of breastfeeding improved from their baseline status in both Transform HDR and non-Transform intervention areas. On the other hand, Early PNC declined in both intervention categories, although the non-Transform areas suffered a considerable decline. At endline, Transform HDR intervention areas performed better than the non-Transform intervention areas, although differences were not statistically significant (Figure 6).

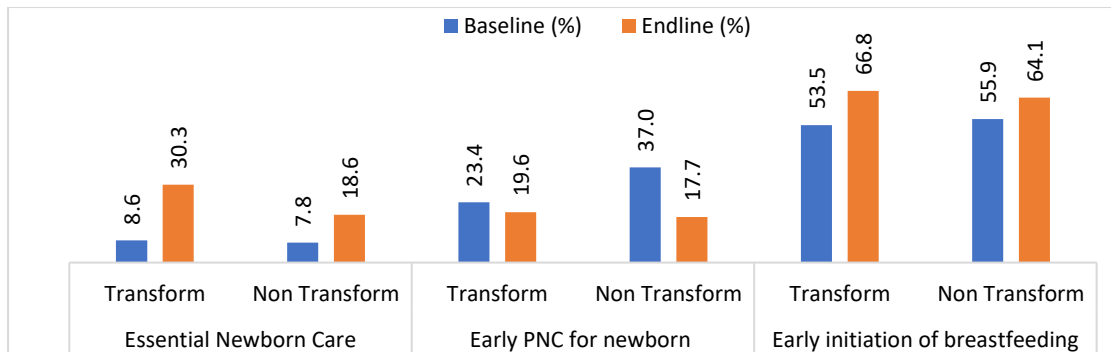


Figure 6. Performance for newborn health KPIs at baseline and endline by Transform and non-Transform intervention areas

#### Box 2: Case Study Vignette: Comprehensive Emergency Obstetric and Newborn Care

Transform HDR provided technical support for Ethiopian Association of Obstetricians and Gynecologists (ESOG) training on CEmONC in ten hospitals in the four HDR regions: five in Somali, three in Afar, one in Benishangul-Gumuz, and one in Gambella. The engagement of this professional association ensured that the quality of care provided and contributed to sustainability and potential scale-up further expansion. These activities were preceded by an assessment of 16,808 deliveries that took place in 15 hospitals, and it was found that 1,942 (11.5%) had not received CEmONC. The most common causes of obstetric emergencies that led to 22 maternal deaths observed in 2018 in these 15 hospitals were: hemorrhage, preeclampsia, uterine rupture, sepsis, and abortion. The assessment also demonstrated that staff had limited clinical skills. About half of the hospitals failed to provide one of nine CEmONC services due to lack of trained staff and equipment. Eighty percent of those providing CEmONC services had not received basic (BEmONC) or emergency training, and three hospitals lacked anesthetists. After CEmONC orientation, each trained hospital staff received regular mentoring visits, and there were successful CEmONC graduates in all ten hospitals. Transform HDR also organized kangaroo mother care (KMC) rooms for mothers and premature babies.

The Hospital CEO and Medical Services Director at the Karamara hospital in Somali reported that Transform interventions contributed to marked reductions in maternal deaths, increases in C-sections from 9.8% to 19.9%, and a reduction in the number of maternal referrals from 72% to 25%. The quality of obstetric care improved due to ultrasound scans and timely transfusions. Hospital staff emphasized the need to continue having the support of Ethiopian Society of Obstetrics and Gynecology (ESOG) to continue improving maternal and neonatal care and to become accredited CEmONC training centers. However, challenges cited by hospital leaders were limited government budget allocation to implement improvements and lack of intra-sectoral collaboration between the MCH directorate in MOH and the public health emergency system.

## Child Health Outcomes

### Preventative child health service outcomes

Measles coverage among children 12-23 months of age who received the vaccine any time before the survey improved significantly ( $p=0.004$ ). Likewise, a statistically significant increase in Vitamin A supplementation for children between the 6 to 59 months was noted ( $p<0.001$ ). On the contrary, full immunization and Penta 3 coverages significantly declined ( $p<0.001$ ) (Figure 7). On examination of the practice of provision of vaccines at the appropriate age of a child (in the first year of life), 13.8%, 30%, and 11.3% of the children had their Penta3, measles, and full immunizations, respectively, and Transform HDR-supported areas were only able to attain less than 30% of the LOA targets set for Penta 3 and full immunization. Conversely, the LOA target for Vitamin A supplementation was overachieved. As evident in Figure 5, performance trends for all the KPIs, exclusive breastfeeding (BF), showed a decline despite the gains at midterm.

Performance trends for all preventive child health KPIs showed a decline despite gains at midterm. However, Transform HDR campaigns played a role in improvements in preventative child health. Although measles containing vaccine first dose (MCV1) is mainly provided as part of routine immunization service, vitamin A supplementation can be linked to services provided through campaigns as well as through routine modalities. In Transform HDR intervention areas, measles coverage among children who received the vaccine any time before the survey and vitamin A supplementation improved significantly.

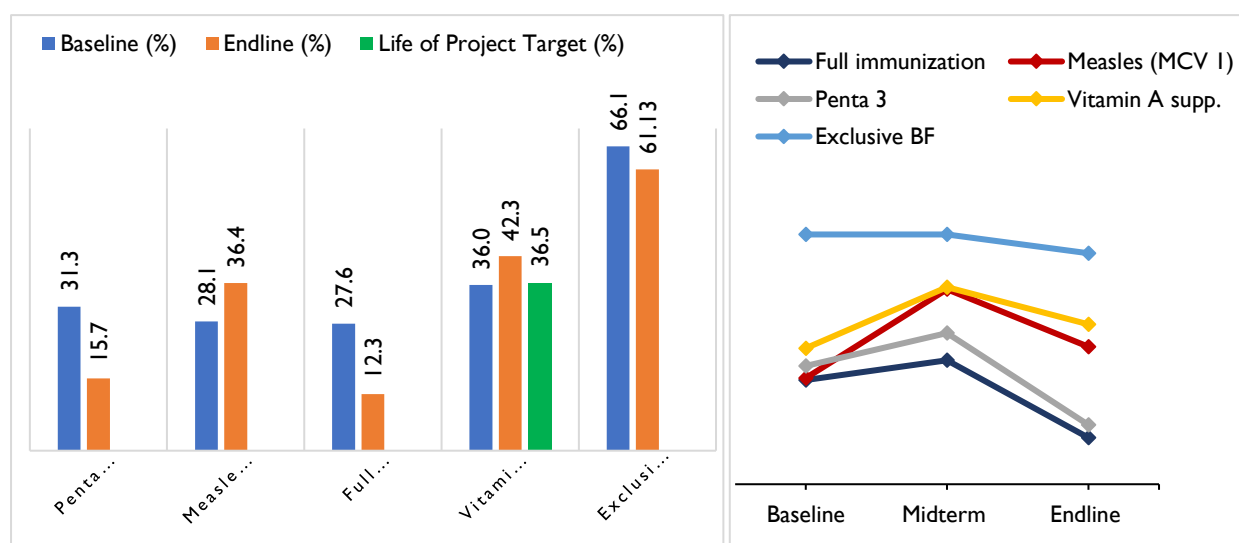


Figure 7. Performance for preventive child health KPIs at baseline, endline and against LOA target (left) and Performance trend (right) in Transform HDR intervention areas

As displayed in Table 9, performance for preventive child health, KPIs vary by region. Measles coverage and Vitamin A supplementation increased in all regions, but Somali.<sup>6</sup> Exclusive breastfeeding also improved in all regions except Afar, where the practice was observed to drop by 27 percentage points from the baseline. Except for exclusive breastfeeding, Afar region

<sup>6</sup> Measles coverage in this case refers to MCV1. Whenever immunization card is available data were taken from the card. However, when this was not the case mothers were asked about the first measles vaccination their children had. Therefore, in the latter case, the possibility of reporting measles vaccines received through such campaigns is higher, which may have accounted for the observed high measles coverage.

improved most for all KPIs, whereas Somali's performance was the lowest between baseline and endline.

**Table 9 Performance for preventive child health KPIs at baseline and endline in Transform HDR intervention areas by region**

Indicators	Period	Afar	B/Gumuz	Gambella	Somali
Penta 3	Baseline	8.7	65.0	39.9	27.1
	Endline	23.7	63.4	26.3	4.9
Measles (MCV1)	Baseline	15.4	41.6	34.0	29.3
	Endline	49.3	85.4	52.6	22.5
Full immunization	Baseline	9.9	61.4	30.4	20.4
	Endline	20.4	46.3	23.7	3.0
Vitamin A supplementation	Baseline	37.2	46.4	29.9	30.8
	Endline	62.9	90.7	58.7	23.9
Exclusive breastfeeding	Baseline	74.1	75.7	77.4	27.7
	Endline	46.8	81.8	93.8	60.4

As presented in Figure 8, comparing Transform HDR and non-Transform areas, Penta 3 and full immunization coverage and exclusive breastfeeding practices dropped in both Transform HDR and non-Transform intervention areas. In Transform HDR areas, measles coverage and Vitamin A supplementation increased in contrast to the performance in non-Transform intervention areas. At the endline, Transform HDR areas had higher performance for all KPIs than the non-Transform intervention areas, although the difference was statistically significant only for Vitamin A supplementation ( $p < 0.001$ ).

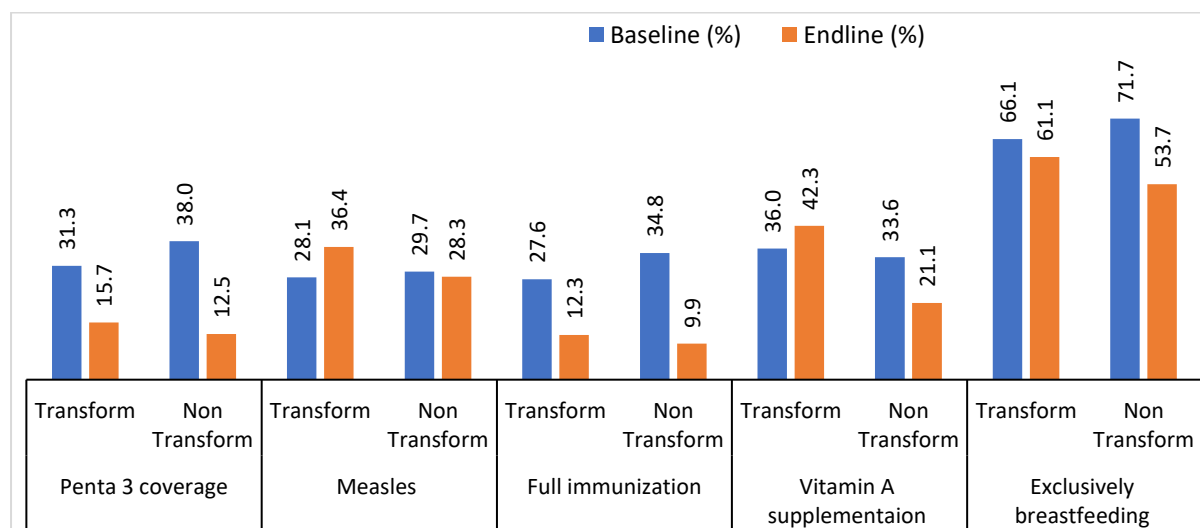


Figure 8. Performance for preventive child health KPIs at baseline and endline by Transform and non-Transform intervention areas

## Curative child health service outcomes

As shown in Figure 9, treatments of ARI with antibiotics and diarrhea with ORS + Zinc increased from the baseline, although the difference was statistically significant only for ARI treatment ( $p=0.001$ ), which may be due to increased COVID-19 cases and a resulting higher number of respiratory cases requiring treatment. On the other hand, deworming and the practice of seeking treatment/advice for children within 24 hours of onset of fever declined significantly ( $p<0.001$ ). Except for diarrhea treatment, which is 2.9 percentage points below its LOA target, performances for ARI and fever treatment were very far from meeting their respective LOA targets.

Transform HDR areas outperformed non-Transform intervention areas for all key performance indicators (KPI) except deworming. At endline, diarrhea treatment showed an increase from its lowest point at midterm. ARI treatment and deworming declined sharply from their respective highest points at midterm.

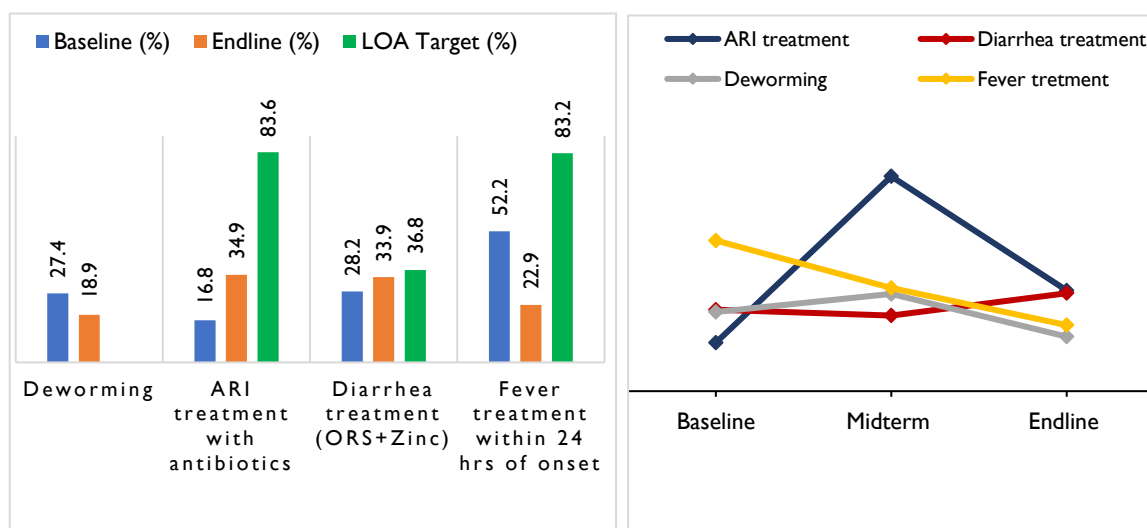


Figure 9. Performance for preventive child health KPIs at baseline, endline and against LOA target (left) and Performance trend (right) in Transform HDR intervention areas

At the endline, ARI treatment and deworming declined sharply from their respective highest points at midterm. On the contrary, diarrhea treatment showed an ascent picking up from its lowest point at midterm. Fever treatment within 24 hours of onset showed a steady decline. Despite the decline in treatment of the three childhood illnesses, 69.2% of health posts in Transform HDR intervention areas provided integrated community management of newborn and childhood illness (ICMNCI), which indicated an achievement of more than 85% of the LOA target.

Compared to baseline status, deworming increased in all regions, although marginally in Gambella. Moreover, ARI treatment increased in all regions except Gambella, and ARI treatment nearly doubled in Afar and Benishangul Gumuz. Fever treatment within 24 hours of onset declined in all regions leading to the overall significant decline. The Gambella region had the largest decline followed by Benishangul Gumuz.

**Table 10. Performance for preventive child health KPIs at baseline and endline in Transform HDR intervention areas by region**

Indicator		Afar	B/Gumuz	Gambella	Somali
Deworming	Baseline	20.7	58.1	31.1	3.5
	Endline	24.0	84.0	31.2	7.8
ARI treatment with antibiotics	Baseline	16.7	25.6	17.2	0.0
	Endline	46.2	79.0	16.7	23.1
Diarrhea treatment with ORS and Zinc	Baseline	22.8	26.5	32.9	33.3
	Endline	41.7	51.2	25.0	26.5
Advice/treatment sought within 24 hours of onset of fever	Baseline	41.3	56.5	70.4	28.9
	Endline	30.4	34.1	25.0	17.6

Comparisons between Transform HDR and non-Transform intervention areas revealed that, except deworming,<sup>7</sup> Transform HDR areas' performance for all KPIs was higher. ARI treatment with antibiotics improved in both Transform HDR and non-Transform HDR intervention areas, whereas diarrhea treatment improved only in Transform HDR areas. On the other hand, the practice of seeking treatment/advice for fever within 24 hours of onset declined in both areas (Figure 10). At the endline, Transform HDR and non-Transform intervention areas' performance was identified to differ significantly ( $p < 0.05$ ) only for deworming.

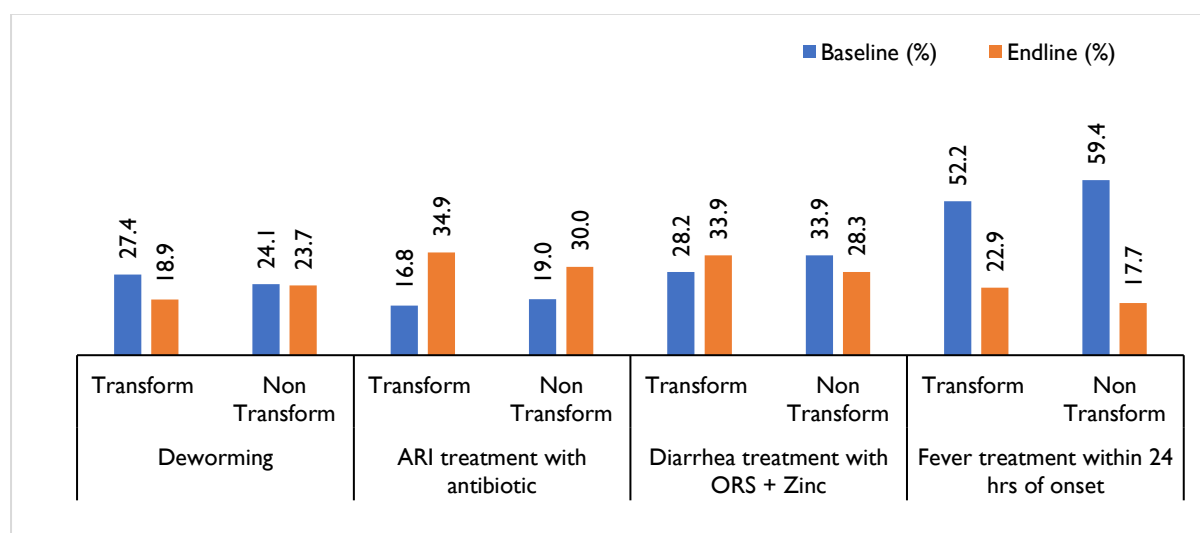


Figure 10. Performance for preventive child health KPIs at baseline and endline by Transform and non-Transform intervention areas

#### Demand for high-impact MNCH/FP services

<sup>7</sup> Although Vitamin A supplementation and deworming activities are provided simultaneously through campaigns, the target groups for Vitamin A supplementation are wider than those for deworming and thus there are children who receive vitamin A but do not get the drug for deworming. Differences may also be attributed to the provision of Vitamin A supplementation in facilities along with MCV1 vaccines, which is not the case for deworming.

## Awareness of MNCH/FP

As shown in Table 11, women who heard/saw specific messages on RH/FP declined from baseline in both Transform HDR and non-Transform intervention areas, whereas the proportion of women who were exposed to MNCH-specific messages tended to improve from baseline. At the endline, although more women reported seeing/hearing RH or MNCH messages in non-Transform intervention areas, the differences with that of Transform intervention areas were not statistically significant.

**Table 11. Performance in MNCH/FP awareness creation at baseline and endline in Transform HDR intervention areas by region**

Indicators	Transform		Non-Transform	
	Baseline	Endline	Baseline	Endline
Specific RH/FP messages	48.1	25.9	52.3	28.0
Specific MNCH messages	19.1	<b>23.6</b>	23.4	<b>24.6</b>

Despite the declines observed in the exposure women had to RH/FP and MNCH messages over the last three months from the survey data, KIs reported that the Transform HDR activities contributed to improved health-seeking behaviors of communities. Several activities were implemented using the existing community health structures. This involved strengthening the capacities of health extension workers and Women Development Army (WDA) members who conducted awareness raising and demand creation activities. On top of the face-to-face interaction Health Education Workers (HEWs) and WDAs had, the spread of tailored messages related to family planning and MNCH through print media, such as leaflets, were reported. These efforts were reported to have improved the knowledge of the community in FP and MNCH, and service utilization at health facilities and outreach/mobile sites. This according to the KI from Benishangul Gumuz is described as follows:

*"Transform HDR has been providing capacity building support to HEWs, who in turn train WDAs. WDAs pass information about MNCH/FP services at the household level. As a result, communities' awareness of the importance of utilizing MNCH/FP services increased especially on institutional delivery. Besides, the project supported the transfer of key MNCH/FP messages through distributing leaflets to the community. These demand creation approaches helped to change attitudes of mothers in favor of facility delivery since they came to realize the risks associated with home delivery."*

Pregnant women conferences are community-based interventions designed to raise awareness of obstetric danger signs and the use of institutional skilled maternal health care services. These were mentioned by KIs as an effective strategy to mobilize the community to provide the necessary support to mothers to use ANC, delivery, PNC, and family planning services. Moreover, the efforts made to engage existing community structures, such as community/religious/clan leaders and elders in the behavior change communication activities, was also reported to improve the acceptability and effectiveness of the works of HEWs and uptake of family planning services. The changes observed in family planning uptake because of use of these structures was described by a KI from Benishangul Gumuz as follows:

"In Maokomo woreda, FP uptake was so low and Transform HDR trained community and religious leaders and they set a three-month plan of action to mobilize the community on FP. After the three months, uptake of both short and long-acting FP methods increased markedly. This was documented as a success story by Transform HDR."

Insecurity in multiple areas of the intervention regions may have led to the decline in the proportion of women who reported hearing/seeing RH/FP and MNCH messages at the endline compared to the baseline.

#### Gender norms and women's empowerment

Women's participation in health care decision-making declined in all regions except in B/Gumuz. More men accompanied their spouses during ANC in B/Gumuz and Gambella. More men accompanied their spouses during the birth of their last child born in Gambella and Somali. Overall, women's participation in health care decision-making and men accompanying their spouses during ANC and delivery declined significantly ( $p < 0.001$ ) (Table 12). As presented in Figure 11, a consistent decline was observed in performances for two KPIs: women's participation in decisions concerning their own health and women accompanied by their spouses at least on one ANC visit. Performance on women being accompanied by their spouses during birth declined at endline despite some progress witnessed at midterm.

**Table 12. Performance for gender and women empowerment KPIs at baseline and endline in Transform HDR intervention areas**

Indicator	Time	Afar	B/Gumuz	Gambella	Somali	Overall
Participation in own health care decisions	Baseline	85.1	79.0	71.0	93.4	82.3
	Endline	73.6	89.4	61.2	78.3	77.7
Accompanied by spouse during at least one ANC visit	Baseline	53.3	52.8	42.4	12.3	44.4
	Endline	23.0	65.7	43.5	9.5	21.5
Accompanied by spouse during last delivery	Baseline	87.8	90.3	66.7	61.1	78.2
	Endline	60.7	87.9	77.3	73.5	74.7

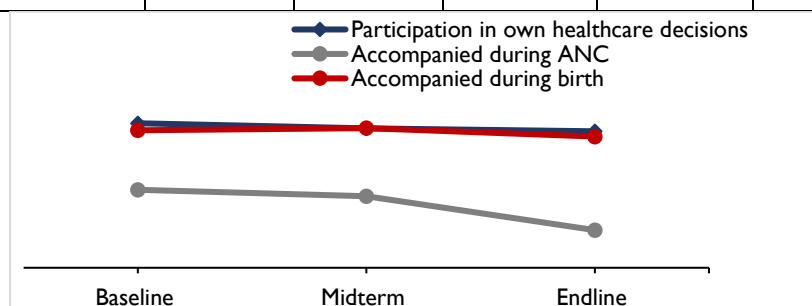


Figure 11. Performance trend for gender and women empowerment KPIs in Transform HDR intervention areas

As can be seen from Figure 12, all three gender and women's empowerment KPIs declined both in Transform HDR and non-Transform intervention areas from baseline; a substantial decline was

observed for women who were accompanied by their spouse during at least one ANC visit. At the endline, Transform HDR intervention areas happened to have higher performance for all the KPIs than non-Transform areas, although the performance difference between the two areas was found statistically significant for only women’s participation in health care decisions ( $p < 0.001$ ).

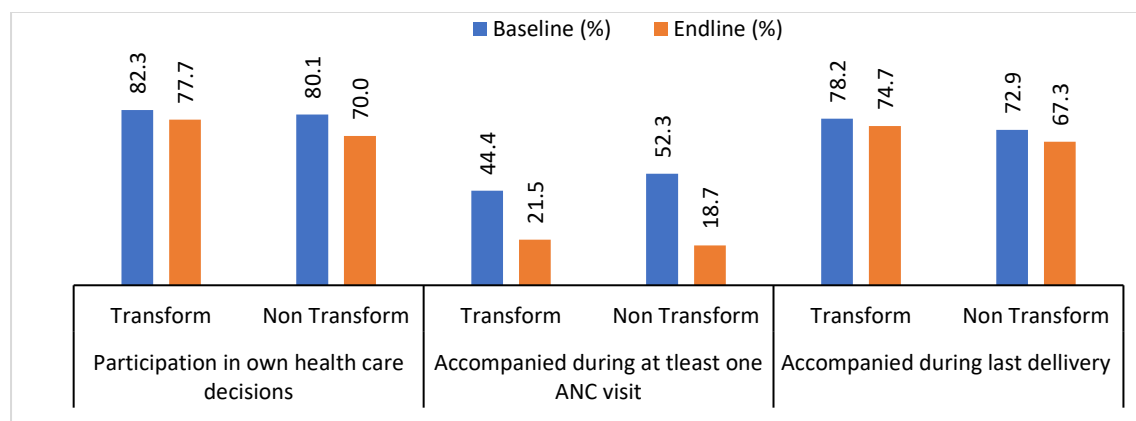


Figure 12. Performance for gender and women empowerment KPIs at baseline and endline by Transform and non-Transform intervention areas

#### Health system performance

##### Availability of family planning service in surveyed facilities

Family planning service was provided in 93% and 76.5% of surveyed health facilities in Transform HDR and non-Transform intervention areas, respectively, demonstrating an improvement in Transform HDR intervention areas. The LOA target (70%) set by the Transform HDR activity for availability of family planning services was exceeded as well. Results on availability of family planning methods also revealed a higher proportion of facilities in Transform HDR intervention areas provided each of the modern family planning methods than facilities in non-Transform intervention areas (Table 13). On the contrary, family planning service availability was very low at surveyed health posts in both intervention and non-intervention areas; 50.8% and 42.1% of surveyed health posts did not provide modern family planning methods in Transform HDR and non-Transform intervention areas, respectively.

**Table 13. Family planning method provided at surveyed health facilities in Transform and non-Transform intervention areas**

Contraceptive methods	Transform (%)	Non -Transform (%)
Combined oral contraceptive pills	87.7	82.4
Progestin-only contraceptive pills	75.4	41.2
Progestin-only injectable	79.0	58.8
Male condom	73.7	52.9
Implants (Implanon or Jadelle)	75.4	41.2
Emergency contraceptive pills	66.7	52.9
IUCD	54.4	47.1

### Availability of post GBV services in surveyed facilities

As is evident in Figure 13, a generally higher proportion of health facilities in Transform HDR intervention areas provided the different components of post GBV services than facilities in non-Transform intervention areas. On average, about three times as many health facilities in Transform HDR intervention areas provided the different components of post GBV services as those in non-Transform intervention areas.

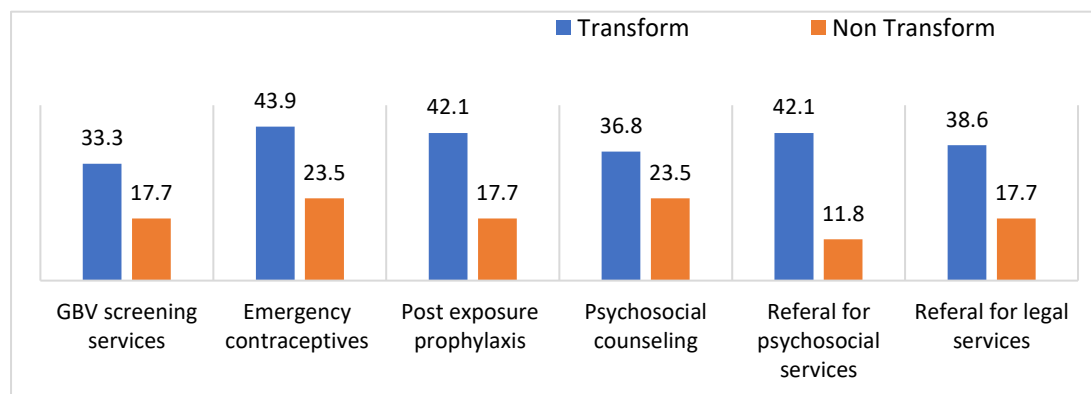


Figure 13. Post GBV service components provided at surveyed facilities in Transform and non-Transform intervention areas

### Availability of adolescent and youth friendly services in surveyed facilities

Adolescent and youth friendly (AYF) services were provided in 22.8% of surveyed health facilities in Transform HDR intervention areas, whereas more facilities (35.3%) in non-Transform intervention areas were identified as providing the services. As can be seen in Figure 14, out of the facilities that provided AYF services in Transform intervention areas, all AYF service components were provided in more than half of them. STI treatment and HIV testing were available in all facilities where AYF services were found to be provided. Each of the remaining eight AYF components were available in a higher proportion of health facilities in Transform HDR than non-Transform intervention areas.

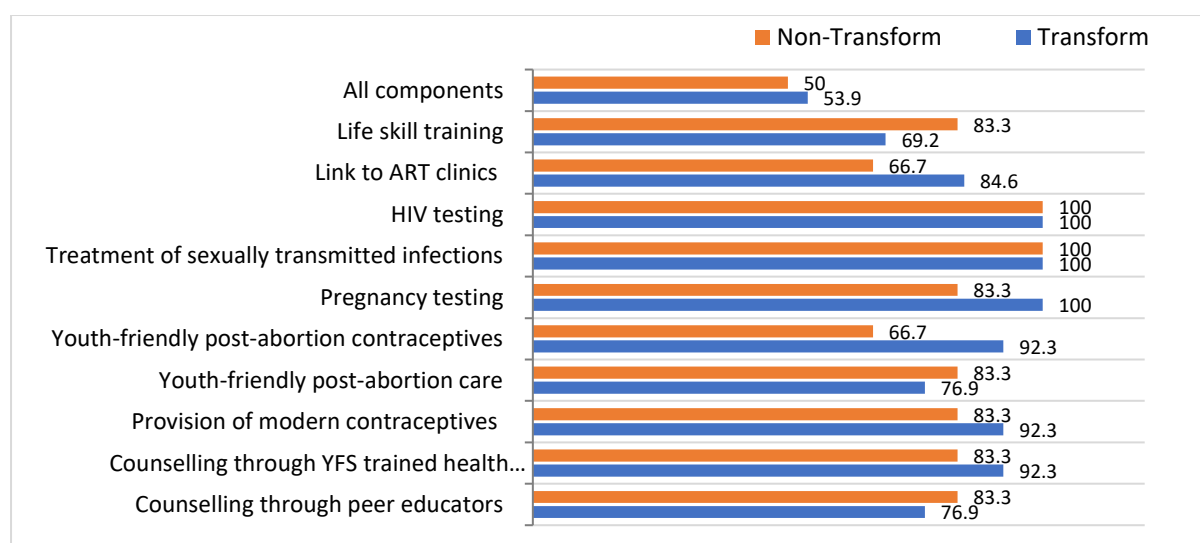


Figure 14. Adolescent and Youth Friendly service components provided at surveyed facilities in Transform and non-Transform intervention areas

## Availability of Basic Emergency Obstetric and Neonatal Care in surveyed facilities

Nearly four out of ten facilities surveyed in Transform HDR intervention areas reported providing all Basic Emergency Obstetric and Neonatal Care (BEmONC) signal functions, which is slightly lower than what was identified in the non-Transform intervention areas. Compared to non-Transform HDR intervention areas, a higher proportion of facilities in Transform HDR intervention areas provided each of the signal functions except for assisted vaginal delivery (Figure 15).

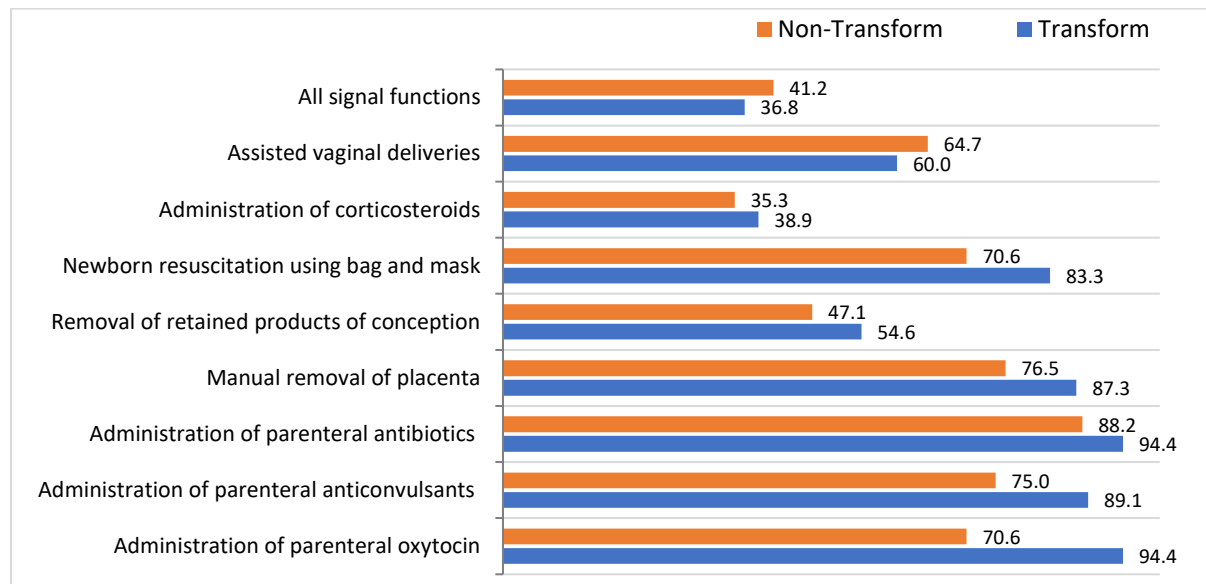


Figure 15. BEmONC signal functions provided at surveyed health facilities in Transform and non-Transform intervention areas

## Health facility performance assessments

All surveyed primary hospitals and 78.9% of the health centers in Transform HDR intervention areas reported conducting monitoring/self-assessments of performance using the Ethiopian Hospital Service Transformation Guideline (EHSTG) and Ethiopian Health Center Reform Implementation Guidelines (EHCRIG). In a majority of the facilities (79.5%), the monitoring was reported to have taken place in the second and third quarter of the current Ethiopian fiscal year (EFY 2014). Results demonstrated that a majority of the facilities (80%) had not analyzed their monitoring data, and from those that had, 27.8% had an overall performance score of more than 80%. Regarding monitoring of implementation status of health information system, 43.9% of facilities reported conducting the exercise regularly, and in 68.2% of the facilities, the practice was identified as taking place in the second and third quarter of EFY 2014. Results showed that 60% of the facilities did not analyze their monitoring data, and among those that did, very few facilities (16.7%) reported an overall score of more than 85%. These findings demonstrate that not many facilities are processing and using the monitoring data they have collected related to health facility performance to inform the decisions they are supposed to make in improving performance.

From all surveyed health facilities in Transform HDR intervention areas, 78.9% of the facilities had annual quality improvement plans in place. Out of those facilities that had a quality improvement

plan, only half reported implementing them. In addition, facilities that received support from Transform HDR for implementation of quality improvement initiatives (22.8% of surveyed facilities), 84.6% had quality improvement (QI) plans. Of the facilities with QI plans, 72.7% reported implementation.

#### Health workforce capacity development

Health workforce capacity building on various thematic areas was one of the core activities of the Transform HDR activity. By the time of its completion, Transform HDR had supported the training of 18,728 health workers on MNCH/FP and related areas. Over the same period, the activity also supported post-training follow-up, onsite mentoring and coaching on BEmONC and family planning for 151 health workers from 79 health facilities, 421 health workers from 301 health facilities, and 60 health workers from 44 health facilities on BEmONC, modern family planning methods (long acting and postpartum), and traditional (standard days) family planning methods. To strengthen the community health system, it also enabled training of 1,503 HEWs and their supervisors on integrated management of childhood illness and community-based newborn care.

According to the KIs, training, post-training follow-ups, mentoring, and coaching activities that were supported by the Transform HDR activity enhanced the competency of health workers and ultimately contributed to improving quality and uptake of services. The need-based nature of the trainings and the follow-up activities implemented afterward were recognized by KIs as the most important drivers of service improvement. These capacity building efforts were reported to specifically improve diagnosis and management of childhood illnesses, provision of long-acting family planning methods, uptake of antenatal care and delivery service, and the early detection and management of complications during labor and delivery. Describing the changes that resulted from the capacity building work by Transform HDR, a KI from Benishangul Gumuz had this to say:

*"Transform HDR provided MNCH/FP trainings to many staff and checked the application of trainings through the post-training follow-ups. As a result of these efforts, we saw many changes. For example, utilization of LAFP is increasing from time to time because of the capacity building works coupled with the many FP promotion works especially targeting native Ethnic Groups who used to associate FP with religion and tradition."*

How effective are the Transform activity strategies and approaches?

Key informants described what they considered to be the most effective approaches that should be sustained or scaled up. Some of the interventions such as community awareness creation and capacity building efforts, including both onsite and offsite trainings, were mentioned as effective approaches in terms of improving service uptake and quality. The most frequently mentioned effective intervention approaches noted by KIs included the provision of mobile ultrasound, capacity building trainings on different topics and material support. Awareness creation, furnishing maternity waiting homes, Leadership Management and Governance (LMG) trainings and mentoring/coaching were also mentioned as effective interventions by KIs. In addition, the

establishment of NICU and mini-blood banks were cited as effective interventions in reducing maternal and infant mortality.

Views expressed by key informants on the effectiveness of some Transform HDR interventions reflecting subjective experiences and were sometimes at variance with performance on key indicators. Performance on KPIs reflected MNCH/FP outcomes in a period that was markedly affected by recurrent/prolonged conflicts, natural disasters, outbreaks, and resulting massive internal displacements. Although the interventions were appreciated, the scale of the intervention compared to needs in developing regions was small, a relatively late start on demand creation for MNCH/FP activities, and external shocks had serious repercussions on improving service quality at health facilities, community awareness on various aspects of MNCH/FP utilization of services.

#### Most effective interventions

The changes in MNCH/FP services observed because of the support received from Transform HDR were described by the KI from Gambella as *effective and the result of providing essential equipment and medical technology, and capacity building to facility staff: "the introduction of portable ultrasound increased the possibility of outreach services. As a result of that, access to maternal health services and the demand for health services increased. Moreover, the clinical coaching and mentoring played a significant role in building the capacities of professionals at health centers leading to a reduction in the number of cases referred to hospitals. These implied improved competencies of the professionals to manage non-complicated maternal and child health problems independently at the health centers."*

A KI from Benishangul-Gumuz also indicated improvement in neonatal care owing to the material and capacity building support provided by Transform HDR. *"The supplies provided to facilities had the greatest role for the improvement of MNCH/FP services, for example, the NICU in Assosa general hospital has substantially improved, because of the training provided to staff on neonatal care and treatment and some medical equipment donated. This support has therefore contributed to the sharp drop in neonatal mortality observed in the hospital."*

#### Regional variations in effectiveness of gender-related interventions

Targeting of men to increase FP uptake had mixed results. KIs underlined the need for much more work on family planning awareness creation targeting men, because many of the developing regions are highly patriarchal societies and women still have no right to independently decide to use family planning methods. As discussed in a later section, targeting men was reported to have contributed to FP uptake in some regions, such as Benishangul-Gumuz and Somali. In Gambella, although engaging religious and community leaders was difficult, some progress was made in terms of women's empowerment through organizing "coffee ceremonies" was reported.

#### Least effective interventions

When asked to mention the least effective interventions, only a few mentioned least effective approaches. And in most cases, those mentioned by KIs as least effective were not because of their problem in terms of the theory of change but rather because the interventions were not adequately implemented. KIs mentioned that the scope of the Transform HDR was wide which stretched its resources. The KI from Benishangul-Gumuz reported this constraint in resources and the impact as:

*"The scope of Transform HDR was so wide from the beginning and its goal was to transform or nearly transform targeted woredas. However, we haven't achieved the anticipated transformation in all woredas since such a goal is too big to be achieved by one development partner. To the worst, health facilities that were making progress on the way to being models were destroyed by the conflict that has been affecting the region over the last two years. Activity implementation was also highly limited by the small number of staff Transform HDR has; there was a mismatch between number of Transform HDR staffs and the area of intervention."*—KII, Benishangul-Gumuz.

Community level interventions, the provision of reproductive health services to young people, and the work done so far to promote male engagement in FP were identified as less effective by KIs from Somali and Gambella, respectively. Lack of follow-up after training of community level health workers and volunteers was the reason mentioned by KIs regarding the limited extent of community level behavioral changes that would have been realized because of the intervention.

The lack of a separate room dedicated to providing youth reproductive services was also pointed out to have limited the tendency of young people to use the services. This gap in youth-friendly services was described as:

*"The least effective approaches were FP services for adolescent and youth because the MNCH/FP service provision at a single compound for all people of different ages challenged the service needed by the adolescent-youth. Access to family planning and other sexual health care services in the same location with their families was difficult for adolescents or youth. This means that due to privacy issues and cultural taboo, adolescents and young people did not feel comfortable visiting the health care center on sexual health-related issues, particularly pregnancy and the management of sexually transmitted infection. As a result, the area of adolescent-youth sexual and reproductive health was not effectively worked on. –KII, Gambella.*

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

Mobile health and outreach services have the potential for greater scale up, particularly in heavily pastoralist communities in the Somali and Afar regions. The success of these measures was reported to be linked to further engaging regional bureaus, coordinating, and harmonizing these efforts with zonal health bureaus and WorHO, and with other IPs that offer outreach and mobile health services. Mobile health is an important innovation that was reported to be particularly well suited for regions such as Somali and Afar and that can be further scaled up. However, important challenges remain to ensure institutionalization of mobile services:

- Woredas do not have transportation budgets to support mobile services, and longer-term sustainability is uncertain due to a dearth of vehicles and fuel.
- Poor road infrastructure and weak “last mile” distribution exacerbates stockouts of medicines and the lack of laboratory services.
- In areas where Transform was working, other NGOs also came and provided partial MNCH services, especially nutrition services, requiring harmonization of mobile services across partner interventions.
- Mobile teams are only able to conduct ultrasound investigations for a few women in the field because of the device’s short battery life and lack of a backup battery.
- Mobile teams are also unable to provide food supplements for children and mothers as other partners do; such offerings attract more women to those services.
- Health workers are demotivated because of differences in payment schemes from partner to partner.

Social and behavior change communication (SBCC) was reported as another potential domain for scaling up, but to operate effectively these efforts will require adjustments. As an early comprehensive MNCH/FP partner in developing regions, the Activity faced strong headwinds, and required time to adequately address social messaging. Future scaling of services was reported to require even more intensive community outreach through women’s groups, community and religious leaders, and other influential local structures to gradually break down resistance in areas such as professional antenatal care and modern family planning adoption. Although women’s and men’s groups such as *Umulgargar* and *Abulgargar* are promising practices, scaling these types of interventions more widely in pastoralist communities would require more intensive support in every activity-supported pastoral community.

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

Several factors affected program implementation. The most frequently mentioned factors reported by KIs in in-depth interviews included: war/conflict, political instability, COVID-19; and leadership turnover within the public health system.

The pandemic caused a decline in reproductive, maternal, and child health services. The Activity’s response was swift, as IPs activated their emergency rapid response funds, mitigation strategies were enacted rapidly, and health systems disruptions were averted. One of the respondents said, “there was a minor decline in service use in the first month, but we installed strategies immediately and were able to reverse the course.”

The impact of conflict, insecurity, internal displacement, drought, floods, and other natural and manmade health system disruptions affected outcomes in Transform HDR regions.

The first two years of Transform HDR’s implementation in the Somali region were challenged by security concerns. More recently, during the last two years since 2020, security problems in Afar and Benishangul-Gumuz regions affected health systems in those regions. Disease outbreaks such as the COVID-19 pandemic, acute watery diarrhea (AWD), measles, malaria, yellow fever, dengue fever, and the Chikungunya virus, which is spread to people by infected mosquitos, affected Activity implementation.

Key informants noted that during 2020 and 2021, war, public unrest, drought, and flooding disrupted the health system. A key informant from Afar RHB stated that most Transform intervention woredas were affected by the war in Northern Ethiopia. A key RHB informant interviewed in the Somali region said that despite the investment from Transform HDR, the performance was affected by manmade and natural catastrophes during these years, including drought, conflict, flooding, and locust infestation. He phrased it as follows:

*"Our health system has been tested this year, which has been challenging. Despite these challenges, we did a lot of activities in collaboration with the Transform program. . . and tried to maintain the achievements in the previous years. We tried to prevent from reversing our achievements. We are encouraged by this because our health system becomes resilient. It keeps performing despite those shocks."*

Transform HDR utilized crisis modifier funds to respond to the effects of these shocks. The Activities supported RHBs in their response to the COVID-19 pandemic to ensure continuity of essential MNCH/FP services. Similarly, the crisis modifier funding was used to support emergency health service needs of internally displaced persons (IDP) in Afar and Benishangul-Gumuz. The crisis modifier was also used to counter a measles outbreak in Somali and flood response support in Afar.

Frequent changes of leadership within the health system also negatively affected the momentum of promising interventions supported by Transform HDR in almost all regions. Key informants across all regional and woreda health bureaus revealed that there was frequent change in leadership at all levels of the health system. According to one respondent: "The leader you met this month and discussed the implementation challenges you experienced may not be occupying the position after a month or two," explaining the challenges the program faced because of increased leadership reshuffles and turnover (KI, Transform HDR Afar office). In some woredas, district health leaders left the position after receiving LMG training, one of the key interventions the Transform program implemented to strengthen the health system. Whereas commitment among some of the woreda leadership contributed to notable coverage for key MNCH/FP interventions, progress was stalled by the war that affected the area in 2021.

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

Most MOH stakeholders had a positive view and a sense of ownership of the interventions supported or introduced by the Activity. KIs from three HDR regions—Afar, Benishangul-Gumuz, and Gambelia—indicated that the approach of Transform HDR was highly participatory, and the activity worked in full alignment with the existing health system.

In terms of coherence, the majority of KIs indicated that the Activity worked jointly with regional, zonal and woreda health bureaus/offices from its design and inception stages, through joint planning, alignment, and review exercises. For instance, Transform HDR involved RHB and zonal experts in all activities such as integrated supportive supervision (ISS), post-training follow up, clinical mentoring, and coaching. At regional levels, health workers were certified as master trainers. These experts can be used to train, mentor and coach health workers in the absence of the program. Through these interventions, the Activity contributed to building the skills of local

health professionals working on issues related to MNCH/FP. To the extent that these professionals remain in their posts, this capacity is likely to be sustained.

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

Key informants agreed that most Transform HDR strategies and interventions were aimed at strengthening the existing health system rather than implementing new or parallel activities. KIs indicated that the role of the program was to facilitate the achievement of the government's strategic plan on RMNCH/FP through system strengthening, service integration and service reconfiguration.

According to a KI respondent from the Gambella RHB, Transform HDR activities were fully integrated within the Ethiopian health system in contrast with other development partner interventions in the Gambella region:

*"[Transform] was a model of working in full effort and in line with national health care protocol or standards, supporting the health system. Transform HDR interventions follow Ethiopian health care system protocols, and nothing was divergent.*

Although most KIs supported this view of full integration into the health system, one respondent from Somali reported gaps in the integration of the program activities and noted that the voice of the regional bureau was less than anticipated:

*"The project can't be said to be well integrated, but [it is] somehow integrated. This is because the RHB has no control or mandate to lead the project, AMREF is the lead and there are other partners. [Key decisions are made] in Addis, so we don't even know what the collaboration looks like. When I say aligned, I mean it is the nature of the design which is strengthening existing services and system. The project also lacks transparency; we don't know the budget and what is assigned for activities. Unlike Transform PHC, which builds the capacity of the government through direct funding, here it is the partners having the sole decision making on the project resources, led by the head offices in Addis. The ownership in TPHC targeted regions is much better because of the support of funding to have direct supervision as well."*

To what extent did government staff/community perceive that the approaches established by the project will be maintained by the government and continue to sustain MNCH/FP improvements in the next 3 and 5 years?

According to KIs, health system staff now have capacity to take over the implementation of most MNCH/FP activities because of the training they received. Certain elements of program activities such as ultrasound services are expected to be fully sustainable. However, most respondents expressed doubts that activities that required substantial financial support were likely to be owned and sustained by the government. Although key informants expressed a strong sense of ownership of the program activities, KIs are concerned that budget and financial constraints could hamper the continuation or sustainability of some program activities, for the following reasons:

- Political instability and conflict affected the implementation of the program and is also a risk factor for sustainability of the activities and observed benefits. Because of conflict, some target woredas have not been accessible for years.
- Staff shortages and staff turnover are also mentioned as risk factors for sustainability.

- Program ownership appears to be weaker in Somali compared to other regions. Government stakeholders are not pleased that the program focused on management and health worker capacity building, whereas greater emphasis should be on providing equipment. Moreover, according to this interviewee, the program has weak engagement with the RHB and weak community engagement in the Somali region.
- The majority of KIs understand that the program will end soon and some of them indicated that they have already had discussions with Transform staff on exit strategies to ensure proper handover of the activities. Some KIs expressed concern that an exit strategy is not well enough planned to ensure sustainability. However, because the Activity was still operational in most regions at the time of interviews, formal closing meetings and workshops had not yet taken place.

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

Transform HDR supported community engagement initiatives implemented by the government to improve health seeking behavior and ensure social accountability. For instance, the Activity supported a government initiative called community score card (CSC) and implemented activities to strengthen and sustain the CSC approach. The activities included capacity building of client councils and community awareness creation. In addition, Activity experts participated in quarterly discussions to rate the performance of the health facilities. Other interventions cited by KIs to involve communities included:

- Support for traditional community structures (e.g., community elders and influential leaders called 'Boto' in Somali region) to improve health seeking behavior (create demand) and ensure social accountability.
- Training for women's development groups, social mobilization committee, clan, and religious leaders to increase demand.
- Support for "pregnant mothers' conferences," a forum where pregnant women can gather regularly to discuss health and health related issues during pregnancy.

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

Key informants pointed to improved awareness of women's health rights because of the program. KIs noted improvements in engaging communities in evaluating health facilities. During the Activity intervention period, women's development groups, traditional birth attendants, and religious and clan leaders were provided with training on community health demand creation and community-based surveillance. Community members also participated in the implementation of the project. For instance, clan leaders in Afar region were engaged in providing support for survivors of gender-based violence. Business associations were involved in detecting and reporting measles cases and outbreaks to health workers/HEWs. According to respondents from the regional health bureau in Afar:

*"The project built the capacity of women development groups and social mobilization committees through training. Mobile outreach teams mobilized the community about the availability of quality maternal health and family planning services. The project actively engaged the community through the process from planning and implementation through the monitoring process. In general, the*

*community was informed about the benefits of the outreach mobile clinic services. In particular, clan and religious leaders, women's development groups program, in selecting outreach sites and organizing the program, in mobilizing community members for which they were part of the outreach mobile team. They were actively engaged in planning and scheduling of the outreach services, in reviewing and monitoring quality of health care services, and in providing feedback."*

How do Transform HDR coordinate with other development partners and their activities?

KIs reported that Transform HDR employed different strategies to foster partnership and harmonize activities with MOH activities and the activities of other partners. Because Transform program activities were aligned with government plans and protocol, KIs indicated that this generally facilitated natural partnerships between the program and government. Transform HDR was regarded as having been active in terms collaborating with other development partners operating in all the targeted regions. As an example, RHB key informants cited Transform HDR as a model partner in the Gambella region in terms of creating and sustaining partnerships with other development partners:

*"And that I may say, Transform HDR is a model on this area. What makes Transform HDR unique was its initiative to establish cooperation and coordination among other partners through its review meeting approach. The HDR effort and tendency to work collaboratively was impressive."*

Transform HDR respondents similarly acknowledged MOH's key role in facilitation coordination inter-partner dialogue. This was particularly important, as regional health bureaus, often through their NGO coordination offices as well as zonal health departments, assigned partners in different areas based on the existing need to avoid duplication of efforts. Transform HDR regional staff in Benishangul-Gumuz, for example, acknowledged the key RHB role in coordinating efforts:

*"The RHB assigns its development partners during woreda base planning each year and each partner supports its target woredas to make the planning sessions successful. Besides, RHB facilitates experience sharing among partners, i.e., by organizing a partners' forum annually or biannually. In the forum, Transform HDR presents its performances from which others can learn and vice-versa."*

Participatory approaches, such as joint planning, and joint program implementation were most often cited by key informants as effective mechanisms to strengthen the partnership among development partners. Transform HDR was an active participant in partnership forums, which were established at national, regional zonal and woreda levels to facilitate coordination among partners, harmonize activities, and avoid duplication of efforts. In this regard, KIs reported that the program was successful in creating strong partnerships with actors, particularly at the regional level, and somewhat less so at zonal and woreda levels, which had fewer functional partnership forums. As one example, through sharing in regional and other forums, the cluster based clinical mentorship approach which was a key Transform HDR strategy was adopted by other partners in the Benishangul region.

Although Transform HDR was acknowledged as an active partner in partnership forums and regular review meetings, some KIs referred to challenges that were external to THDR. Partnership challenges were sometimes hampered by the fact that some other development partners were reported as being non-transparent in terms of disclosing their budgets. In such cases, plan

alignment and coordination were challenging. In other cases, KIs cited a reluctance among some of these other development partners to attend partnership forum meetings, to cooperate and work together. In other cases, particularly at lower levels, partnership forums were not strong, and some were not active or held no regular meetings. Moreover, several respondents indicated that there is no shared partner database on management or health workers that have received training on specific topics, and that in some cases, these individuals attended repeated trainings offered by multiple partners on the same topic. Still others pointed to conflicts of interest and competition among partners for funding, which can also be a barrier to partnerships.

### 5.3 HOW DID TRANSFORM ACTIVITIES CONSIDER GENDER DYNAMICS IN ACTIVITY DESIGN AND IMPLEMENTATION? WHAT GENDER EQUITY RESULTS DID TRANSFORM ACTIVITY INTERVENTIONS ACHIEVE?

Transform HDR considered gender in the activities, such as conducting training on the issue of gender streamlining and integrating gender in SBCC activities. According to KIs, the Activity increased women's leadership through its leadership training and training of female schoolteachers on gender issues and establishment of gender clubs in schools. Awareness and advocacy of gender issues was conducted through Motherhood Day and Women's days and other community activities, such as coffee ceremonies and sending invitation cards to involve men in ANCs, delivery, and FP conversations. HDR also strengthened mother's waiting homes by supplying equipment and other supplies and training new graduate midwives.

According to one respondent, although changing attitudes in patriarchal societies such as those found in Gambella is difficult, some progress was made in terms of women's empowerment and male engagement in that region:

*"Coffee ceremonies enable advocacy activity to promote women empowerment. The understanding level of the male partners increased, and the resistance from the male partner on the females'*

Box 3: Case Study Vignette: Umulgargar Implementation in Awbare Health Center

"Umulgargar" a Somali word translated as "save mothers at risk group." It was established seven years ago by staff from maternity unit in Awbare health center. The establishment of the group was inspired by an incident that involved a mother who was fighting for her life after losing a large amount of blood following childbirth, which the maternity unit staff have witnessed firsthand. Staff were able to mobilize resources from the facility and the community to refer the mother to a public hospital in Jigjiga, which allowed the mother to continue accessing service to this day. That incident and the positive outcome that followed it motivated staff to organize a group of mothers who make monthly contributions to financially support fellow mothers from poor families to get necessary health care during pregnancy and childbirth.

Mulo Abdi was one of the founders of the group. She is currently working at the woreda health office as a CBHI coordinator as well as serving as a focal person for *Umulgargar*. She noted that there are 190 Umulgargar members in Awbare woreda, out of which 50 are in the Awbare town. Each woman in the group is responsible for five more households and the member responsible for her group provides a written referral card printed by Transform HDR to the nearest health center. Members also facilitate mother-to-mother support groups sessions, which promote linkages of pregnant mothers to health centers for antenatal care and delivery services. They keep track of the referrals made by using the referral cards shown in the picture below.

*Umulgargar* also played a part in the launch of the *Fredo* ("good woman") initiative, which promotes uptake of modern and traditional (standard days method) family planning methods. The uptake of modern family planning methods, specifically IUCD, Implanon and oral contraceptive pills has increased as a result. *Umulgargar* members are also engaged in notification of maternal and neonatal deaths that occurred in their community and also provide food and sanitary materials to mothers staying at the maternity home located in the health center premises. *Umulgargar* is supported by UNFPA in addition to Transform HDR. If these implementing partners pull out, interviewees expressed concerns that support for review meetings and associated transportation costs may be difficult to cover.

*decision making to have family planning minimized. Therefore, the inclusiveness approach of "have coffee" and mothers' conferences showed fruitful progress. –Gambella RHB*

The activity also supported women's groups such as pregnant women conferences and a traditional women-only community structures in the Somali region called *Umulgargar*, whose work was complemented by *Abulgargar* groups for men. These groups worked to engage influential community elders and religious leaders to discuss male dominance, GBV and early marriage.

One demonstration GBV center was established successfully in Afar Region. According to an Afar RHB respondent the Dubti Hospital One-Stop GBV center was successful in uniting various elements of the community to support GBV survivors:

*"...Through the support provided by Transform HDR, a one-stop center in Dubti Hospital was established and strengthened in response to effort to provide comprehensive services including medical treatment, law, and psycho-social counseling for sexual and gender-based violence survivors."*

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

At the start of the activity, a gender and socio-cultural assessment was conducted to identify gaps and what services were available. The assessment also identified what factors hinder or facilitate health service providers in the delivery of gender-based violence services. HDR developed several gender interventions to address selected service delivery gaps, which are at the demonstration stage. These interventions were implemented in selected woredas and some, such as the Mothers' Group, *Umulgargar*, and youth friendly services—according to KIs—demonstrated their effectiveness in selected woredas only. However, according to KIs, scaling of these interventions so they become an integral part of the MNCH/FP routine services had not started yet, and therefore, it is possible to demonstrate only limited measurable social change and results.

IPs discussed examples of how the T-HDR changed its activities to include the establishment of one-stop centers for GBV survivors. According to KIs, this intervention was not included in the initial plan but was added after conducting context analysis. The program also often amended its budgets according to the context and stakeholders' needs. These budget amendments and shifts were possible within activities under the RMNCH/FP umbrella. A program staffer in Afar described the Activity's flexibility under changing contexts as follows:

*"Since the Transform program is flexible, the program activities adapted to the changing context. First context analysis is done to ensure the continued relevance of the program activities and planned activities are amended on the basis of the results of the analysis. So, budgeting and spending is aligned within the amended program activities. For example, some of interventions (e.g., the one-stop center for GBV survivors) which were not included in the plan are added during the course of the implementation, and these interventions produced positive results."*

#### 5.4 HOW AND TO WHAT EXTENT HAVE THE TRANSFORM IPS BEEN ABLE TO ADAPT THEIR INTERVENTIONS ABOUT LEARNINGS AND NEW EVIDENCE?

This question was primarily raised with regional IP respondents, who noted that from their perspectives, the Activity was flexible and adaptive to address the changing needs of stakeholders and dynamic contexts. Regional managers appreciated the flexibility of the Activity and indicated that if there was a need and stakeholders requested support, the program amended its plan and acted accordingly. In this regard the program staff worked with national and local stakeholders to identify the changing needs and modify the program approach accordingly. Joint planning, joint supervision, and joint review meetings further helped the program to align its activities with government priorities.

To what extent did key informant respondents perceive that the project established processes are functional to track and address gender and inequitable health outcomes?

Gender related findings discussed Transform HDR had three RMNCH officers who were tasked to support all MNCH/FP activities. However, it was reported it had one SBCC and gender officer to support 10 woredas in the Benishangul Gumuz region during the first two years of

implementation. These respondents indicated that gender issues did not receive adequate support and that social communication requires more attention in future programming:

*"Decision making at the household level regarding reproductive and sexual health is made by males in our region, which is a huge challenge for us, to change this we organized discussions with community leaders and men. Both themes (gender and SBCC) are vast and how can they be managed by one person? As a result, it wasn't possible to reach all woredas."*

Despite the challenges, a woreda health office head midwife in the Somali region indicated some improvement in male engagement:

*"There is some improvement, they tried to engage men on SRH issues, the project helped mother to mother groups, and outreach services also targeted women beneficiaries, delivery service improvement, furnishing maternity waiting room, etc., are all good actions to make sure that women benefit from the intervention."*

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

KIs reported that the Activity used evidence from the mid-term evaluation to improve implementation approaches and introduce new activities. For instance, KIs mentioned that based on evidence from the mid-term evaluation, the Activity revisited its plan, identified good practices for scale up and facilitated sharing of experiences among facilities and woredas. Also informed by findings of the midterm evaluation, the Activity supported the implementation of DHIS2 in health facilities with the intention to improve the collection of quality data, and information use practices in the learning woredas. Moreover, the Activity gave feedback to health facilities to help them better address gaps identified during the midterm.

Strengthening woreda coordination mechanisms was also another activity that was implemented in using evidence. The findings of the midterm evaluation enabled design of the "ANC revitalization initiative" that repackaged relevant interventions and was implemented in the 20 learning woredas. Also, based on evidence generated from Transform MELA's high level monitoring and operational research conducted by Transform HDR, new traditional birth attendant structures were established, and existing structures were strengthened with the purpose of strengthening service linkage with health facilities, particularly disease surveillance systems. Gambela-based IP respondents pointed to the fact that evidence generated from evaluation, monitoring, and research output was helpful for revisiting and re-exercising the planning, to identify strengths and weaknesses, to observe good practices and scale up, to get input, to share experiences and to reduce resource wastage, and to replicate something good practices implemented in other areas. Afar respondents discussed how the use of evidence generated from Transform MELA's midterm evaluation, high-level monitoring (HLM) and from operation research gave them direction for improving quality service delivery. For instance, these key informants reported that the Activity helped to strengthen woreda coordination mechanisms by filling the gaps through training.

Moreover, Transform HDR made use of evidence it generated from the annual random follow-up visits conducted it inform interventions, activities and KPI targets. However, these visits did not reveal declines in performance for most of the indicators that would have helped in making timely adjustments to associated targets

How did respondents perceive innovative or best practices that contributed to MNCH/FP outcomes?

KIs were asked to mention innovative/best practices implemented by the T-HDR related to MNCH/FP outcomes. KIs discussed the provision of ultrasound machines to health centers; the provision of laboratory equipment, reagents, mini-blood banks, and neonatal intensive care units (NICU); and solar energy systems as key material contributions. KIs also pointed to facility linkages and experience sharing, joint planning exercises, LMG training, review meetings and supportive supervision, training for data quality improvement, and post-training follow-up and mentoring and coaching activities as key technical assistance contributions. In terms of gender-related activities, KIs mentioned advocacy to strengthen mothers' conferences and the use of community structures to decrease child marriage and GBV. In terms of coordinating with partners, some KIs found that partnership mechanisms contributed to avoiding duplication of efforts. A KI in the Somali region described the importance of material support:

*"The innovative good example is bringing ultrasound, V-scan, lab equipment, and solar (energy) systems as well as the data quality improvement component of the project. Most projects implemented in this region mostly lack this data quality component, T-HDR is very good at that, I worked in the area ten years, and I can prove that."*

A KI from Gambella described the importance of LMG, essential lab testing, and quality assurance:

*"The training offered by Transform HDR on leadership, management, and governance also enabled them to understand the role of leadership in the health system. Furthermore, support of the essential lab test mechanism and quality assurance in review form, mobile ultrasound: catchment-based service, and transfer of skills and knowledge, such as clinical mentorship and coaching, were best practices."*

A KI in Afar described the importance of partnership mechanisms, participatory annual planning, and post-training follow-up and mentorship in enhancing coordination and skills:

*"The partnership mechanism is an important platform to avoid duplication of efforts. Participatory detailed annual plan exercises are key to addressing the needs of the region. Post training follow up and mentoring are effective tools in enhancing the skills and knowledge of health workers. Using the existing structure (religious and clan leaders) is effective in overcoming (the) GBV issue."*

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

Most KIs, when asked to give recommendations for future programming, focused on sustaining what they perceived as the most effective interventions. Most KIs suggested that best practices need to be strengthened and scaled up in future programming. KI recommendations included the following:

- Mentorship and coaching activities should be sustained in the future as these activities are effective in improving service quality.
- The number of experts was insufficient in certain technical areas, especially for gender. The number of personnel should more appropriately match the scope of required work for future activities.

- Holistic approaches are required to address development challenges in the developing regions: agriculture, schools, and health facility infrastructure; that is, roads, water, electricity, internet access, etc.
- Adequate consultation with local stakeholders (religious leaders, traditional leaders, etc.) is key during the design of future programs. For example, the problem of FP use in pastoralist regions could not be addressed by interventions that work in other areas, but potential effective approaches are understood by local stakeholders.
- The HDR activity was planned, managed, and led from Addis Ababa, which is not advisable for the future. Planning and management control should be more decentralized. This might contribute to greater flexibility and responsiveness to emerging local needs.
- More emphasis should be given to sustainability at the outset. For example, Transform HDR expects the government to allocate resources for maintaining activity-provided equipment, but some local facilities indicated that they do not have budgeted resources for maintaining ultrasounds and solar energy systems when activity funding ends.
- Woreda health offices are critical to implementation and should be fully engaged in implementing program activities in the future, so interventions are part of their work plans and budgets to build sustainability from the start.
- The Activity's primary focus has been on training, but a greater supply of equipment, materials, and health facility infrastructure (NICU, mini blood banks, waiting homes, etc.) would be highly appreciated by health facilities in the future.
- Training alone does not bring change, but follow-up, coaching, and monitoring are crucial for better performance. Therefore, all these activities should be sustained and made part of the routine activities in every woreda's workplan and budget.
- Community dialogue is effective and community dialogue structures such as mother's groups should be sustained.
- Involving community leaders in the implementation of MNCH/FP promotes sustainability. Use of the community score card is an effective approach for improving health seeking behavior and community utilization of public health services.

According to KIs in the Somali region, because there are limited numbers of other implementing partners there, complementary multi-sectoral programs are key to meeting different critical needs of the community. KIs viewed Transform HDR as an important opportunity to improve the health system, but in that region, they indicated that a more holistic approach which integrates elements of health, education, agriculture, and access to water is preferable. KIs indicated that some health facilities lack WASH infrastructure, for instance, making it more difficult to achieve health goals than it would be otherwise. Somali RHB respondents also felt that the activity structure was not appropriate given the scale and scope of needs in the region. According to a Somali RHB respondent:

*"The program was planned, managed, and led from Addis Ababa, which is not advisable for the future. We have other partners, to whom we give office space here at the RHB, they sit and work with us, and we can equally talk about their work and consider it as it is our own. Transform HDR rather rented its own office, has the vehicles going in their own direction, and resources are wasted here. Rather than putting one seconded staff at RHB, and putting many staff in their office, they*

*could come here with a lower number of staff and cost as we can work effectively together. Having seconded staff of course is very good but having a full team here would help more."*

## 6) CONCLUSIONS

Performance on almost all MNCH/FP KPIs in Transform HDR intervention areas declined by the endline, despite progress at the midterm. For almost three quarters of the KPIs, performance at the endline descended below the respective baseline values. These performance declines are likely attributable to the recurrent security problems, primarily in Afar and Benishangul Gumuz; the protracted drought in Somali, flooding in Afar and the massive internal displacement that followed these shocks. In addition, disease outbreaks (the COVID-19 pandemic, measles, cholera) shadowed the period after the midterm evaluation and substantially affected the supply and demand side of the services. However, for most of the outcome indicators, Transform HDR intervention areas had better performance at the endline compared to the non-Transform intervention areas, which were generally higher at the baseline. This would indicate that the Transform HDR Activity contributed to preventing deterioration in most MNCH/FP outcome measures.

KIs and the IP had the general perspective that the Transform HDR activity made important contributions to improving the access to and quality of MNCH and FP services. However, many of the outcome data cited in this endline study do not support the view of improved outcomes, and indeed, the continuity of MNCH/FP services (e.g., ANC1 to ANC4+ dropout) remains a challenge.

### Family Planning Outcomes

The Activity faced strong headwinds in terms of FP, and its strategies were not adequate to break the deeply entrenched attitudes about FP in some cultures in which the Activity operated. The evaluation found that effectiveness in improving FP coverage was mixed. FP KPI performance (MCPR and PFPF) declined, whereas LAFP use remained unchanged. The decline in MCPR appears to have resulted from a decrease in the use of short-acting methods, largely because of weak performance of health posts and stockouts of commodities.

### Newborn, immunization, and Child Health Outcomes

KIs noted that maternal, neonatal, and child mortalities have declined over the period of the program implementation. Indeed, this evaluation confirmed that Transform HDR did contribute to improvement in several newborn, immunization, and child health KPIs, including:

- Essential newborn care and early initiation of breastfeeding
- Measles coverage
- Vitamin A supplementation
- ARI and diarrhea treatment

Measles vaccination increased due to campaigns. However, full vaccination and Penta 3 coverage remained low.

IFA intake showed a steady decline from baseline to endline. There was also variation in performance among regions as measured by KPIs. The decline in KPIs at endline is more pronounced in Somali followed by Gambella, where community health services were weak.

### Sustainability

Transform HDR capacity building interventions, integrated systemic interventions and efforts made to engage experts at different levels of the health system in the planning, capacity building, and monitoring activities is believed to have enabled the sustainability of MNCH/FP services and results achieved. However, the impact of recent shocks show that future interventions need to be designed within existing social and community structures so they can work during and despite these shocks.

The program's capacity building and quality improvement activities, community sensitization activities, and the introduction of portable ultrasound equipment were responsible for the observed positive changes. Specifically, some potentially sustainable activities that contributed to improved MNCH/FP service access and quality include:

- Establishment and functioning of maternal waiting homes and training on respectful and compassionate care and BEmONC seemed to improve care quality.
- Implementation of CEmONC and MPDSR to reduce maternal and neonatal mortality.
- Quality improvement initiatives, clinical mentoring and coaching, and clinical skill-labs established by the program were recognized by KIs as effective interventions that improved maternal health service quality.
- Distribution of safe birth checklists
- Community level awareness activities, such as engaging traditional community structures (elders, religious and clan leaders) and pregnant women conferences appear to increase health seeking behavior and skilled delivery coverage.
- Introduction of ultrasound equipment to health centers appears to increase ANC attendance and continuum of care.
- Achievement of greater equity through outreach mobile clinic service to address marginalized communities in hard-to reach areas.

However, the recurrent conflict in some areas, staff turnover, lack of ownership at some levels of the health system, and the nature of certain activities requiring more investment were reported to potentially undermine the sustainability of some interventions and results achieved.

### Gender

In terms of gender related activities, the evaluation found that advocacy to strengthen mothers' conferences and the use of community structures to decrease child marriage and GBV were important interventions from the perspective of KIs. Post-GBV service availability increased in health facilities supported by Transform HDR. Transform HDR also considered gender in activities such as conducting training on the issue of gender streamlining and integrating gender in SBCC activities. The Activity increased women's leadership through its leadership training and training of female school teachers on gender issues and the establishment of gender clubs in schools. The activity also supported local women's groups through activities such as pregnant women

conferences and women-only community structures and worked with influential community elders and religious leaders to discuss male dominance, GBV, and early marriage. One demonstration GBV center was established successfully in Afar Region. According to an Afar RHB respondent the Dubti Hospital One-Stop GBV Center was successful in uniting various elements of the community to support GBV survivors. Despite these achievements, respondents indicated that much more effort is needed to fully engage women in decisions relating to maternal, child, and neonatal health-seeking behavior and family planning.

### Adaptation and Learning

There were good practices in the use of evidence generated from Transform HDR led studies/assessments and those that were conducted by Transform MELA, to inform activity planning, design of new initiatives and implementation. Joint planning, joint supervision and joint review meetings further helped the program to align its activities with government priorities. Through such use of evidence and adaptive planning, for example, the Activity actively supported initiatives such as the Afar One-Stop Center for GBV survivors. In terms of community-based communications efforts, the Activity initially faced challenges in tailoring messaging designed for agrarian regions to pastoralist regions. Traditional cultures and practices in the pastoralists regions also made it difficult for messaging and promotion of behavioral change on MNCH/FP issues to have the desired level of impact.

## 7) RECOMMENDATIONS

### Activity-Level Recommendation

As the Transform HDR is slated to close in early 2023, it will be essential for the activity to consolidate the improvements made and plan and implement a smooth transfer and handover of lessons, tools, and know-how to RHB, zonal, and woreda counterparts, and, as applicable, to successor programs. Therefore, it is recommended that an overlap of the existing activity with the new one be facilitated to ensure the regions, zones, and supported woredas integrate previous and new interventions into their next year's work plans and budgets and thus sustain the previous investment.

### Recommendations for MOH

- Reinforce coordination of development partners to effectively implement HSTP II. HSTP II set goals for woreda transformation in the context of multisectoral development and a set of targets. It is essential that MOH, USAID, and other development actors work together to demonstrate an effective model that can be implemented in a pre-determined number of models woredas in each of the developing regions.
- Continue support for quality improvement initiatives: Transform HDR supported a range of quality improvement activities. However, there are still considerable gaps in the quality of MNCH/FP interventions along the continuum of care. This is demonstrated by low coverage of essential components of ANC, a high ANC 1 to ANC 4 dropout rate, and unavailability of essential supplies. MOH, with support from development partners, should take the lead in implementation of measurable quality improvement activities in a pre-determined

number of woredas that can serve as learning sites. Quality improvement should be institutionalized as a continuous process and show measurable progress in the quality of care at all levels. Implementation of quality improvement activities should be rigorously monitored and evaluated, and course correction actions should be undertaken in a timely fashion.

- Improve use of monitoring data for decision making at health facilities. Evaluation findings demonstrated that most facilities are not processing and using the monitoring data they have collected related to health facility performance to inform decisions for improving performance. MOH and partners should provide technical support for use of data for decision-making through regular post-training follow-up.
- Strengthen and standardize mobile health service delivery to expand access to MNCH/FP services for pastoralist communities: Future GOE and donor budget support to pastoralist regions should prioritize mobile health approaches to reach underserved communities. Mobile health service approaches should be considered as a key service delivery mechanism. Developing a well-functioning mobile health system will require adequate human, logistical and financial resources, coupled with a strong monitoring system and the attention of health system leadership at different levels. A mobile health system is particularly important for services that require repeated visits (e.g., immunizations and antenatal care) and are designed to reduce discontinuation rates.
- Implement mobile services policy and guidelines for developing regions. The lack of a standardized federal mobile services policies and guidelines has led to variation across partners which poses a challenge to institutionalizing mobile health approaches. Some partners provide certain services and not others; some provide incentives, and some do not; and per diems vary in ways that creates disincentives for health workers. As a result, there is a need for standardization of approaches across the GOE. Mobile health program standardization, particularly in Afar and Somali regions, is required to ensure the institutionalization and sustainability of access to key MNCH services to hard-to-reach pastoralist populations.
- Implement innovative health approaches when designing programs to pastoralist communities. Services to pastoralist communities should be designed in coordination with livestock health outreach programs that consider not only human health but also livestock health, which is highly valued by pastoralist communities.
- Assign more female providers, especially for childbirth services: The lack of female providers was reported to be a barrier to improving MNCH intervention coverage. Regional health bureaus should give priority to female applicants for enrollment and encourage donors to provide scholarships in midwifery training programs.
- Integrate FP counseling across all contacts in the continuum of care: Contraceptive use is low in developing regions. Counseling for postpartum family planning was also rare and has not been integrated into programming. There is need for standard integrated FP guidelines and service delivery checklists to ensure that every woman and man that comes

to a facility gets counseled. Therefore, integrating family planning counseling during all contacts in the continuum of care (ANC, childbirth, postnatal care, immunization) should be demonstrated and achieved in the follow-on project.

- Ensure availability of family planning services at health posts: Family planning is one of the packages of the health extension program in Ethiopia. Nonetheless, this evaluation found that more than half of surveyed health posts did not provide family planning services. MOH/RHB-supported activities programs should ensure full availability of family planning services in all health posts and work with partners to ensure sustainable “last mile” distribution of FP commodities and to help mitigate for distance and transport related problems.
- Develop a national HR database and keep track of participation in continuous education programs funded by donors, and support context specific MNCH/FP health workforce and leadership development and retention strategies. High turnover of trained personnel and leaders at woreda health offices and regional health bureaus was one of the key challenges to improving service delivery. The evaluation found that some health workers attended the same training multiple times in part because there is no database that would allow RHBs to track who has been trained and to plan accordingly. High turnover of trained personnel and leaders at woreda health offices and regional health bureaus was one of the key challenges to improving service delivery. This problem is particularly acute in developing regions. Therefore, MOH should develop minimum retention standards for health workers and health system leaders. In conjunction with implementation of a national training database and staff development, this will better allow MOH and foreign assistance providers to efficiently address capacity gaps and reduce duplication of effort.

## Recommendations for USAID

To ensure careful planning and execution that meets desired targets for future interventions, several key tasks will be required at the outset, such as a careful mapping of tailored strategies for pastoralist regions, and, with guidance and collaboration from regional structures, support for strengthening and expanding mobile outreach to pastoralist communities. In addition, it will be important to support community structures or groups in developing community-based strategies and service delivery programs. In tandem with SBCC activities, it will be important for future activities to build on and continue strengthening male engagement in family planning and assist MOH through RHBs and ZHB to ensure the availability of family planning services and commodities in remote areas. As part of baseline and continuing research, ethnographic studies of pastoralist communities are recommended.

- The design of future activities should be performance-based and include a revised target setting assumptions and monitoring methodology. Targets against performance should be monitored periodically by a third party for course correction and adjustment of targets. Most Transform HDR Life of Activity targets were not satisfactorily achieved, which should have been detected and corrected sooner through periodic outcome monitoring and timely adjustment. This may have increased the likelihood of achieving targets.

- The design of future activities should continue have a plan to mitigate potential crisis/shocks in the developing regions. Given the increased vulnerability of the developing regions to natural or manmade crisis/shocks, USAID should strengthen it crisis modifier funding mechanism to support timely response to potential crisis and protect development results obtained because of USAID’s investment in health programming.
- The design of future activities should consider selection of intervention sites that have a mix of performance levels – high, moderate, and low. This will facilitate cross learning through instituting twinning partnerships for improvement and using high performers as demonstration sites.
- The design of future activities should employ performance-based support that can also be complemented with allocation of a matching fund from government. This approach will better ensure continuity of interventions and results achieved.
- Develop and implement context specific MNCH/FP intervention strategies for each of the developing regions: Developing regions are contextually different and require different strategies and performance targets. For example, the context in Benishangul-Gumuz and Gambella is different from the context in Somali and Afar, which, because of the predominance of pastoralist societies, should be a priority for future programming. Future programs should be designed in line with the context in each region and have measurable targets e.g., number of woredas that will be able to provide quality MNCH/FP services in all their facilities and implement regular outreach and mobile services.
- Develop and implement innovative, tailored and context appropriate facility and community based SBCC approaches for sustained behavioral change in MNCH/FP practices. Despite some progress, coverage for key MNCH/FP indicators in Transform HDR regions is low and has declined in the last two years. As examples, many women noted that they did not visit health facilities during pregnancy and childbirth because of the belief that these services are not needed unless some disorder is observed. Similarly, MCPR is low. Therefore, context specific SBCC approaches should be further designed and implemented to help change such perceptions and promote demand for facility and community based MNCH/FP services. Moreover, traditional community structures should be further strengthened, institutionalized, and expanded to promote MNCH/FP-related behavioral changes. The use of successful approaches, such as *Umulgargar* (women’s groups), are effective in mobilizing communities, but the current reach of these initiatives is limited. Replicating such structures may accelerate MNCH/FP coverage.
- Strengthen male engagement in adolescent and youth services and in family planning: Many women in developing regions reported that they are not currently using modern contraceptives because of partner refusal. Such challenges may be mitigated by increasing male involvement in awareness raising, FP counseling, and other MNCH service provision.
- Develop an operational research agenda to identify causes of service bottlenecks and explore the underlying factors contributing to the decline in performance of selected KPIs. Determining the root causes for the decline in performance for selected KPI requires further

research. For example, few health posts in Transform HDR intervention areas provided modern family planning methods and although there were declines in the reported essential components of ANC, essential newborn care and early initiation of breastfeeding indicators improved. Also, the number of facilities that have IFA and can provide lab tests and vaccines but are not providing them to clients is not known. In some instances, regional discrepancies have been exacerbated, with Somali performing lower on several indicators compared to other developing regions. The outcome of operational research on these and other subjects could inform future design and programming and contribute to the design of more effective and efficient SOPs to improve operational productivity and coverage of supported health facilities and woredas.

- Support ethnographic health research focused on pastoralist lifestyles for activity planning. Future activities should determine the best ways to reach pastoralists. Ethnographic research that provides more understanding of pastoralist lifestyles, belief systems and their relation to their livestock can help inform programming that better fits with sociocultural dynamics.
- Establish institutionalized mechanisms for field-level sharing of information between primary health interventions and interventions targeting pastoralist regions and communities. USAID cooperative agreements with successor primary health interventions in developing regions should include specific clauses for formal mentoring and capacity development. As one example, USAID primary health care implementing partners possess a wealth of experience in operations and implementation research, SBCC, and technical support for training and quality improvement. Future programming should formally leverage this capacity to ensure that lessons learned over the past decades in agrarian regions can be successfully adapted to developing regions.
- Future MNCH/FP investment in developing regions should anchor capacity-building and SBCC to primary health care institutions. Technical assistance for quality improvement initiatives should be anchored to health facility level interventions. Health facilities can serve as demonstration centers for replicating best practices, accountability, and generation of valid and reliable data on outcomes, as well as serve as a nexus for community-based health interventions and social and behavior change communication for their respective catchment populations.
- Future USAID investments should integrate essential health systems strengthening (HSS) interventions in developing regions. Transform HDR had most components of HSS embedded in its scope, but resources and coordination with other USAID/Ethiopia HSS mechanisms was limited. Greater integration of these essential health systems strengthening approaches should begin with intentional geographic convergence with other key HSS mechanisms in developing regions to ensure complementarity. Starting from planning through execution phases, designs for community and health facility level interventions should integrate human resource development, health financing and health insurance, supply chain management (last-mile delivery), and health information systems.

## ANNEX 1: EVALUATION QUESTIONS AND DATA SOURCES

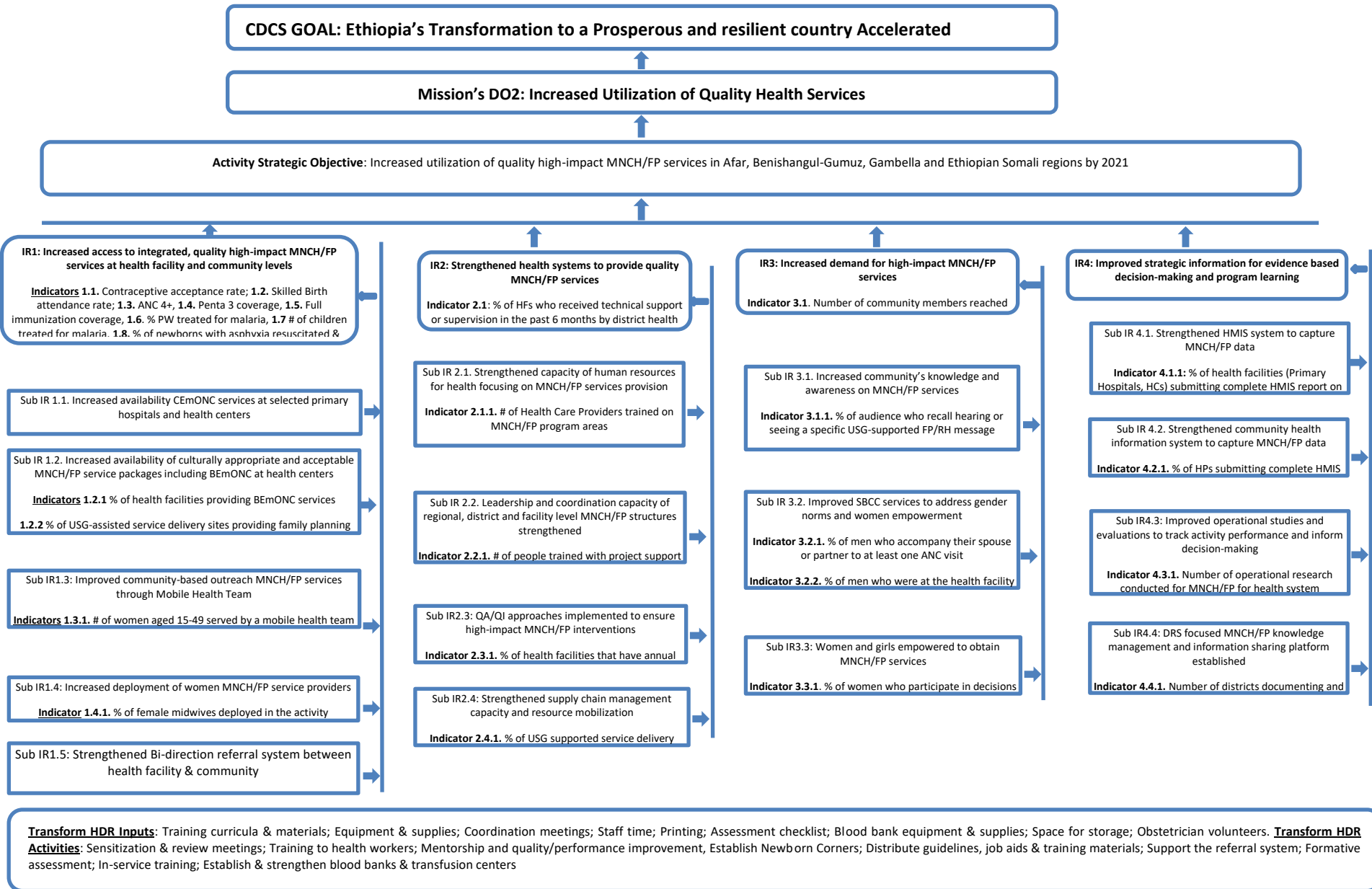
Key Evaluation Questions	Specific and Probing Questions	Design	Data Source
1. How effective were the Transform Program Activities' approaches in contributing to improving MNCH/FP outcomes?	<p>1.1. Were Transform activities implemented as planned? If not, why not?</p> <p>1.2. To what extent did the Transform improve MNCH/FP outcomes and reduce outcome inequities in different groups in intervention areas compared to control areas?<sup>8</sup></p> <ul style="list-style-type: none"> <li>● To what extent did activities achieve their targets?</li> <li>● Which targets were met or exceeded?</li> <li>● Which targets were not met?</li> </ul> <p>1.3. How effective are the Transform Activities strategies and approaches?</p> <p>1.4. In your opinion which of the Transform Activity interventions are replicable or can be scaled up/applied to a different setting?</p> <p>1.5. What is the effect of context (Conflict, Covid 19 pandemic, internal displacement) on Transform Activity interventions and achievement of intended results?</p>	Mixed methods	<p>- HH respondents</p> <p>- HF respondents and observation</p> <p>- KIs from USAID, MOH, IPs, RHBs</p> <p>- Transform IP reports and documents from MOH</p>
2. How did Transform Program Activities facilitate local ownership, sustainability, and coherence?	<p>2.1. What mechanisms are in place to ensure government ownership of Transform health system interventions?</p> <p>2.2. To what extent did government staff/community perceive that the approaches established by the project will be maintained by the government and continue to sustain MNCH/FP improvements in the next 3 and 5 years?</p> <p>2.3. To what extent did the project improve community involvement and its role in accountability, transparency in decision-making, and advocacy for community health needs?</p>	Qualitative	<p>- KIs from USAID, MOH, IPs, RHBs</p> <p>- Transform IP reports and documents from MOH</p>

<sup>8</sup> Note: We intend to measure inequities in terms of geographic variations among regions, residential locations (urban/rural), age, educational status, and others.

Key Evaluation Questions	Specific and Probing Questions	Design	Data Source
	<p>2.4. To what extent did the project improve community engagement for advocacy and health service oversight?</p> <ul style="list-style-type: none"> <li>• What capacity for community engagement did Transform build?</li> </ul> <p>2.5. How do Transform Activities coordinate with other development partners and their activities?</p>		
3. How did Transform Activities consider Gender dynamics in activity implementations?	<p>3.1. To what extent did the government staff/people perceive that the project established processes are functional to track and address gender and inequitable health outcomes?</p> <ul style="list-style-type: none"> <li>• Provide examples to substantiate perceptions.</li> </ul> <p>3.2. What gender equity results did Transform Program Activities' interventions achieve?</p> <p>3.3. What gaps exist in the current USAID/Transform intervention design/programming in terms of addressing the key gender issues in the targeted regions of Ethiopia?</p>	Qualitative	<p>- KIs from USAID, MOH, IPs, RHBs</p> <p>- Transform IP reports and documents from MOH</p>
4. How and to what extent have the Transform IPs been able to adapt implementation approaches based on learnings and new evidence?	<p>4.1. To what extent did the project make adaptive changes?</p> <ul style="list-style-type: none"> <li>• Based on what evidence? (e.g., responses to Transform midterm recommendations and IP-led studies)</li> </ul> <p>4.2. How did respondents perceive that these adaptations contributed to MNCH/FP outcomes?</p> <p>4.3. What lessons were learned for project future design, management, and monitoring?</p>	Qualitative	<p>- KIs from IPs,</p> <p>- Transform IP reports</p>
5. To what extent did the Transform program improve MNCH/FP outcomes	5.1. To what extent did the Transform program ensure improvement in MNCH/FP outcomes?		<p>- HH respondents</p> <p>- HF respondents and observation</p>

Key Evaluation Questions	Specific and Probing Questions	Design	Data Source
<p>in Transform intervention wordas compared to non-Transform intervention wordas?</p>	<p>5.2. Are there any unintended results (positive or negative) specific to Transform program interventions?</p>		<ul style="list-style-type: none"> <li>- KIs from USAID, MOH, IPs, RHBs</li>   <li>- Transform IP reports and documents from MOH</li> </ul>

## ANNEX 2: TRANSFORM HDR ACTIVITY RESULT FRAMEWORK



## ANNEX 3: GLOSSARY

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

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

## ANNEX 4: TRANSFORM HDR INTERVENTION ACHIEVEMENT AT ENDLINE COMPARED TO TARGETS

No.	Key performance indicators	LOA target <sup>9</sup>	Endline value
Family planning			
1.	Modern method contraceptive prevalence rate among currently married women	23.6	8.8
Maternal and newborn health			
2.	Percentage of women who had at least 4 ANC visits pregnancy (for the last birth over the last 12 months prior to the survey)	28.8	15.4
3.	Percentage of deliveries attended by a skilled birth attendant such as Doctor, Nurse, or Midwife (for the last birth over the last 12 months prior to the survey)	39.3	23.8
4.	Percentage of women who received Iron folate supplements for at least 6 months during pregnancy of their last birth over the last 12 months prior to the survey	51.1 <sup>10</sup>	0
	Percentage of women who received Iron folate supplements for at least 3 months during pregnancy of their last birth over the last 12 months prior to the survey	-	6.7
5.	Percentage of women who received postnatal care at least once within two days of childbirth (for the last birth over the last 12 months prior to the survey)	NA	20.1
6.	Percentage of newborns who received postnatal care within two days after birth (for the last birth over the last 12 months prior to the survey)	43.6	19.6
Child health			
7.	Percentage of children aged 12-23 months who received DPT3/Penta3 vaccine by 12 months of age	50.5	13.8
	Percentage of children aged 12-23 months who received DPT3/Penta3 vaccine at any time before the survey	-	15.7
8.	Percentage of children aged 12-23 months who received their first dose of measles-containing vaccine (MCV1) by 12 months of age	NA <sup>11</sup>	30.0
	Percentage of children 12 to 23 months of age who received their first dose of measles-containing vaccine (MCV1) at any time before the survey	-	36.4
9.	Percentage of children aged 12-23 months who are fully immunized at the age of one year	37.0	11.3
	Percentage of children aged 12-23 months who are fully immunized at any time before the survey	-	12.3
10.	Children under 5 who had a fever in the past two weeks for whom advice/treatment was sought within 24 hours of the onset of fever	83.2	22.9
11.	Percentage of under-five children with ARI who received antibiotics (in the last two weeks prior to the survey)	83.6	34.9

<sup>9</sup> Source for Life of Activity targets: Transform HDR FY 2022 work plan.

<sup>10</sup> Target set for 2022 was taken. Source is Transform HDR Source MEL plan revised October 2021

<sup>11</sup> Target set in count/number not percentage

No.	Key performance indicators	LOA target <sup>9</sup>	Endline value
12.	Percentage of under-five children with diarrhea received ORT & Zinc (in the last two weeks prior to the survey)	36.8	33.9
13.	Percentage of children aged 6-59 months who received Vitamin A supplementation in the last six months prior to the survey	36.5	42.3

## ANNEX 5: LIST OF PERSONS INTERVIEWED

1. USAID/Ethiopia Transform HDR Activity Agreement Officer's Representatives
2. MOH, health systems strengthening and special support director
3. Transform HDR chief of party and management team
4. Amref Health Africa Afar regional office, regional manager
5. Amref Health Africa Benishangul Gumuz regional office, regional manager
6. Amref Health Africa Benishangul Gumuz regional office, M&E officer
7. Amref Health Africa Gambella regional office, regional manager and RMNCH officer
8. Amref Health Africa Somali regional office, regional manager
9. Afar RHB M&E coordinator
10. Benishangul Gumuz RHB EPI officer
11. Gambella RHB MCH director
12. Gambella RHB MCH officer
13. Somali RHB Planning, resource mobilization and NGO coordination director
14. Assaita WoHO MCH coordinator (non-Transform HDR intervention woreda in Afar)
15. Telalak WorHO head (Transform HDR intervention woreda in Afar)
16. Telalak WorHO EPI coordinator (Transform HDR intervention woreda in Afar)
17. Assosa WoHO MCH coordinator (Transform HDR intervention woreda)
18. Itang WorHO MCH director
19. Itang WorHO MCH case team leader
20. Babile WorHO head (Transform HDR intervention woreda in Somali)
21. Babile WorHO, Albahr HC MCH focal (Transform HDR intervention woreda in Somali)
22. Arores WorHO deputy head (non-Transform intervention woreda in Somali)

## ANNEX 6: BIBLIOGRAPHY OF DOCUMENTS REVIEWED

1. Transform HDR annual progress reports
2. CEmONC assessment report
3. Afar and Somali Region: GPS Mobility Mapping
4. 2021 and 2022 Transform HDR annual workplans and MEL plans
5. Assessment of gender and other sociocultural barriers to RMNCH service utilization in Afar, Benishangul-Gumuz, Gambella, and Somali Regional States of Ethiopia (2019)
6. Quality RMNCH service assessment in Developing regions of Ethiopia (2019)
7. Health care quality improvement assessment in four developing regions of Ethiopia (2018)
8. Reduction of neonatal death through quality improvement intervention in Dubti general hospital of Afar region (2018)
9. Quality of Antenatal Care (ANC) through improving the essential laboratory services for ANC in Developing Regional States (DRS), Ethiopia
10. Amref Health Africa's Response to Equity: Transform Health in Developing Regions (T-HDR), Ethiopia
11. Mid-term performance evaluation of USAID Transform HDR Activity.
12. Transform Midline Evaluation Report 2020
13. Health Sector Transformation Plan (HSTP) II 2020/21-2024/25
14. Ethiopia Mini Demographic and Health Survey 2019
15. Ethiopia National Health Accounts Report 2019/20
16. Essential Health Services Package of Ethiopia