“I teach from experience. I know the hardships of raising many children…my husband now sees the benefits of what I started 8 years ago, even though he wasn’t convinced of it then.” Marketplace FP/RH Agent Yeshi Alem, Kemissie village, member of (prevention of) early marriage committee, Woreda Advisory Committee, and Women’s Association member.
# TABLE OF CONTENTS

Acknowledgements .................................................................................................................. 3  
Acronyms ................................................................................................................................. 4  
Executive Summary .................................................................................................................. 6  
INTRODUCTION ....................................................................................................................... 11  
THE DOCUMENTATION PROCESS ......................................................................................... 14  
LESSONS-LEARNED DURING DOCUMENTATION PROCESS .................................................. 15  
DOCUMENTED PRACTICES ....................................................................................................... 18  
  Community-based Reproductive Health Agents Reaching Un-Served Rural Women with Family Planning Services ................................................................................... 19  
  Capacity-building to Increase Access to Quality Long-term and Permanent Family Planning Methods for Persons Living in Under-Served Areas in Ethiopia .................................................. 27  
  Service-Based Training for Long-Term Family Planning Methods ........................................ 27  
  Community Youth Centers Promoting Healthy Sexual Behavior ............................................ 33  
  Youth-Friendly Reproductive Health Services ........................................................................ 43  
  Integrated HIV/AIDS and Reproductive Health Services for Youth ....................................... 46  
  Mobilizing Communities to Eradicate the Practice of Early Marriage .................................... 53  
  Community Mobilization to End Female Genital Mutilation and Other Harmful Traditional Practices ................................................................................................................................. 62  
  Obstetricians/Gynecologists Advocating for Sexual and Reproductive Health Rights in Ethiopia ............................................................................................................................................. 67  
  Accelerated uptake of the practice for active management of third stage of labor (AMSTL) .................................................................................................................................................. 70  
  Making Pregnancy Safer (MPS) ................................................................................................. 72  
  Save the Mother Initiative ......................................................................................................... 81  
  Early Identification and Referral of Pregnancy-Related Emergencies ...................................... 84  
  Decentralized On-the-Job Training for Integrated PMTCT Service Providers ......................... 93  
  Comprehensive Care for Rape Victims .................................................................................... 99  
  Increasing Access to Comprehensive Post-Abortion Care ....................................................... 102  
PRACTICES TO DOCUMENT ................................................................................................... 106  
DISCUSSION ............................................................................................................................... 114  
RECOMMENDATIONS ............................................................................................................. 125  
CONCLUSION ............................................................................................................................ 126  
REFERENCES ............................................................................................................................ 128  
ANNEX I. List of Agencies and Organizations Interviewed ......................................................... 129  
ANNEX II. List of Initial Draft Documents .................................................................................. 131  
ANNEX III. Interview Guide to Gather Information about Potential Best RH Practices ............... 132  
ANNEX IV. Interview Guide to Gather Information about Practices That Make Programs Work .................................................................................................................. 133
Acknowledgements

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Implementing Best Practices Initiative, Ethiopia
May, 2006
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ACNM</td>
<td>American College of Nurse Midwives</td>
</tr>
<tr>
<td>ACQUIRE</td>
<td>Access, Quality and Use in Reproductive Health</td>
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<tr>
<td>ADA</td>
<td>Amhara Development Association</td>
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<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<tr>
<td>AMTSL</td>
<td>Active Management of Third Stage Labor</td>
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<tr>
<td>ANC</td>
<td>Ante-Natal Care</td>
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<tr>
<td>ARSH</td>
<td>Adolescent, reproductive and sexual health</td>
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<tr>
<td>AWA</td>
<td>Amhara Women's Association</td>
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<tr>
<td>BCC</td>
<td>Behavior Change Communications</td>
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<tr>
<td>CBO</td>
<td>Community Based Organization</td>
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<td>CBRHA</td>
<td>Community-based reproductive health agents</td>
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<td>COPE</td>
<td>Client-Oriented-Provider-Efficient</td>
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<td>CORHA</td>
<td>Consortium of Reproductive Health Organizations</td>
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<td>CPR</td>
<td>Contraceptive Prevalence Rate</td>
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<tr>
<td>CSW</td>
<td>Commercial Sex Workers</td>
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<td>CYP</td>
<td>Couple Years Protection</td>
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<td>DHS</td>
<td>Demographic and Health Survey</td>
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<td>DSW</td>
<td>German Foundation for World Population</td>
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<td>ECLS</td>
<td>Ethiopian Contraceptive Logistics System</td>
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<tr>
<td>EGLDAM</td>
<td>Ethiopia Goji Limadawi Dirgtoch Aswogaj Mahiber (formerly the National Committee on Harmful Traditional practices)</td>
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<tr>
<td>EmOC</td>
<td>Emergency Obstetric Care</td>
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<td>ENMA</td>
<td>Ethiopian Nurse Midwives Association</td>
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<td>EPHTI</td>
<td>Ethiopia Public Health Training Initiative</td>
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<td>EPS</td>
<td>Ethiopian Pediatric Society</td>
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<td>EWLA</td>
<td>Ethiopian Women Lawyers Association</td>
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<td>ESHE</td>
<td>Essential Services for Health in Ethiopia</td>
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<td>ESOG</td>
<td>Ethiopian Society of Obstetricians and Gynecologist</td>
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<td>EU</td>
<td>European Union</td>
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<td>FEMME</td>
<td>Foundations to Enhance Management of Maternal Emergencies</td>
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<td>FGM</td>
<td>Female Genital Mutilation</td>
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<td>FHD</td>
<td>Family Health Department</td>
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<td>FGAE</td>
<td>Family Guidance Association-Ethiopia</td>
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<td>FGM</td>
<td>Female Genital Mutilation</td>
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<tr>
<td>FIGO</td>
<td>International Federation of Obstetrics and Gynecology</td>
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<td>FMOH</td>
<td>Federal Ministry of Health</td>
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<tr>
<td>FP</td>
<td>Family Planning</td>
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<tr>
<td>HBLSS</td>
<td>Home Based Life Saving Skills</td>
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<td>HF</td>
<td>Health Facility</td>
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<td>HSDP</td>
<td>Health Sector Development Program</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HMIS</td>
<td>Health Management Information Systems</td>
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<td>HTP</td>
<td>Harmful Traditional Practice</td>
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<tr>
<td>IBP</td>
<td>Implementing Best Practices</td>
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IEC  Information, Education, Communication
IGA  Income-generating activities
IMPAC  Integrated Management of Pregnancy and Childbirth
INSYGHT  Initiative to Save Young Generation's Health Today
IP  Infection Prevention
IU[C]D  Intra-Uterine (Contraceptive) Device
KAPB  Knowledge, Attitude, Practice and Behavior
KMC  Kangaroo Mother Care
KMG  Kembatti Mentii Gezzima
LAM  Lactational Amenorrhea Method
LR  Logistics Report
LTPM  Long Term and Permanent Methods
MCH  Maternal Child Health
MDA  Maternal Death Audits
ML/LA  Mini-Laparotomy with local anesthesia
MOH  Ministry of Health
MPS  Making Pregnancy Safer
MSI  Marie Stopes International
MVA  Manual Vacuum Aspiration
NCTPE  Committee on Harmful Traditional Practices in Ethiopia
NFSS  National Family and Fertility Survey
NGO  Non-governmental organization
OB/GYNs  Obstetricians and Gynecologists
OTJ  On-the-job
PAC  Post-Abortion Care
PDQ  Partnership Defined Quality
PI-E  Pathfinder International- Ethiopia
PLWHA  Persons living with HIV/AIDS
PMTCT  Prevention of Mother to Child Transmission
PSP  Peer Service Providers
PVO  Private Voluntary Organization
QI  Quality Improvement
RH  Reproductive Health
SIDA  Swedish International Development Co-operation Agency
SNNPR  Southern Nations, Nationalities and Peoples Region
SRH  Sexual and Reproductive Health
STI  Sexually Transmitted Infections
TFR  Total Fertility Rate
TT  Tetanus Toxoid
TTBA  Trained Traditional Birth Attendant
UN  United Nations
UNFPA  United Nations Population Fund
UNICEF  United Nations Children's Fund
USAID  United States Agency for International Development
VCT  Voluntary Counseling and Testing
VSC  Voluntary Surgical Contraception
WAC  Warda Advisory Committee
WHO  World Health Organization
Executive Summary

Brief Description of Documentation Process:

In June 2004, the Implementing Best Practices Initiative (IBP) which promotes and aims to expand use of evidence-based Reproductive Health (RH) practices, was launched in Uganda to “improve access to and quality of reproductive healthcare”. Stakeholders in Ethiopia, including government, donors, civil society, professional associations and universities, joined together to support this initiative.

In February 2006, the USAID and WHO IBP advisers visited Ethiopia and with the IBP Core Team planned the documentation of “best practices” to be presented and discussed at a consultative meeting focused on the DHS 2005 preliminary results. The meeting was planned in agreement with the Ministry of Health for the first week of April. EngenderHealth - ACQUIRE Project was identified to oversee the documentation process, the format for which was prepared during this visit.

The following thematic areas were chosen to be the focus of the documentation project because they addressed priority reproductive health issues in Ethiopia today.

- Long-term and Permanent Family Planning
- Family Planning-Birth Spacing
- Contraceptive Security
- Assisted Birth
- Neonatal Health
- Gender-based Violence/Female Genital Cutting
- Post-Abortion Care
- Fistula Care
- Integration of Family Planning with VCT/PMTCT

Two consultants, Dr. Yirgu Gebrehiwot, and this report author, Ms. Beverly Stauffer, began in March to assist the IBP Core Group to gather information and document practices that are viewed as “successful”. The primary purpose of this documentation exercise was to identify and document successful practices for presentation as recommended responses to reproductive health issues. The documentation was not meant to be exhaustive, but rather an initial exercise providing a catalyst for further discussion.

A field team was hired to assist in collecting information from NGOs, governmental departments, donors and associations/professional societies about practices known to be successful. Information was gathered on more than thirty practices considered successful or offering valuable lessons-learned by the submitting agencies, organizations or other. (Note ANNEX I.)
Nine of the practices were selected to use as illustration/talking points at the IBP Consultative Meeting that was held April 3-4 in Addis Ababa and interviews were conducted with the following submitting agencies, who then presented their practices during the relevant small group sessions:

- Training-service delivery of long-term family planning methods (Pathfinder International);
- Mobile Teams to Build Capacity to Provide Quality Long-term and Permanent Family Planning Methods (EngenderHealth-Ethiopia);
- Community Reproductive Health Agents Promoting Family Planning (Pathfinder International/Implementing Partners);
- Community Youth Centers Promoting Reproductive Health (PACT/Implementing Partners);
- Community Mobilization to Eradicate the Practice of Early Marriage (Pathfinder International/Implementing Agencies);
- Comprehensive Post-Abortion Care (Ipas);
- Integrated Reproductive Health Services for Youth (Family Guidance Association-Ethiopia);
- Making Pregnancy Safer (Family Health Department-MOH/WHO); and
- Save the Mother (Ethiopian Society of Obstetricians and Gynecologists).

The practice of conducting Decentralized (on-the-job) Training used by IntraHealth to establish Prevention of Mother to Child Transmission (PMTCT) services was distributed to illustrate both a successful practice and the format being used for the documentation.

The consultative meeting was well attended, providing a venue for discussion about the illustrative practices, other related practices, approaches as well as the issues/challenges facing RH programming.

A total of twenty practices (ANNEX II.) including those mentioned above were drafted based on the initial information gathered and sent with the questions that had been posed by the consultants and advisors to the submitting agencies for their review, modification, and for additional information.

Additional information and input were received for sixteen practices from the submitting agencies and are included in this report as final drafts.

It is hoped that the practices that have been documented and this report will be used as a working document by the Ministry of Health, IBP Core Group and other key stakeholders to facilitate discussion about what process will be most effective in promoting and documenting evidence-based RH programming for the purposes of scaling up.
Key Lessons-Learned from IBP Documentation Process

1. There is a need for clear and shared definitions about “practices”, the level of “evidence” needed to validate the success of a practice, the criteria for analyzing results and assessing the practices, and the descriptive terminology that will be used, e.g. “best”, “promising”, “successful”, “good”, or “is working” to be established prior to the documentation process.

2. As there was a weak response to both of the pre-project requests for submissions of best practices, the team used a “snowball technique” interviewing large number of agencies, donors, and organizations to rapidly gather information about potential practices to document in preparation for the up-coming IBP meetings.

3. Gathering good information was challenging and may be symptomatic of larger issues. Generally speaking, these challenges included:
   - Lack of sufficient information from the informants as to the baseline situation and specific needs in the project or service area that had been identified pre-intervention; how the response was designed e.g. were the practices known to be evidence-based, innovative, or adapted; description of the implementation process, and qualitative or quantitative data to show change or “evidence” of the success of the practice.
   - Hesitancy noted at times on the part of the informants to share detailed and specific information whether verbally or with written documents; reportedly due to fear of piracy in a highly competitive environment for funding.
   - Lack of readily accessible data. As information was gathered primarily at the headquarters or main offices in Addis Ababa, it is likely that more useful information would have been available at the sites where practices are being used and data collected and recorded. Frequently there were a limited number of assessment, study or report documents (hard-copy only).

4. Analysis of the information was difficult given the lack of sufficient data about the original situation, objectives, targets, process, and verifiable success of the results.

5. Further exploration of specific practices identified through this process but could not be documented given time constraints are encouraged; these are listed in the “Practices to Document” section of this report.

6. To build the capacity of the RH community to design and document the effectiveness of their work, it is recommended that learning opportunities are facilitated to further explore the concept of “evidence-based practices”, to teach basic principles of evaluation, and to improve skills of RH workers to develop a strong and doable Monitoring and Evaluation plan to measure process, outputs and outcomes, and to have the tools to creatively document their own practices.
7. A lot of information and practices are already in place. We need to focus on learning from this existing evidence.

Successful RH Practices Identified During Documentation Process and Consultative Meetings

- Community-based Reproductive Health Agents not only promote and distribute oral contraceptives and condoms to under-served and hard to reach women, they provide instructions about other methods including natural family planning methods, and refer women to services providing medium, long-term and permanent methods as are available. They are instrumental in providing guidance and promotion of good reproductive health encouraging maternal child health care, educating communities about dangers of abortions, signs of post-abortion complications, signs of complications related to pregnancy and labor, and working with community committees to prevent early marriages. This community-based family planning promotion/delivery practice was viewed by many as a major contributor to the increase in CPR in several regions in Ethiopia as noted comparing 2000 and 2005 DHS data.

- On-the-job training programs provide more opportunities for practical application of technical and problem-solving skills, prevent interruption of health services, and allow for training of more personnel including ancillary workers - this promoting better integration of PMTCT and other RH services.

- “One stop shopping” approach to integrated Family Planning and Voluntary Counseling and Testing (VCT services) with a trained health professional that can provide reproductive health services and VCT in one room is user-friendly and has been found to reduce the stigma and fear of clients that others will see them enter special rooms and know the purpose of their visit.

- Youth involvement is important in planning more effective services and responses to meet their needs. Activities that offer life skills development, e.g. in-school girls clubs or income-generating assistance and training at youth centers encourage participation in RH promotion as well as HIV/AIDS prevention activities.

- The mass event approach used by the training-service delivery of long-term methods was viewed as an efficient approach to reach large numbers of women wanting long-term and permanent methods and provides opportunity for effective skills transfer, given the extensive practicum experience.

- Improvement in quality of family planning services and both client and staff satisfaction has resulted from the utilization of COPE, an internal participatory audit methodology. It was suggested that more attention be given to monitoring quality of
all facility and community-based family planning education, information, promotion, delivery and follow-up services.

- Community mobilization approaches, e.g. use of Community Conversation methodology are encouraging communities to take action to address harmful traditional practices including early marriage.

- The initiatives to equip facilities, train staff, and provide supplies and materials to build the capacity of hospitals and health centers to provide quality emergency obstetrical care and post-abortion services are critical to reducing maternal mortality.

- The comprehensive RH approach including HIV counseling and testing to treating clients with post-abortion complications and rape victims is seen as critical and needing to be expanded throughout Ethiopia.

**Issues Affecting Practice as Identified During Documentation Process and Consultative Meetings**

- There was expressed need among the RH Community to know how to appropriately use data from different sources including DHS findings and MOH service delivery statistics to plan targets, design strategies, programs, and services and forecast necessary inputs/commodities.

- To meet the national contraceptive prevalence rate (CPR) target of 44% by 2015, successful practices must continue to be supported, e.g. community-based family planning programs to achieve a 2% increase in CPR per year.

- Improving contraceptive security is critical to achieving national fertility targets; this will require strong partnership between government, donors, NGOs, and public sectors to better forecast demand and ensure adequate supply of specific methods.

- There is deep concern about the sustainability of effects of family planning and obstetric initiatives to build capacity of governmental health institutions to deliver quality services given the reported high attrition of staff and lack of budget to maintain steady supply of necessary commodities, consumables, and equipment.

- Strong linkages between the capacity-building of health facility initiatives (e.g. family planning, pregnancy care, post-abortion care, post-rape care) with community-based promotion and mobilization activities are important to promoting behavior change of both clients and service providers.

- The continued need for more integration of RH services with VCT and PMTCT; the recognized challenges to integration and the need to know more about evidence-
based proven interventions were issues raised during the course of the documentation process.

- The need was identified to upscale communication strategies to expand the demand for long-term and permanent family planning methods.

- Strengthening the referral system between health extension workers, community workers, and higher level facilities and follow-up of contraceptive users are two of the critical components to increasing the comprehensiveness of the family planning services to increase the CPR and lower the TFR.

- More targeted behavior change interventions are needed to reach youth (married and unmarried, rural and urban) to prevent unwanted pregnancy, STIs, and HIV/AIDS. Questions of whether unmarried youth are being reached with RH promotion and services and the attitudes of reproductive health and VCT workers toward providing services to sexually active unmarried youth were raised.

- There is a need for more demographic and disaggregated data to be gathered, recorded and compiled at the project or service level to know if the target populations are being reached.

- The recommendation was made during the meetings that more attention be given to the coordination of RH interventions and services at the regional and woreda levels and that the National RH Task Force and sub-groups with oversight of the Ministry of Health remain active, promoting the sharing of information and serving an advisory role to strengthen the quality and coordination of RH interventions. Several members suggested the need for a specific sub-group of the RH Task Force to be formed and funded to implement the IBP process (documentation and sharing of evidence-based practices and lessons-learned).

- And more broadly, there is a need for more focus on specific critical reproductive issues, e.g. unwanted/unplanned pregnancies, bringing stakeholders together at the regional and woreda level to plan a multi-pronged strategy, to share what they know about the situation and the targeted (high-risk) populations, to share relevant practices that are working or have been successful elsewhere, to design effective behavior change interventions, to develop the necessary linkages and partnerships to implement comprehensive programming and then to closely monitor results.

**INTRODUCTION**

**Global IBP Initiative:** “IBP was created to minimize duplication of effort and maximize the use of resources to ensure that the best, most appropriate practices are being used to
improve access to and the quality of reproductive health the goal of IBP is to **improve access to and quality of reproductive healthcare**. The mission is to support countries to fulfill their reproductive health agendas by strengthening international and country cooperation to share experiences aimed at improving the introduction, adaptation, utilization and scaling-up of evidence-based and/or proven effective practices in reproductive health.”

At the individual country level, the IBP Initiative mobilizes networks of reproductive health professionals and advocates to: create communities of practice, identify common areas of performance, and conduct activities to meet local needs.”

1. **Background of IBP-Ethiopia Initiative**

   The IBP in Ethiopia started in 2004 as a collaborative effort by USAID and WHO, when the Reproductive Health Task Force-Ethiopia comprised of the Family Health Department-Ministry of Health, donors, NGOs, and professional societies was invited to become part of this initiative. A team of twenty-five reproductive health professionals were selected to participate in the IBP initiative launch in Uganda along with teams from Kenya, Tanzania, Zambia and small country teams from Angola, Cameroon, DR Congo, Ghana, Mozambique, Nigeria, Rwanda, and South Africa.

   The IBP team was asked to identify a priority issue and associated plan. They returned from Uganda with a country plan to coordinate efforts among partners so that family planning is integrated with VCT and PMTCT in eight regions of the country. A consultative meeting was held with key Reproductive Health providers to plan the integration initiative; at the meeting a decision was made to also document best reproductive health practices. The Policy Project was appointed to facilitate this process. Solicitation of best practices was done by email to the Reproductive Health community with little response.

   The integration of family planning with VCT/PMTCT services initiative led by Pathfinder International included: development of proposals and training in family planning service delivery for VCT/PMTCT counselors in four regions. Implementation of this initiative as was planned has reportedly been hampered by lack of funding.

2. **IBP Documentation Planning.**

   In February 2006, the USAID and WHO IBP advisors visited Ethiopia and with the IBP Core Team (comprised of members of the RH Task Force Family Planning Technical Group) planned the documentation of “best practices” to be presented and discussed at a consultative meeting focused on the DHS 2005 preliminary results. The meeting was planned in agreement with the Ministry of Health for the first week of April. Engender Health - ACQUIRE Project was identified to oversee the documentation process, the format for which was prepared during this visit.

   The following thematic areas were chosen to be the focus of the documentation project.
- Long-term and Permanent Family Planning
- Family Planning-Birth Spacing
- Contraceptive Security
- Assisted Birth
- Neonatal Health*
- Gender-based Violence/Female Genital Cutting
- Post-Abortion Care
- Fistula Care*
- Integration of Family Planning with VCT/PMTCT

* Prior to the consultative meetings, the priority areas were reduced by the IBP Advisors to exclude neonatal health and fistula care and place more focus on family planning practices.

In February, an email was sent by the WHO IBP Advisor to the RH Community. There were four responses: PACT with a one page description of their community-based youth center and RH activities, a document from UNFPA with short descriptions of their integrated HIV/RH projects, a brief from FHI about their capacity-building work with regional governments and short descriptions from Pathfinder of four of their reproductive health projects.

Criteria for best practices as established by UNESCO and others was presented and discussed by the IBP Core Group:
- Innovative,
- Successful (evidence-based),
- Sustainable effect,
- Potential to be replicated.

Preliminary DHS data relevant to the thematic areas was presented noting the increase in tetanus toxoid coverage, CPR increase in four regions, and change in attitude toward female genital circumcision/FGM.

Dr. Yirgu Gebrehiwot, and this report author, Ms. Beverly Stauffer, began in March to assist the IBP Group to gather information and document practices that are viewed as “successful”. The primary purpose of this documentation exercise was to identify and document successful practices for presentation as recommended responses to reproductive health issues raised during the review of 2005 DHS data and national strategies at the April consultative meetings.

The following report describe the process of information-gathering and drafting of the documents, lessons-learned from the process, recommendations for strengthening the documentation process, final drafts of practices, discussion of the documents, and recommendations for use of the information that was gathered.
1. Information-Gathering Process:

The IBP Documentation Team met to discuss how to expedite information-gathering given the tight deadline. Agencies, organizations or other entities were listed and sorted (priority was given to those involved in policy development, advocacy, service delivery, community-based promotion relating to the thematic areas or were anticipated to be good sources of information about successful practices). It was decided to use interview methodology with open-ended questions to collect information. An interview guide was drafted by the team and submitted to IBP advisors at USAID and WHO. Their suggestions were incorporated and the guide was pre-tested. (ANNEX III.) A proposal was made early in March to limit the scope of the project to focus solely on a few thematic areas that would illustrate improvements health status data (DHS 2005), e.g. Family Planning. The thematic areas were limited later in the month to exclude newborn health and fistula care because of the wide scope of the work and the tight timeframe.

To rapidly gather information, it was decided to hire a temporary field team. Six potential candidates with reproductive health practice and research experience were interviewed; five were selected. The temporary field team consisted of Drs. Lia Tadesse and Muhidin Abdo Banko, Ato Hussein Mekonnen, Nursing Professor, Dr. Dawit Abreham, and Dr. Hassen Mohammed, PhD candidate and staff person at the Family Health Department. An orientation and training was conducted to explain the purpose of the documentation project and instructions how to use the interview guide. A letter was prepared and signed by EngenderHealth to provide official explanation of the purpose of the interview.

Each day the field interview team reported their findings to members of the IBP team and participated in discussion of the findings and in brainstorming ways to gather better information as rapidly as possible. Team members submitted completed notes of the interviews they conducted with documents obtained from the agencies and organizations. Information was gathered on more than thirty programs, projects, or services with potential practices to document.
2. Process for Prioritizing and Drafting Practices

The initial information was compiled and drafts were completed. Analysis of the information was challenging given the general lack of sufficient information about process and verification of results. A sorting exercise was done to choose practices from each thematic area that would be able to describe their process, success or lessons-learned and would stimulate discussion. Ten practices were selected to use as illustrations at the IBP Consultative Meeting. The IBP Team worked with nine of the submitting agencies to prepare presentation of these practices during the plenary sessions.

Following the Consultative Meetings, questions and requests for information posed by the IBP documentation team and Advisors were incorporated into twenty draft documents and sent to the submitting entities. (ANNEX II.) The interview guide was revised with technical assistance of IBP Advisors for future work in gathering additional information. (ANNEX IV.) Nine drafts were completed and sent on May 5 to the IBP Team and Advisors for review. All final drafts are incorporated into this report.

**LESSONS-LEARNED DURING DOCUMENTATION PROCESS**

- The National RH Strategy as well as preliminary DHS data served as reference points to contextualizing the documentation project.

- Early on, the team realized that the language (the use of qualifiers), “best”, “promising”, or “innovative” practices, was having a negative affect on participation by and attitude of some RH partners toward the documentation process.

- Even with good follow-up and very specific requests for data including anecdotal information, there was often a lack of adequate “evidence” to validate or illustrate success or results. In general, the documentation team had difficulty gathering the following information that is necessary for analyzing “success” of a practice:
  - The “Need”, pre-intervention situation or baseline assessment information; national data were most frequently quoted.
  - Clear or focused goals; SMART objectives or targets.
Description of implementation process to closely examine the implementation process that resulted in impressive results, e.g. outputs as the practices may be sub-standard.

Valid indicators of stated success.

Process or output data; quality of output data to produce hoped-for outcomes.

Demographic and disaggregated data to know who is being reached or served.

Qualitative or quantitative data to support the “gut” feeling that the practice is working.

- There was good attendance at the consultative meeting and active discussion about selected practices by participants during the plenary session. Feedback from participants included appreciation for the opportunity to discuss program practices, issues and results and criticism that there is a need for examples of “best practices”.

- Several submitting agencies suggested that it would be easier to do their own documentation. To support this idea, a clear guide that details expectations for content and scope as well as a standardized documentation format is needed. A participatory approach to the development of this guide is recommended.

- Possible motivators to further documentation are to publish “Successful RH Practices in Ethiopia” or “Lessons-Learned in RH Programming” annually and/or highlight with award ceremonies at national and international conferences.

- Learning opportunities are recommended to build the capacity of the RH community to further explore the concept of “evidence-based practice”, basic principles of monitoring and evaluation, and to improve skills of RH workers to develop a M&E plan, and to document their own practices.

- Skills-building activities in appropriate use of data are recommended as well for key stakeholders/policy-makers

- Conducting site visits to observe activities and to talk to both practitioners and as is possible beneficiaries or clients is an important additional method to use to gather information when conducting an external documentation of a practice.

- Overseeing the IBP activities has largely been done by an appointed (volunteer) NGO working with the Family Health Department-MOH. Pathfinder International has provided leadership to the initiation of the integrated HIV/AIDS and RH programming. EngenderHealth provided oversight of this
project during a very busy time period that included their hosting an international conference. The task of overseeing the IBP processes has put great demand on these organizations in terms of time and the use of assets. It is suggested that designating and supporting an IBP focal person or coordinator seconded to or employed by the Ministry of Health, perhaps the Monitoring and Evaluation unit would strengthen the IBP Initiative. It was suggested by several that a specific sub-group with representatives of the priority thematic areas be established as part of the RH Task Force.

- Based on discussions during the documentation process it is suggested as well that information-sharing, collaboration and coordination would be improved if there was focus on a critical reproductive health issue, e.g. unwanted pregnancies with stakeholders coming together to plan a multi-pronged strategy that addresses the multiple causal and contributing factors, to share what they know about the situation and the high risk population, to share relevant practices that are working, to design effective interventions, to develop the necessary linkages and partnerships to implement comprehensive programming and then to measure and follow results and the lessons-learned.

- Strong donor commitment to and promotion of information-sharing and documentation of evidence-based practices would contribute to more active involvement of NGO and government initiatives in documenting their practices.

- The IBP initiative under the leadership of the Ministry of Health is important to increase knowledge of evidence-based RH programming designs, to share lessons that have been learned nationally and internationally, and to improve monitoring and evaluation activities to identify what is working.

- If the RH community and stakeholders are committed to documentation of “best or promising” practices, a review and evaluation process will need to be established and adopted that meets international standards.

- The proposed criteria for assessing practices: Success, innovativeness, sustainable effects and potential for replication needs to be well discussed with consensus and clear definitions about each of the terms/concepts as well as a system for rating practices. The purpose is not to judge.
The following are considered final drafts as submitting agencies have provided additional information and have given input to the initial drafts. These documents are followed by comments or questions that have been raised by the IBP Team and Advisors. No attempt has been made to analyze the success of most of the practices given lack of adequate data or to use qualifiers to describe the practices as there is no consensus on an evaluation/rating framework. The documented practices and this report will be submitted for further discussion and analysis of the practices and documentation process by the IBP Core Team and Ministry of Health.

Included with the final drafts are brief abstracts that describe practices of interest, using information gathered during initial interviews and from review of reports or other documents.
Community-based Reproductive Health Agents Reaching Un-Served Rural Women with Family Planning Services

NEED:

Lack of knowledge of modern family planning methods as well as access to family planning services was recognized as a major concern and an unmet need in particular for rural populations in the 1990s. While family planning had already been integrated into the Maternal and Child Health services in the public health care institutions, the deficits in available trained personnel as well as contraceptive supplies were affecting service delivery.

RESPONSE

The utilization of volunteer Community-based Reproductive Health Agents (CBRHAs) in developing countries had been recognized by many to be a low cost and effective practice to educate the public about family planning methods, to promote modern contraceptive methods and to increase the availability and accessibility of methods for birth spacing in rural communities.

This community-based delivery model, initiated by the MOH and the Family Guidance Association-Ethiopia, was designed to involve volunteers in a wider scope of reproductive health promotion. In 1996, this practice of utilizing CBRHAs was adopted and scaled up by Pathfinder International/Ethiopia. Currently 47 local Implementing Partner Organizations are supporting over 8,000 CBRHAs to provide community-based services in 278 woredas and over 5000 Villages established in Amhara, Oromiya, SNNPR, Tigray and Benshangul Gumuz Regions.

Key Components or Practices:

1. Community Mobilization

Community stakeholders are invited to meetings to learn and discuss the purpose of the program and to select community volunteers.

Given the high degree of suspicion about family planning methods and resistance to workers visiting women in their homes in many communities, Advisory Committees are now formed at the woreda (district) level to oversee the community reproductive health
promotion activities and results and lend credibility to and provide official recognition of the implementing agencies and the community-based services. Committee members include: respected community leaders, *woreda* officials from health, education, social services, youth and sports, women’s affairs bureaus, and religious leaders.

2. Capacity-Building

The volunteers are trained using Ethiopian Ministry of Health standardized CBRHAs curriculum that includes theoretical and practical learning experiences usually over a two week period. The Consortium of Reproductive Health Associations (CORHA) managed the training using a cascade approach and the above MOH standardized curriculum.

Supplies of donor-funded oral contraceptives and condoms, reporting supplies and IEC materials related to reproductive health are provided to each CBRHA by the Implementing Partners.

Refresher and in-service training to expand CBRHA skills and knowledge and to introduce new methods or IEC materials are provided each year. The initial and refresher training programs are supported by the Implementing Partners.

3. Community Outreach

CBRHAs reach community members through several activities with reproductive health education and information about resources including available family planning methods, and distribution of oral contraceptives or condoms. Referrals are made to health facilities to obtain medium, long-term, or permanent family planning methods as are available, as well as for maternal health care and immunizations. The CBRHAs keep registers of women wanting methods that are not available locally, i.e. long-term or permanent methods; these documented needs are communicated to international NGOs that are providing long-term and permanent method training and service. When mass service events are planned, the CBRHAs assist with scheduling and education. CBRHAs, that have been provided specialized training, provide information about natural family planning methods (Standard Days Method and Lactational Amenorrhea Method). CBRHAs also sensitize communities on harmful traditional practices and HIV/AIDS prevention.
Outreach activities include:

- Door to door visitation to provide education, instruction, methods, and support.
- Group discussions and information sessions with religious or women’s groups or others such as idbiirs.
- IEC dissemination and group or one-to-one discussions at social gatherings, public events or meeting areas, e.g. watering points.
- School events to provide information about family planning to the students.
- Provision of oral contraceptives and/or condoms from the CBRHA’s home.
- Linkages with health facilities to recruit and schedule clients for long-term or permanent family planning methods.
- Follow-up of users to provide supplies or give reminders to get next injection, to assess for complaints of side effects and to refer to health care as is needed.

4. Oversight, supervision is conducted by Woreda Advisory Committee and Implementing Agencies with site visits and monthly review meetings.

RESULTS:

1. Availability of accessible family planning services.

   - About 7,000 CBRHAs are deployed in over 5000 communities. (Pathfinder Annual Report, 2005).

2. Utilization of modern family planning methods.

   - By the third year of the project, there were 590,158 new family planning acceptors.
   - Total CYP generated is 649,154 exceeding the project’s expected achievement, according to their annual plan.

3. Effectiveness of community-based interventions.

   A comparison study of woredas with and without CBRHAs found:
• “The proportion of women who ever heard of at least one family planning method was significantly higher in the project area (81.4 %) than the non-project (53.6%) and the difference was statistically significant (p<0.0001).

• Ever use of family planning was significantly higher in the project area than the non-project (33.2% versus 17.3%, p<0.001). Likewise, the contraceptive prevalence rate (CPR), an indicator of current use of family planning method, was 20.3% in the project area, which was significantly higher than the 8.3% in the non-project area (p<0.0001).

• The most widely used family planning methods in both areas were injectables and pills. Nearly 12% of the women in the project area were using injectables, followed by pill (8.0%) and very few (0.4%) reported that they had undergone female sterilization.

• The current incidence of family planning use (new users) was significantly higher in the project area than the non-project (14 % per year versus 5% per year, p<0.001).

• About 39% and 42% of women in the project and non-project area have unmet need for family planning, respectively. The difference in the proportion of women with unmet need between the two areas was not statistically significant.

• The total demand for family planning was slightly higher in the project area than the non-project though not statistically significant (59.1% and 50.2%, respectively).”

(Pathfinder Study, 2002)


In December 2004, in Dendi-North Shoa, Seiyo-West Welega, Meket-North Wollo, and Sodo Zuriya-Wolayita, as part of a Georgetown University/Pathfinder pilot project, 86 Community-based Reproductive Health Agents were trained to provide promotion and instruction on Standard Day Method (SDM) using the Cycle Beads. Pathfinder reports that:

• Within one year, 276 Clients are using SDM.
• For 42.4% of them, this is their first time to practice family planning.
• The other 57.6% had previously used other methods but had stopped for one or another reasons.
• One pregnancy has been reported over a period of nine months.
• Greatest struggle for CBRHAs is to promote EXCLUSIVE breastfeeding.

In 2004, LINKAGES in partnership with Pathfinder International conducted pilot projects to train CBRHAs to promote the Lactational Amenorrhea Method (LAM). A follow-up assessment in Areka, Bodito and Sodo included interviews with 9 CBRHAS that reported:

• 102 clients used LAM successfully
• 59 transitioned to contraceptives with Norplant and Depo-Provera the most common methods.
• 1 woman became pregnant after 45 days.
• Satisfaction of women using LAM: cost-free, no side effects “gift from God”, healthy babies, and time to decide on contraceptive method.
• (LINKAGES, 2005)

5. Community Involvement and Support.

A Special Study of Woreda Advisory Committees (WACs) conducted in 2004 found:

• These committees are critical to linking sectors necessary to work together to improve reproductive health and embrace issues beyond family planning. 100% of the Implementing Agencies reported that their partner WACs have goals to advocate for Reproductive Health/Family Planning, Prevention of HIV/AIDS and STIs, and against Harmful Traditional Practices.
• All of the CBRHAs interviewed stated that their work is much easier and there is less resistance from husbands and religious leaders now that the WACs support them.
• The WAC members are advocates of outreach activities versus mass media promotion; those interviewed see person-to-person contact as the most effective channel for health education and promotion in rural areas.
• While committee membership was largely male, discussions were gender-sensitive and the few female members were strong and spoke freely.

(Simpson-Hebert, Pathfinder, 2004)
6. Replication.

The practice of using CBRHAs to promote family planning/reproductive health has been replicated by community-based groups, religions organizations, and national and international NGOs in rural areas in Ethiopia.

LESSONS-LEARNED:

1. Selection of volunteers is critical; it is important to keep to minimal selection criteria with the community selecting residents that are:
   
   • Respected and accepted by community
   • Able to read and write
   • Willing to volunteer

2. Low attrition rate (<10%) of CBRHAs is attributed to community selection of volunteers, strong initial training program, recognition of volunteers by community, and volunteers reporting satisfaction of seeing changes in the knowledge and practices in their communities.

3. CBRHAs actively refer and facilitate access for medium, long and permanent methods as they are available. Two pilot projects show that they have the capacity to effectively promote natural methods.

4. Innovative approaches have been used to reach women with family planning promotion and methods who can not be reached easily with regular home visits:

   • Regular coffee ceremonies in the forest area for female wood-gatherers.
   • Promotion of reproductive health and family planning services by marketplace vendors.
   • Conducting home visits on holidays when families are not working.

5. Given that CBRHAs provide information and education about other reproductive health issues, e.g. childhood immunizations during home visits, it is reported that
wives, in marriages where the spouses are not supportive of contraceptive use, can more easily access family planning information (and methods) during the visits.

6. Reports note a natural response of CBRHAs to relate (“report”) to new health extension agents as they have helped to orient the health extension agents to the community and are a referral resource for clients needing Depo-Provera or clinical care. Formal linkages between Health Extension Workers and CBRHAs or Community Health Peer Promoters and shared continuing education could strengthen supervision and comprehensiveness of community services.

7. Stock-outs occur, given the need of health bureaus for more contraceptive supplies, and occasionally affect the CBRHAs program. A few CBRHA projects have initiated service fees and a blocked fund to buy supplies as needed.

8. The Woreda Advisory Committees can play more of a coordination role. To promote this it has been recommended that all NGOs working on reproductive issues in the area be invited to be part of the steering committee or to formally interact with the committees.

9. With the introduction of the Health Extension Worker program by the Ministry of Health, the continued need for CBRHAs is in dispute. Observers believe that there continues to be a need for family planning outreach education, information, and promotion services in the community linked to the Health Extension Workers. The question arises as to the continued need for community-based delivery of contraceptives. The concern is that without this outreach service it will be difficult to reach “hard-to-reach” females with education, information, supplies, monitoring of adherence, and early identification of reproductive health-related problems and to promote referrals to the Health Extension Worker or higher level of care.
AVAILABLE RESOURCES:

- *Woreda* Advisory Committee Training Manual and Materials
- CBRHA Initial and Refresher Training Manuals (MOH)

CONTACT INFORMATION:

Pathfinder International
Ato Tilahun Giday, Country Representative
Tgiday@pathfind.org
251-1-61330
www.pathfinder.org

Documentation: April 2006
Capacity-building to Increase Access to Quality Long-term and Permanent Family Planning Methods for Persons Living in Under-Served Areas in Ethiopia

NEED:

The total fertility rate (TFR) in Ethiopia was found to be high at 5.9 (2000 DHS-Ethiopia) though an improvement from the reported 6.4 in 1999 (NFFS). Both the high fertility rate and the low Contraceptive Prevalence Rate of 8% were viewed as serious concerns. Further review of the 2000 DHS-Ethiopia data found both a low current usage of all methods (oral contraceptive 1.9, IUD 0.1, injectables 2.1, condom 0.4, female sterilization 0.2, and implant 0.0) as well as lack of awareness of long-term and permanent methods (13.6 % of all women interviewed had heard of implants, 11.1% of IUDs, 23.1% of female sterilization and only 4.8% of male sterilization) Fourteen percent (14%) of women surveyed had an unmet need for limiting.1

In 2000, an assessment team that included Regional and Federal Ministry of Health (MOH) officials, representatives of Family Guidance Association-Ethiopia (FGA-E) and a representative from Marie Stopes International-Ethiopia (MSI) visited 27 public, private and non-governmental organization (NGO) health facility sites in Addis, Oromiya and Amhara. Objectives included to: 1) assess the current situation as regards to availability and capacities of personnel for providing long-term and permanent (LTPM) method services in the focus regions and 2) assess the availability and quality of health facilities for providing long-term and permanent methods.

Key assessment findings included:

1. Personnel

   • There was a significant lack of personnel trained in the provision of long-term and permanent methods of contraception, due to lack of training, poor deployment and high public sector attrition rates.
   • In general, neither public nor NGO institutions were exploiting the potential of on-the-job training as a means for increasing the numbers of skilled staff.

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• There appeared to be a lack of motivation and commitment at public sector sites for providing LT&P methods, particularly sterilization.

2. Facilities, equipment and supplies

• The large majority of static facilities, especially outside of Addis, are MOH. NGO sites were generally quite well equipped; private and public sector less so.
• There was a shortage of Mini-laparotomy with local anesthesia (ML/LA) kits in the public sector, as well as expendable supplies.
• IEC materials for VSC were weak or non-existent.²

RESPONSE:

To address the unmet need for limiting by improving the availability and accessibility to long-term and permanent family planning methods, EngenderHealth, an international NGO specializing in providing technical assistance in clinical contraception, postpartum services, and quality improvement of reproductive health services, initiated an intervention in July 2001 to assist 55 public health care institutions in under-served areas to strengthen their family planning services overall with a client-oriented approach and to provide quality long term (Norplant and IUCD) and permanent family planning methods (tubal ligation and vasectomy).

EngenderHealth is supporting family planning services in partnership with Family Guidance Association-Ethiopia in Addis Ababa and capacity-building mobile teams in Jimma, Dessie, and Addis Ababa in coordination with the Regional Health Bureaus. The project covers four zones in Amhara and four zones in Oromiya working with local governmental health centers.

Key components of the intervention include:

1. Provision of inputs for quality long term and permanent family planning services in the selected facilities.

• Clinical skill and counseling training for staff (provided on-the-job as needed).
• Adequate equipment and supplies at service delivery sites.
• Mobile service delivery teams to build capacity of staff and facilities and to assist with provision of services for underserved populations.
• Medical guidelines, protocols and job aids according to the MOH standards are available at all sites and routine supervision ensures that materials are properly used by health workers.
• Facilitative Supervision training for supervisors for each site from the woreda and region.

2. Establishment and strengthening of continuous quality improvement systems for long term and permanent family planning service delivery capacity.

• Introduction of range of quality improvement (QI) tools including facility COPE, Facilitative Supervision, Whole Site training, medical monitoring, and Community COPE at the service delivery sites.
• Strengthening of infection prevention practices for routine and emergency services with whole site trainings.
• Institutionalization of quality assurance systems including: follow-up procedures, medical monitoring and facilitative supervision in the public health system.

3. Creation of demand for long-term and permanent contraceptive services by improving and expanding information through communication, marketing, and community mobilization.

• Community mobilization through Community-Based Reproductive Health Agents (CBRHAs) of partner organizations and Health Extension Workers to strengthen the referral linkages.
• Interpersonal communication skills-training for providers to promote improved quality of interaction between clients and providers.
• Development of targeted communication messages for specific family planning methods.
RESULTS

1. Availability of LTPM Services.

- 55 supported sites now have sustainable capacity to provide LTPM services.
- A critical mass of service providers of 249 providers have been trained to provide long-acting and permanent contraceptive services.

2. LTPM Usage.

- The project has to date provided LTPM services to 26,432 clients:
  - 10,780 women had IUDs inserted,
  - 12,723 women received Norplant implants, and
  - 2,929 sterilizations were performed.
- Trend analysis shows that LA&P services between the first two years and the last two years of the project implementation have shown an incremental growth of 60% for long acting methods and 24% for sterilization service.

3. Quality Improvement.

- To increase the capacity of the facilities to undertake continuous quality improvement (QI). Client-Oriented-Provider-Efficient (COPE) was introduced at 55 sites.

COPE is a proven methodology used by facilities to continually self-assess, improve and maintain the quality of their services. COPE focuses on the rights of clients, the needs of health care staff, as well as the medical quality of the services.

- In Addis Ababa, COPE was also used as a tool for institutionalizing civil service reform in health institutions.
- Remarkable improvements in quality of services were documented at the supported sites. Improvements related to clients rights includes
information to guide clients within the facility by using nametags, signage and establishing an active desk to provide information on range of available services, initiating a consent form for minor surgery, and improved access within the facility by re-organizing the service area.

- All the facilities have made improvements in their infection prevention (IP) practices following the COPE introduction. The interventions focused on procuring IP supplies and equipment and providing staff training. Some of the facilities used the whole site training approach to train all staff in improved IP practices, including proper decontamination and processing of instruments and disposal of waste, including sharps. One hospital improved the kitchen procedures for handling food.

- Supported sites addressed issues of confidentiality and privacy by re-arranging the rooms and constructing partitions, some by putting screens.

- Many facilities now offer new, improved or cleaner toilet facilities, as well as showers for clients who are admitted as in-patients.

- One provider made the following statement, also echoed by others: “In general, the patient approach of each staff has changed. There is now respect, privacy, safety and protection of clients.”

- Facilities have started to seek feedback from their clients. Even though putting a suggestion box is mandatory in Civil Service Reform, not all supported sites were in compliance before COPE was introduced. Staff in one facility mentioned that they had installed a suggestion box in town where people may feel more at ease to provide feedback and suggestions. Another facility had recently introduced a suggestion book because they were not satisfied with the level of response from the suggestion box. Based on the feedback received by the respondents, there are indications that clients and surrounding communities notice and appreciate the changes that are taking place in the facilities visited.

- Improvements in infrastructure improved services for clients and created better working conditions for staff. Focuses were given to improve maintain and repair existing water tanks, pipes, latrines, incinerators etc.

- The use of the QI approaches and tools increased staff motivation and commitment to clients’ rights through increasing staff involvement in management; improved supervision and support, and helped facility administrators understand RH/FP services and client needs.
4. Replication:

COPE continues to be introduced in Ethiopia and can easily be replicated with the assistance of trained facilitators.

LESSONS LEARNED

- Strengthening of facility management, logistics and service delivery systems and an orientation to client-oriented care using COPE improves the health care delivered at the sites in general.
- COPE contributes to the sustainability of quality family planning services but requires on-going support and facilitative supervision to be provided by the regional health bureaus.

AVAILABLE RESOURCES

- “Guidelines on COPE and Quality Improvement”, EngenderHealth, 2003

CONTACT INFORMATION

www.engenderhealth.org
EngenderHealth-Ethiopia
251-116-638 125/26
gkindane@engenderhealth.org
Service-Based Training for Long-Term Family Planning Methods

NEED:

Increasing demand for and utilization of long-term and permanent family planning methods has been identified as a particularly effective and sustainable approach to meeting the unmet need to limit births and to reduce fertility rates. While the DHS 2000 found few women mentioning long-term contraceptives as a future preferred method, family planning service providers report a growing demand for implants and are challenged with providing sufficient supplies. The 2005 DHS found an increase in IUD usage from 0.1 to 0.2 and Norplant usage from zero to .2 with short or medium term methods remaining the most preferred.

RESPONSE:

To address the lack of awareness and access to and availability of long-term birth control methods, Pathfinder International has developed an intervention that combines community-based family planning promotion and service delivery to meet high unmet need with capacity-building of governmental health facilities to provide long-term family planning services. A secondary objective is to improve the practicum component of Norplant insertion training programs. Working closely with Regional Health Bureaus and local health facilities in Amhara, Oromiya, SNNPR, and Tigray regions and NGOs implementing community-based reproductive health programs, Pathfinder teams provide on-site training, contraceptive commodities, and assistance with service delivery that includes: Norplant implantation and IUCD insertion and removal. The major components associated with this intervention are:

1. **Linkages with Community-Based Reproductive Health Agents**

These community-based volunteers visit women in their homes or invite them to group discussions to provide information about reproductive health issues and to promote short, medium, and long-term modern family planning methods. While the agents are able to supply condoms and birth control pills during the visit, they advocate for medium, long-term and permanent methods and are aware of women that desire long-term methods and community members wanting permanent methods. Thus, unmet demand is clearly identified and quantifiable. Individuals are registered for long-term methods and the lists submitted to the local health facility.
Linkages are also being created with the new Health Extension Workers that are based at community health posts. They are providing oral and injectable contraceptives and are referring clients desiring long-term or permanent methods to the health clinics and centers.

2. Institutional and Staff Capacity Building

Pathfinder International works closely with regional, zonal, and woreda health bureaus to plan and conduct training and service activities to increase access to and availability of long-term family planning methods. Activities include:

- When there are sufficient clients, a local site is selected and a training program is scheduled with the regional, zonal, and woreda health bureaus.
- An assessment is conducted of the facility to determine if basic infection control standards are met and to ascertain need for equipment, supplies and materials.
- Additional health professionals from the zone are brought to the site for training or to help provide services. Norplant and IUD supplies and necessary equipment and supplies are provided by Pathfinder.
- Using the MOH Family Planning Training Curriculum for Facility-based Practitioners, MOH or Pathfinder-trained physicians provide instruction to local and other regional health professionals (nurses, health officers and doctors). The curriculum includes 4 days of theoretical work and practice on models followed by 7-10 days of practical experience in several sites with supervision. Practicum sites are chosen based on identified high unmet need by local health bureaus. Trainees do Norplant implants and IUD insertions and removals with direct supervision of the trainer until they demonstrate proficiency and can work more independently.

RESULTS

1. Availability of long term contraceptive services for un-served and largely rural populations.

The Amhara Development Association (ADA) in collaboration with the Regional Coordination of PI-E recently conducted a training and service delivery in Tach Armachiho woreda (Sanja Health Center) and Adarqay woreda (Zarima clinic and Adarqay Health center) and reports the following results:

- During the four days of the service delivery 206 clients received services including 203 Norplant insertions, one Norplant removal and 2 vasectomies.
- 45.9% were in the age group 15-24.

### Experiences in Oromiya Region January 2005-March 2006

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A 2005 monitoring report of visits to sites in North and South Gondar zones, Amhara region, found that the trained health workers continue to provide services in their respective facilities. From October 15 to December 31, 2005, a total of 108 women were served in the five randomly selected facilities.

- Close to 65% of the clients were from rural villages; this is noted as a significant increase from previous years.
- Fifty percent of the clients were under age 30.
- Sixty-two % of the clients had used Depo-Provera previously showing a shift from medium to longer term methods.

**Testimonial:** A woman from East Gojjam complained, “At first, my cow and I both got pregnant in the same week. We delivered around the same time, 9 months later. However, after that, I was pregnant again before she was. I was worse off than my cow!” Now, through Pathfinder’s CBRHA program with partner Ethiopian Aid, she is on Depo-Provera and waiting for Norplant. (Report from Ethiopian AID, 2006)

2. Trained health professionals to perform Norplant implantation and IUCD insertion.

As may be noted from the above table, this training-service delivery model is effective in training large numbers of professionals.
3. **Sustainability of the services.**

Provision of long-term methods as part of governmental family planning services is increasingly sustainable with a growing cadre of trained personnel. Utilization of long-term methods is expected to increase given the effective promotion being currently conducted by the CBRHAs and Health Extension Workers. On-going quality service delivery will require continual training given the high attrition rates within the public health facilities, adequate infection control at the facility levels, and a stable uninterrupted supply of long-term methods.

4. **Replication.**

This practice continues to be expanded to other *woeredas* in the regions;

**LESSONS LEARNED**

- This practice is efficient and brings additional resources including skills, materials and supplies to areas with high unmet need.
- Untrained health workers receive training and good practical experience on-the-job without interruption of primary care services.
- The current supply of long-term methods can not meet the identified demand.
- This approach builds the capacity of local governments and health bureaus to identify and quantify reproductive health demands and unmet need in the community.

**CONTACT INFORMATION**

Ato Tilahun Giday, Country Representative  
Pathfinder International  
Tgiday@pathfind.org  
251-1-61330  
www.pathfinder.org

Documentation: April, 2006
Community Youth Centers Promoting Healthy Sexual Behavior

NEED:

The vulnerability of youth, in particular girls, in Ethiopia to reproductive health problems is heightened given social, cultural, and environmental factors that include: traditional practices of early marriage and genital circumcision, unprotected sexual behavior that may be transactional in nature between teenage girls and older men increasing their risk for exposure to HIV/AIDS, societal taboos about discussing sexual issues in general and youth sexual behavior in particular, lack of available sources for good information and education about reproductive health and lack of available and/or accessible family planning services.

“Baseline knowledge, attitude, practice and behavior (KAPB) surveys conducted in Northern and Western Shoa in 2001-2002 show that while knowledge of family planning ranges from 13% to 67% among rural and urban population groups respectively, contraceptive use is much lower, ranging from 19% - 27%. Rural respondents stated that more than 63% need to walk two to three hours to access contraceptives. Traditional behaviors such as early marriage, rape, abduction, and female genital mutilation are widely practiced in semi–urban and rural communities. Although 89% of the respondents have heard about HIV/AIDS, more than half of them do not believe they are at risk…” (PACT website)
To reach both male and female youth with reproductive health interventions is often difficult particularly for those out-of-school youth as they are scattered in the community. Most communities do not have a designated place for youth to meet.

Assessment of rural and urban communities found that youth were engaging in generally whatever was available in the area: pastime activities included chewing chatt, watching video film shows including pornographic films, playing games such as football if enough playing fields were available or engaging in petty robbery. Most of the out-of-school youth were jobless and idle. Library services were non-existent in the small towns and rural areas.

(PACT Program Manager)

RESPONSE:

Since August 2000, PACT-Ethiopia has supported 20 local NGOs to work in primarily rural areas (20 to 30 kilometers from urban towns) in Oromiya-North Shoa, Amhara-North Shoa and North Wollo and SNNOR-Seite Zone to promote reproductive health and prevention of HIV/AIDS targeting youth age 10-24 years of age.

The aim of establishing the youth centers is mainly to provide a meeting place for youth to discuss their Reproductive Health and other issues so that they can protect themselves from RH problems including HIV/AIDS. In addition, the centers are used as sites for: developing life skills that promote healthy sexual behaviors, engaging in healthy relaxation and recreation, learning new livelihood skills and becoming involved in community services.

Kebele administrations usually provide the youth with old rooms to be renovated. In some rural areas where no rooms were available, the community contributed materials to build the centers with the youth contributing their labor. The project bought construction materials that were not available in the rural areas. The PACT Implementing Agencies then purchased furniture, education aids such as radio tapes, TV and VCR, books and reading materials for the libraries, equipment and training materials for income-generating activities (IGAs). Youth are involved with selection of sites and provision of labor in the renovation or construction of the centers.
Management of the centers in the urban areas is usually done by existing Anti-AIDS clubs which have advanced into associations and are licensed by the government to operate officially. Where there are no existing youth clubs, new clubs have been established by Pact’s RH partners in collaboration with Kebele administrations and other community-based groups like Idhirs. Interested youth are invited to be members, a meeting is then called and the youth select their leaders. These centers are managed by the local NGOs because of accountability issues related to being officially registered with the government. The youth are encouraged to be fully involved with the NGO to manage the club and exercise their leadership.

Small income-generating activities to support the center include a service charge for playing tennis, other indoor games, entrance fee for outdoor games, sale of tea/coffee and vegetable sales, etc.

These community youth centers offer:

1. **Learning Opportunities:**
   - A library to promote learning and improved school performance.
   - Skills-training programs to do income-generating activities such as sheep and cattle-raising, vegetable production, and tea and coffee selling are facilitated by the Implementing Agencies.
   - Peer education/promotion training using the DSW (German AID) curriculum.

2. **Reproductive Health Promotion and Referral**
   - Group or individual health education and information is provided about the available family planning services at the local clinic and referrals are made for reproductive health services by trained peer promoters at the center. Training of peer educators is done by the Implementing Partners using the DSW curriculum. Condoms are kept at the centers for distribution.

3. **Recreation**
   - At the centers, youth can play indoor and outdoor games as options to riskier recreation, e.g. chewing chatt or watching pornographic videos.
4. Community Service Opportunities

- Anti-AIDS, Reproductive Health and other Youth Clubs meet at the centers to prepare and practice edutainment that promotes HIV/AIDS prevention and reproductive health. Working with schools, health posts or clinics and community officials and leaders they plan and conduct edutainment using a variety of communication channels including drama, broadcast of radio messages and group discussions to increase the communities’ awareness of reproductive health issues and promote prevention of HIV/AIDS, and harmful traditional practices.

RESULTS:

1. Availability of Community-based RH-focused Youth Services.

   Eleven (11) rural and 26 urban small youth centers have been established.

2. Youth Involvement in Community Awareness-Raising about Reproductive Health Issues

   An example of a collaborative intervention between a club, school and a public clinic is seen in Chimbre Kebele in North Shoa where together they have increased awareness in the community about reproductive health and the dangers of harmful traditional practices using a variety of edutainment channels: drama, broadcast of radio taped messages, and discussions.

3. Youth involvement in community dialogue and action:

   In Chimbre Kebele, Kebele administration and community leaders with the youth clubs have established and enforced a community law to stop early marriage. The law says: “If parents give away their daughter before the age of 18, they shall be sentenced to five years imprisonment”.

   Sharing responsibility for the enforcement of the law, the school teachers report any arranged marriage to Kebele administration based on information they get from other students in the school or neighborhood. The Kebele administration then talk to the parents to stop the marriage, if the parents refuse, the case is reported to the legal authorities.
While not confirmed by the project, the Chimbre Kebele Administrator, who works closely with the Reproductive Health Clubs and School Administration reports that school dropouts among girls has reduced and most arranged marriages at early age have stopped in the Kebele.


- As mentioned earlier, Kebele administration and communities have contributed toward the establishment of the centers with construction materials and/or space.
- The Chimbre Kebele administration has promised to donate land to the youth to initiate income-generating activities.
- Implementing partners report that the attitudes in the community become more positive toward the youth as they observe them educating their peers and the community about HIV/AIDS/RH and also becoming more self-supportive.

5. Increased utilization of family planning services.

The nurse in the Chimbre Health Clinic states:

- The number of females coming to the clinic increased dramatically, tripling in one year since the family planning education initiative was started by the clubs. Currently, the number of clients registered from this specific Kebele for injectables is over 300 females. This was verified by the project by doing a comparison between annual service utilization data from the last two years.
- The clients report that they are happy about the services as it is in the center of the village, which provides easy access with enough choices such as pills, injectables, IUD and condoms.
- Most of the clients are young females who have married at an early age.
- Unmarried youth are generally accessing condoms as family planning/HIV prevention measures at the youth center.

6. Increased livelihood skills of youth

- As one example, in Debre Sina and Debre Berhan in Amhara Region, the clubs have organized self-help groups to do shoe-shining, highland water selling, car washing and car parking. Seventy-seven (77) street children are now able to
continue their education and support themselves, have started a group savings, and reported hopeful of a better future. A self-help group involved in cattle-raising in Debre Birhan is also involved in orphan care, providing a free half liter of milk a day to each of twenty-one orphans.

LESSONS LEARNED:

- The involvement of youth in designing and managing the project creates a sense of ownership.
- The livelihoods/IGA, library, group discussions, games and classes all contribute to reaching a wide variety of youth, with different interests, with reproductive health promotion. Most of the youth using the youth centers are unmarried except in the rural areas where a few married female and males attend the activities.
- In rural areas, harvest time must be taken into consideration when planning youth center activities.
- There is a need for continued recruitment and training of peer educators at the centers as the youth move on to jobs or further schools.
- Linking income-generating activities to reproductive health promotion was found to be effective because it attracts youth to promotion activities and is being used by other NGOs and CBOs now in Ethiopia; this linkage also helps to increase the sustainability of community-based adolescent sexual health promotion.

CONTACT INFORMATION:

PACT-Ethiopia
Sister Fekete Belete
0116613330
fbelete@pact.org
www.pactet.org

Documentation: April, 2006
Youth-Friendly Reproductive Health Services

NEED:

In 2002, in Addis Ababa and urban areas in Oromiya Region, focus group discussions were conducted with unmarried in-school youth to learn about their attitudes toward reproductive health services provided at the local public health care facilities. The major concerns expressed by the youth were:

- Unfriendly treatment by staff.
- Staff providing family planning or other reproductive health services were judgmental and openly critical of youth being sexually active “too young” or “not married”
- When family planning methods were provided at the facility there was insufficient explanation of correct usage or potential side effects.
- Lack of confidentiality
- Lack of privacy, feeling uncomfortable that elders could see them accessing reproductive health services such as family planning.
- Staff don’t listen to us, “if a girl has an STI”, maybe the girl was raped”
- Not feeling comfortable to ask questions related to sexual matters during the family planning visit, and a need for more information by and discussion with the professionals about family planning methods, HIV/AIDS and STIs.

(Focus Group Discussions, 2002 as reported by INSYGHT)

RESPONSE:

Since 2002, Save the Children US’s “Initiative to Save Young Generation’s Health Today” (INSYGHT) is working in partnership with the MOH-Ethiopia to address these barriers relating to youth utilization of or satisfaction with reproductive health services at the public health care facilities. The objectives of this project are to improve accessibility, acceptability and availability of adolescent reproductive health services at 25 health centers in Addis Ababa and 17 health facilities in Oromiya Region.
Key components include:

1. Reproductive and sexual health (ARSH) clubs. These clubs are established primarily in schools. This approach has been used effectively in other countries to “capture” the in-school youth and involve them with planning and implementing reproductive health promotion activities including education and information about reproductive health services, peer counseling, as performing edutainment for other students and the wider community. These clubs provide a venue for both female and male youth to discuss sexual issues.

2. Facility and Staff Capacity-Building

   Based on the findings of the focus group discussions, INSYGHT developed a training program to train health professionals how to better relate and care for the special reproductive health needs of youth. Focal persons were selected from each facility to be trained and to act as the primary provider of youth services. As part of the training, the focal persons were assigned to conduct an assessment of their facilities to address the frequently expressed concern of the youth about the lack of privacy. The facility assessments were used to select an appropriate room where a variety of reproductive health services including family planning and counseling could be provided. The rooms were equipped and supplied with videos, IEC materials and posters as well as medical supplies and teaching aids.

**RESULTS:**

In April 2005, a process evaluation was conducted by INSYGHT of five facilities and found low utilization of the special youth services. On review of the registration logs, it was apparent that youth were being served by the STI, Family Planning and other reproductive health services at the facilities. Interviews were conducted with staff and youth who stated that the room was not being used because of an inadequate number of professionals to staff a special “youth-friendly” room so the room was often closed. Additionally, there is a high attrition rate of staff including the trained focal persons. Youth continued to complain about the unfriendly treatment by the staff that had not received the training by INSYGHT, but were continuing to access services.

The project design was modified to orient ALL of the staff at the facility including facility guards to the needs and rights of youth to quality care, confidentiality, and emotional support. The aim is now “youth-friendly facilities”. Each facility continues to have a focal person to serve as a liaison with the ARSH clubs (this requiring only a few hours a month).
INSYGHT is also working with regional health bureaus to incorporate more client information and service utilization indicators in the HF register and the HMIS to learn more about the youth (age, sex, in or out of school or other, marital status) and the type of RH services that they are utilizing.

Beneficiary satisfaction is being monitoring through group discussions with the ARSH club members and communicated to the facility by the identified focal person.

LESSONS-LEARNED

1. Special reproductive health services for youth have been successful, e.g. FGA-E Youth Clinics, but may not work in the public health care facilities unless there are secure and adequate human resources to cover designated special clinics.
2. The needs of youth for youth-friendly, confidential and private services may not require a special space, but does require the respect, awareness of and attention to their needs by facility staff.
3. The youth rooms are being maintained at the facilities to serve as a place for education and counseling for youth (by appointment or schedule).

AVAILABLE RESOURCES:

- “Comprehensive, Community-Based Adolescent Health Intervention Trial in Ethiopia, Baseline Report: Adolescent Survey”, Tulane University School of Public Health and Tropical Medicine and Save the Children US.
- Save the Children/US INSYGHT Orientation Guide for Youth-Friendly Services
- Save the Children/US INSYGHT Youth-Friendly Services Process Evaluation Report
- Save the Children/US INSYGHT Focus Group Discussion Reports.

CONTACT INFORMATION:

Save the Children US
011 372 8455
www.savethechildren.org/

Documentation: April, 2006
Integrated HIV/AIDS and Reproductive Health Services for Youth

NEED:

The DHS Survey conducted in 2000 in Ethiopia found that sexual debut is early with female youth age 15-19 reporting first sexual intercourse at an average age of 13.5. By age 18, 50% of females report having had sexual intercourse.

Approximately 75% of the female youth age 15-24 surveyed were aware of at least one contraceptive method, most likely oral contraceptives, with only 11.7% having ever used contraceptives and 4.8% currently using a modern method.

In addition to the increased risk of early and potential unwanted pregnancy, there was the recognition of the high prevalence of HIV/AIDS among the 15-24 age group. The Ministry of Health sentinel surveillance data found the prevalence of HIV to be 11% among mothers age 15-19 seeking antenatal care. The 2000 DHS found that fairly good awareness of HIV/AIDS (80%) among 15-19 yr. old females, but that they are less likely to know a way to prevent the spread of HIV. Use of condoms was found to be very low; less than two percent of sexually active women (married and unmarried) age 15-24 had used a condom during their last sexual intercourse.³

Factors that affect the low usage of contraceptives among youth were thought to be: lack of accessible services that are friendly to youth, fears of accessing services given societal disapproval of sexual activity of unmarried youth, the desire for children among young married women, or the common and general reasons for poor utilization of family planning services that include lack of awareness or availability of methods or services.

While there was known to be an interest in HIV testing of youth and the general population, the major reasons for not being tested included: stigma and discrimination if found to be positive and unavailable or inaccessible voluntary, testing and counseling services.⁴

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RESPONSE:

To address the identified reluctance of youth to access reproductive health services including VCT, strategies have been developed to increase knowledge about risks to reproductive health and of HIV/AIDS and to provide accessible youth-friendly VCT and RH services. Family Guidance Association-Ethiopia has established youth centers and adapted their one-stop integrated HIV/AIDS and Reproductive Health Services model to meet the special needs of married and unmarried youth age 10-24 years. The Bahir Dar Model Youth Center was opened in 2004.

Young professional staff were recruited and received training about the reproductive needs of youth, communication skills, VCT and psycho-social counseling. Center activities include:

1. **Youth-friendly reproductive health services.**

   The following services can be provided in one room by one of the two nurses:

   - Family planning counseling and methods including emergency contraception
   - STI diagnosis and treatment and post-abortion care
   - Voluntary Counseling and Testing (VCT) services.
   - Pregnancy testing and Antenatal care
   - Primary Care
   - Post-rape care
   - Psycho-social counseling. Most frequent problems are related to sexuality and unwanted pregnancy.

   Peer promoters provide support, education and information to clients in the waiting room area through one-to-one discussion, educational videos or IEC materials.

   A special weekly program for “girls-only” serves young females that are too shy to be seen in the clinics by males.

2. **Outreach by peer service providers (PSP).**

   Twenty trained youth provide information about HIV/AIDS and reproductive health issues and services, promote prevention measures, and make referrals to youth in and out of the center. Targeted outreach activities including regular home visits and one-to-
one contact with migrant teenage sex workers to provide them with HIV/AIDS prevention and contraceptive information, condoms and oral contraceptives and to refer them to the youth center health services for other clinical family planning methods, VCT counseling or STI treatment.

Initial and refresher training includes building communication skills, knowledge of contraceptives including emergency contraception, adolescent and youth rights, identification and referral of STIs or post-abortion complications, behavioral risks for HIV/AIDS, VCT promotion, and facilitation of discussion to prevent gender-based violence.

3. Referral System.

- HIV/AIDS treatment, care and support, e.g. the Persons Living with HIV/AIDS (PLWHA) Association (Dawn of Hope) for care and support services
- Legal advice and assistance to the Ethiopian Women Lawyers Association.

4. Publicity about services.

A variety of activities are done to provide information about and to promote the youth center and clinic: local radio, coffee ceremonies in the community, posters, leaflets, a Saturday mini-media program and group discussions led by peer educators, librarian and/or nurses. The youth center conducts music and drama presentations to promote RH health and services to youth and adults in the community.

5. Other youth activities at the center.

- Library
- Meeting hall
- Recreational and sporting facilities
- Tea room with light refreshments

6. Youth involvement.

Youth are organized into Sexual Reproductive Health Committees comprised of ten executive members. Their role is to plan RH health promotion edutainment and strategies to involve more youth in the center.
7. Parent Involvement

Twice a year, the center organizes a Parents' Day. Facilitated discussion is held on pertinent topics related to adolescent/youth sexual and reproductive rights and needs. Tours are given of the clinic to explain available services. Center staff are involved as well in leading community panel discussions about key issues relating to reproductive health and HIV/AIDS and facilitating learning opportunities, e.g. “Gender Focused Sensitization Seminar for Young Girls and Parents”.

RESULTS:

1. Utilization of Youth center services (by type)

<table>
<thead>
<tr>
<th>Activity/ Service</th>
<th>Unit</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counseling</td>
<td>Persons</td>
<td>2026</td>
<td>9383</td>
<td>11409</td>
</tr>
<tr>
<td>SRH Services*</td>
<td>Persons</td>
<td>63</td>
<td>1076</td>
<td>1139</td>
</tr>
<tr>
<td>VCT</td>
<td>Persons</td>
<td>559</td>
<td>618</td>
<td>1177</td>
</tr>
<tr>
<td>Library Users</td>
<td>Persons</td>
<td>10031</td>
<td>4085</td>
<td>14116</td>
</tr>
<tr>
<td>FP service</td>
<td>Persons</td>
<td>2820</td>
<td>5954</td>
<td>8774</td>
</tr>
</tbody>
</table>

2005 plan versus Achievements

<table>
<thead>
<tr>
<th>Activity/ Service</th>
<th>Unit</th>
<th>Plan</th>
<th>Actual</th>
<th>% achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counseling</td>
<td>Persons</td>
<td>10561</td>
<td>11409</td>
<td>108</td>
</tr>
<tr>
<td>SRH Services</td>
<td>Persons</td>
<td>840</td>
<td>1139</td>
<td>135</td>
</tr>
<tr>
<td>VCT</td>
<td>Persons</td>
<td>1000</td>
<td>1223</td>
<td>122</td>
</tr>
<tr>
<td>Library Users</td>
<td>Persons</td>
<td>17300</td>
<td>14116</td>
<td>82</td>
</tr>
<tr>
<td>FP service</td>
<td>Persons</td>
<td>8800</td>
<td>8774</td>
<td>99.7</td>
</tr>
</tbody>
</table>
2. Utilization of family planning services.

- At the Bahir Dar Youth clinic, 1998 new Family Planning acceptors were reached surpassing their annual target of 1291.
- The target for continued family planning users was also surpassed with 3594 youth serviced.
- The commonly preferred method was condoms (59% of users). (Source: 2003 FGAE-North West Branch Annual Report)
- Numbers of youth accessing FP services is increasing.

(Source of preceding graphs and data: FGA-E)

3. Utilization of VCT Services

- Number of youth (male, female) reached with VCT. (Source: 2003 FGAE-North West Branch Annual Report)

From January 2003-June 2004, the FGA-E combined youth services report:

- Reached 5464 youth with VCT Services.
- Less than one percent (.07%) of the youth tested positive;
- 78% of the youth testing positive were females (age 10-24).


- Counseling is primarily on FP methods, VCT, and STIs.

5. Utilization of post-rape care services.

- Twenty-six rape survivors were provided medical and counseling services.  
  (Source: 2003 FGAE-North West Branch Annual Report)

LESSONS LEARNED:

- Involving the youth in planning and implementation wins confidence of the youth.
- Recreational and sport programs at the youth center are good entry points to attract youth to promotion of reproductive health and HIV/AIDS prevention services and activities.
- To address the low participation of girls in recreational events, the girls were clear, “they need to be brought on board to design appropriate programs”. Programs that have been designed include: assertiveness training, girls clubs, Woman to Woman Forums, and girls only table tennis, volleyball and sewing as well as the mentioned girls only clinic.
- Open communication between providers, promoters and the youth increased service utilization.
• Integrated VCT and RH services for youth has created client satisfaction as noted by the comments of the youth who worried about being seen by adults in the waiting room and the stigma of others knowing what service is being accessed.

• As noted at other FGA-E Services, integrating VCT into FP has addressed the problem for adults coming for VCT as well who before were easily pin-pointed; it was found that signage for special rooms was a barrier. All the family planning service providers were provided VCT counselor training. Staff have been trained for couple counseling, see this during the marriage season.

• Youth programs are more successful with parent involvement.

• In order to avoid burnout, the nurses/VCT counselors rotate every month.

• To address the lack of clarity about national parental consent guidelines and the differing policies among the various youth centers for VCT consent, FGA-E has developed a standardized policy.

• To ensure that youth center staff and participants are representative of the surrounding community and gender-balanced, policies are being put into place that peer promoters and clinic management positions are gender-balanced as well as representing the local majority, e.g. religious affiliation.

CONTACT INFORMATION:

Family Guidance Association of Ethiopia
Ato Amara Bedala, Executive Director
011 151 4111
http://fgae.org

Documentation: April, 2006
Mobilizing Communities to Eradicate the Practice of Early Marriage

NEED:

In several parts of Ethiopia it is common that parents will consent to their young daughters’ consummated marriages; the girls are reportedly often as young as 10 or 12 years of age. In Amhara Region, 42% of girls are married by the age of 15 despite the enactment of the revised Family Law which sets the legal age for marriage at 18. (DHS, Ethiopia, 2000)

“Early marriage” is considered a harmful practice by Ethiopian law given the consequences of adolescent pregnancy which present profound risks to both mother and infant, the increased probability of young married girls not continuing their education, the potential dominance of an older husband and his family, and increased chances of divorce.

RESPONSE:

In 2003, Pathfinder and Key Partners: Ye Ethiopia Goji Lemadawi Dergitoch Aswegaj Mahber (EGLDAM), formerly National Committee on Traditional Practices), Ethiopian Women Lawyers Association (EWLA), Women’s Affairs Office, Ministry of Education, Regional Women’s Associations, and regional implementing partner NGOs initiated work at the federal level and in Amhara and Tigray Regions to eradicate the practice of early marriages.

Key components of their response included:

1. **Formation of Partnerships to Strengthen Legal Framework**

For legal bodies including judges and police, workshops were conducted at the federal and regional levels to raise awareness of the revised Family Law, the new Penal code and their effect on the practice of early marriage, the consequences and punishments associated with such harmful traditional practices and how to address these through the legal system.

2. **Mobilization of Senior Religious Leaders.**

In each region, senior religious leaders from the Orthodox, Catholic and Protestant churches as well as Islamic clergy were invited to a consultative meeting to learn about the new family law and revised penal code, the harmful affects of early marriage, and to discuss ways to
advocate for prevention of early marriages. A statement of commitment to address early marriage was written and signed by the participants.

3. Mobilization of Local Communities.

To reach community stakeholders, public forums using "Community Conversation" methodology, promote discussion and awareness-raising about the harmful effects of early marriage. As a result of these public forums, early marriage prevention committees have been established.

The Early Marriage Prevention Committees, made up of Kebele officials, teachers, Community-based Reproductive Health Agents (CBRHAs), women's association leaders, police, judges, religious and other community leaders, are established to facilitate discussion among the wider community and to serve as formal reporting and response structures. Community sensitization carried out by the committee members, most particularly by religious and women’s association representatives, has enabled the committee to intervene in the community without facing reactionary consequences.

4. Education and Awareness-raising.

- Women’s Associations train their representatives to disseminate the information and to work with the membership, many of whom are rural women, to promote prevention of early marriage.

- Teachers and in-school Prevention of Harmful Traditional Practices (HTP) club leaders were provided training in the new law and to plan actions about how to identify girls vulnerable to early marriage and how to address the issue at the local level in cooperation with the Early Marriage Prevention committees.

- Community religious leaders committed to the prevention of early marriages provide guidance to parents and may refuse to bless the marriage.

- Community-based Reproductive Health Agents discuss early marriage and its consequences during their house to house visits or in group discussions about reproductive health.

- At the village level, students, CBRHAs or Women’s Association members will hear about a “metamamen” (engagement) planned between the two fathers; this arrangement requires witnesses.
- They will inform the committee and often the school director and a representative from the women’s association will together go to counsel the parents.
- In some kebeles there is an active traditional practices/early marriage screening committee comprised of 3 recognized decision-makers at Kebele or peasant association level (including the CBRHA) who will hear the case. They are authorized to fine the parents upwards of 1500 birr. After this intervention, they will follow-up with the girl’s family after the expected date of the ceremony.
- In other locations, if the parents persist with the marriage, the school or women’s association representative will inform the woreda court or woreda administrator. If it is a clear-cut case, police will be notified and will come to take the father into custody.
- The woreda will send out a judge and police to assess the girls’ ages in several villages at once with a list of names provided by women’s association representatives (those that can marry/ those that can’t marry because of age.) If there is disagreement about the age, the girls will be sent to the hospital for age determination.
- Families in violation of the law will be called into court, and fined up to 5,000 birr with up to 7 years in jail. The marriage will be annulled.
- The CBRHAs will testify against families but do not accuse them; in Amhara Region, the women's association representatives or school directors formally accuse families.
- CBRHAs are considered key members given their training in reproductive health education and as community leaders in health. As one Amhara Women’s Association representative says, “They know everything that is happening because they go home-to-home. They are more trained than any other members of Kebele committees and other AWA members, so they are very active, more so than others, to give information on early marriage.”
RESULTS:


Early Marriage Prevention committees have been established in 38 woredas of Amhara region by the Amhara Women's Association.
Eighty (80) schools brought teachers, parents and students together for sensitization activities on the harmful effects of early marriage and strategic-planning to stop the practice.

2. Enforcement of Legal Code.

Judge Kassa Firdal, court chairman of Awabel Woreda, Amhara Region travels to remote areas to educate the community on early marriage and screen engaged girls and boys and reports:

- “Instead of punishing people, we prefer to educate them. So we travel to rural areas…when I speak, everyone listens, because they know who I am.”

- He identifies girls of an age to marry during these educational visits to towns by sending a message to the Kebele chairman before his visit to assemble girls and parents.

- If they do not come to get their daughter screened for marriage, the Kebele chairman will report to the woreda level.

- Now that they are enforcing penal code and punishments, people are responding and changing their behavior. “From year to year, we are seeing behavior change.” Court cases increase each year.
3. School Involvement.

Tarik Abeje, leader of a girls’ club at a school in Amhara Region reports:

- The girls’ club has 50 members (5 are married) and carries out peer education on RH/FP, HTPs, and life skills
- “The students themselves report information and come to me. We call the parents and give them advice. If they don’t agree to stop the wedding we report them to the woreda court.”
- When persuading the parents to not marry daughters early, the school director & Tarik discuss the danger of complications like fistula, the supremacy of the husband over his young bride, need for FP, and the connection between education & a better quality of life.
- “Mostly, they will disagree with us. But sometimes they take our advice.”

4. Use of role models.

Community-Based Reproductive Health Agents Lule and Teferra were both married around 14 years old. Now, they both have 14-year-old daughters, who are in school, and not engaged.

- “We don’t want our children to pass life the way we did. We want them to help themselves first, and choose their partners.” (Teferra)
- When they hear of an engagement, they talk to the parents, and if the child is in school, report it to the school director.
- They counsel families to save the money they spend on weddings and instead use it to educate their children.
- “I give them examples of other daughters who went to school, got jobs, and now help their families.” (Lule)

5. Prevention of Early Marriages.

- In Amhara Region in 2004-2005, planned marriages of 10,477 female students under age 18 were canceled.
• In five zones in Tigray Region, the intervention succeeded in cancellation of marriages involving 968 youth under age 18. (Source: Pathfinder International Annual Report 2005)

• From July 05 to January 2006, 1,783 early marriages were prevented through court intervention at the woreda level. 147 cases are currently in court awaiting resolution. (Source: Amhara Women's Association, Pathfinder report)

6. Awareness of the Negative Consequences of Early Marriage.

• “We give education everywhere in the kebeles through Amhara Women’s Association and CBRHAs. They know it! Some accept, some do not. But they have the information.” (Haimanot Mekonnen, AWA)

• “Often, meetings will convince husbands, but in most cases, the hardest push comes from the mother, who thinks she is protecting her daughter and reinforcing good social connections with other families and tribes.”

• There is a misperception of the law on behalf of community advocates, where it is believed that if a girl gives her consent at any age, she can be married. (Source: Pathfinder reports)

• The meeting for senior Orthodox, Islamic, Evangelical Protestant, and Catholic leaders in Tigray Region resulted in statements against unplanned large families, female genital mutilation and the following specific to early marriage: “We understand that early marriage is not only causing physical and psychological health problems to our girls but also exposes them to death. Therefore we strictly condemn and oppose the practice…..Finally we promised to do all we can so that our religious followers are aware of the three points mentioned above.”

• “When girls are married at a young age they get hurt because their bodies have not matured as yet. Adam’s children are respectful in the eyes of God, and hurting those bodies is a crime. If whatever we do hurts that respected body then we should stop this. We, as religious leaders should be serious about this.” Rape and marriage by abduction are even worse than early
marriage. It is taking away the life and right of young girls forever.” (A Muslim Leader at advocacy session in January 2005, Tigray Region).


- Radio spots in regional languages,
- An educational booklet on the new Penal Code (enacted May 2005) explicitly condemning early marriage and other HTPs such as FGM and abduction, and outlining punishments for such offenses.
- A video on obstetric fistula was produced, positing fistula as a direct result of early marriage and addressing other factors affecting early maternal mortality such as FGM and unattended births.
- Video on female genital circumcision was disseminated through mobile vans and at advocacy sessions with newly elected officials.

8. Replication.

Mobilization efforts to prevent early marriages continue in new communities in Amhara and Tigray Regions.

LESSONS LEARNED:

- Community awareness-raising activities at the grass-root level helps build a network that can help to identify potential or planned early marriages and to initiate community interventions to prevent early marriages.
- Teachers (in particular female teachers) have proved the most effective first line of defense at the community level, as they are familiar with the girls’ situation, and girls are more comfortable approaching them in times of need.
- Religious Leaders have proven invaluable advocates on national and community levels in raising awareness, acceptance of these initiatives and creating communitywide censorship of early marriages, as well as reaching people outside the normal sphere of projects also known as out-of-school girls and their parents. They do, however, require accordance from national leaders in their faiths, requiring simultaneous community and national level advocacy with religious bodies.
• The voluntary women’s associations in Ethiopia, with their large membership, e.g. Amhara Women’s Association has 300,000 members, are effective at mobilizing at the district and community levels, while government branches of women’s affairs are useful for carrying out formal reporting and enforcement activities around early marriage.

• Community-Based Reproductive Health Agents have been instrumental in increasing the awareness of the harmful consequences of early marriage linking this to broader reproductive health issues.

• Communities that are most active are those that have in place in-school and out-of-school girls or prevention of harmful traditional practices clubs.

• Expanding education opportunities is important as in rural areas, formal education for girls ends at Grade 8, at which point they are still at risk for early marriage.

• Interventions are needed to address the economic and social pressure that may cause early marriages as communities report that daughters are often married in order to settle a debt; to calm a clan feud; to certify a business transaction; or to pay for the boy’s marriage.

• It is hard to identify the time & place of a violation of the law. Children can be betrothed as young as 3 to 5 years old. They grow up together as brother and sister, and eventually begin sexual activity.

• Preventing early marriages without an adequate safety net may result in negative results, e.g. girls running away from home to become servants or prostitutes in town with loss of their support network.

• Some parents go to extreme measures to avoid getting caught, like presenting an elder daughter for screening and holding ceremonies in the recesses of the gorge, accessible only by donkey.

AVAILABLE RESOURCES:

• Recommended reading: Yebedel Wurse Yikir, by Yesewdeg Getachew, a documentation of oral tradition on how early marriage affects the lives of women and girls in Amhara Region

• Pathfinder documentary film: “Is It Worth” on harmful traditional practices.

• Educational booklet on new Penal Code.
Aleme Salil (right), Grade 5, age 13, was to marry a year ago, but her friend (not her) heard about the engagement and informed the school. The school called on her parents, who didn’t respond, then wrote a letter to the judge and put her dad in prison as a warning. She was not married, and still attends school. “Now they [parents] insult me because the wedding was disrupted. But because of the judge’s decision they cannot do anything.” She likes to study English and wants to be a doctor. On marriage, she states, “after I finish my education, I would like to marry, after my aims are fulfilled.” Although Aleme’s parents have been warned not to marry her before she is 18, her future is still not secure. They have attended many weddings and spent money on wedding presents: clothing, food, and money, in a net amount that they hope to recoup through marrying Alame off.

Records of averted early marriages and those cases pending court decision are kept at the kebele and woreda levels.
Community Mobilization to End Female Genital Mutilation and Other Harmful Traditional Practices

NEED:

A survey conducted in 1998 found that female genital mutilation (FGM) is practiced by 73% of the households surveyed in the 10 regions. The practice of FGM is considered significant because of the pain that is caused and other potential health consequences: bleeding resulting in shock, infection, urine retention, tetanus, laceration and transmission of HIV/AIDS or other blood-borne diseases. (Baseline Survey Report, NCTPE, 1998)

RESPONSE:

Since 1993, Ethiopia Goji Limadawi Dirgitoch Aswogaj Mahiber (EGLDAM) formerly known as the National Committee on Harmful Traditional Practices, has been working with various partners to address harmful traditional practices, including advocating for the elimination of female genital mutilation. Key components of their work are advocacy for legal protection against harmful traditional practices, and facilitation of public awareness about harmful traditional practices and mobilization of communities to action either directly or by building capacity of partners to do so.

1. Public awareness-raising and education

   • Developing and disseminating of variety of IEC materials including video films, audiotapes, booklets, leaflets, posters and T-shirts with messages in several different local languages.
   • Supporting school Anti-HTP clubs.
   • Integrating education about FGM into primary and secondary curriculum development; training teachers.
   • Identifying key stakeholders that could address the social norms, misconceptions, and beliefs associated with FGM as identified through listening to communities. EGLDAM identified that health workers including Traditional Birth Attendants, Traditional Healers, Community-based Health Workers (CBRHAs), and Health Professionals and religious leaders needed to be involved in educating the community given the beliefs and misconceptions about the health benefits of FGM and the religious obligations.
Facilitating mass awareness-raising activities “Anti-FGM Days” that reach a large number of people with information and education and a venue to speak out about FGM.

The first event was held in Oromiya Region in cooperation with the Women’s Affairs office in Assela town in November 2002 and have since been held annually in other towns in the region. The event included: speeches against FGM by high level officials, drama or other arts events, and awards for prominent religious and tribal leaders who have made significant contributions to fighting FGM and to women who married without being circumcised. The Anti-FGM day is held every year in different locations in the region.

Others as well have successfully used the practice of this mass event to raise awareness of the public about the harmful effects of FGM. Kembatti Mentii Gezzima (KMG) a strong local NGO working to improve reproductive health of women in the Southern Region of Ethiopia organized a “Celebration of Whole Body and Healthy Life and Freedom from Female Genital Excision in Durame, Ethiopia on October 31, 2004. The event included:

- Recognition of young women that were publicly committed to refusing to be cut.
- Speeches by KMG, representatives from international donors and NGOs,
- Wedding of couple who had rejected tradition and were married without the bride first being circumcised,
- Traditional games, dances, and displays of traditional handicrafts.

2. Community Conversation

NCTPE provides 1-2 day training for volunteer community members to learn how to facilitate Community Conversation in the communities about harmful traditional practices that include early marriage, FGM, and abduction. Coffee and tea are provided to those participating in the conversations.
Community Conversation is a methodology designed by United Nations Development Programme to promote discussion about taboo subjects, to explore cultural and traditional beliefs and practices and to plan how to address community-identified and prioritized problems. It has been found to be effective and inexpensive practice to inform and mobilize communities.

KMG is using this methodology successfully to bring old and young women and men together in schools, churches, mosques or the open air to discuss harmful traditional and sexual practices, HIV/AIDS and to skillfully lead them to planning community actions.

RESULTS:

1. Increased Public Awareness.
   - NCTPE reports that the Anti-FGM events are well-attended with up to 30,000 people coming from the town and surrounding rural areas.
   - The crowd that attended the Durame event on October 31, 2004 at the municipal soccer field was estimated by the media to be 70,000-100,000 men, women, youth and children.
   - Wide media coverage of these events has been provided by Ethiopian television, radio and print press.

2. Change in Attitude about FGM
   - Fifty-four Mothers in Alaba pledged during a Community Conversation that they “would not touch” their daughters.
   - The number of registered uncut girls in Alaba has risen to 500. (KGM Newsletter, Fall 2003)
   - EGLDAM reports that change in attitude is most dramatic among young girls.
   - DHS 2005 preliminary data as compared to 2000 data shows that support for the practice declined among the interviewed women age 15-49 with only 29% of the younger women now supporting the practice.
3. Change in Practice of FGM

- These efforts have contributed to change in practice of FGM, a reported 6% decrease in FGM practices (DHS preliminary data, 2005).

4. Community Action

- Stephen Lewis, UN Special Envoy for HIV/AIDS in Africa on his May 2004 trip to Ethiopia reported meeting a 70 year old Islamic leader in Alaba that had led 130 men to be tested for HIV/AIDS after the community conversations about the spread of HIV/AIDS. (Ethiopian Herald, June 04, 2004)
- No enforcement of the new law concerning FGM has been reported; the FGM procedures are generally done in the privacy of the homes. (interview with EGLDAM)

5. Sustainability: As a result of the community conversation facilitation training to community members, awareness-raising at the community-level will continue in many places. Funding is needed to continue on-going advocacy and training of more facilitators.

6. Replication: Pathfinder International and Implementing Partners in Amhara and Tigray Regions are using community conversation methodology in communities to also address the practice of early marriage.

LESSONS LEARNED:

1. Earlier awareness-raising with community groups was done using over-head projectors and lecture methodology; community members reported that they did not like this teaching style and wanted a more interactive approach and that the (volunteer) facilitators must be getting money to teach them. The methodology was changed to a participatory approach using stories and facilitating dialogue using community conversation methodology.

2. The use of the two methods: mass annual event and the community-level mobilization using community conversation enhanced each other, participants come to the event having discussed the issue in the community, to celebrate their decisions, and/or return to the community to discuss what they heard from speakers at the mass event.
3. The mass events attract the involvement of high level politicians and policy-makers that are present to hand out awards and make speeches.

4. EGLDAM reports that the integration of advocacy and awareness-raising with development activities (e.g. income-generating for women) as practiced by KMG is very effective as it enhances community involvement and fosters change.

AVAILABLE RESOURCES:

- Brochures Leaflet No.2 Female Genital Mutilation
- FGM Network Update newsletter

CONTACT INFORMATION:

EGLDAM
Ato Abebe Kebede, Executive Director
011 618 2607

Documentation: May, 2006
Obstetricians/Gynecologists Advocating for Sexual and Reproductive Health Rights in Ethiopia

NEED:

In Ethiopia, the medical code of ethics did not specifically addressed the rights of individuals or reproductive health issues except for articles that instructed that informed consent must be obtained before any procedure, an article on abortion in line with the penal code emphasizing treatment of complications and reporting of deaths related to abortions, and an article on family planning, that couples beyond the age of 16 can access family planning.

There was recognition in the professional community of obstetricians and gynecologists (OB/GYNs) that the code needed to be revised and improved from the rights perspective and in light of the newly revised penal code and family law as well as to meet international standards.

RESPONSE

In 2001-2004, a project to address these issues was designed and implemented by the Ethiopian Society of Obstetricians and Gynecologists (ESOG) in collaboration with the International Federation of Obstetrics and Gynecology (FIGO). Aims of the project were to raise the awareness of Obstetricians and Gynecologists on the issues of sexual and reproductive health rights and to develop a Code of Ethics for professional reproductive health practitioners.

Key components of the code development process included:

1. Awareness-Raising for Obstetricians. A workshop was held for ESOG members to raise their awareness of violence against women and to discuss issues related to the profession’s role and responsibility in respecting, protecting and promoting the rights of individuals. Information was provided to re-orient members to the new 1987 constitution and the articles subscribing to rights, explicit about rights of women and to the newly revised penal code and family law, to the 12 pillars of reproductive health rights and through discussion to build a consensus as a society and as an individual.

2. A Code of Ethics for Reproductive Health Workers was drafted by ESOG and approved as a draft by the Executive Committee.
3. A national consultative meeting that involved ESOG, and leaders from ENMA, EWLA, Nurses Association, Family Guidance Association-Ethiopian, and University Medical Schools and other providers and advocates was held to discuss and critique the draft code of ethics. Each sub-group focused on three of the issues and gave comments about what was relevant to Ethiopia and should be included. This group also established two priority advocacy issues to address as a community: unsafe abortion and gender-based violence (issues of sexual assault).

4. The draft was revised based on the input of these reproductive health specialists and practitioners and returned to ESOG Executive Committee for review and their approval.

5. At the annual meeting of ESOG the draft was submitted for further discussion and was approved by Assembly.

6. The approved draft was communicated back to the ENWA, who agreed to conduct a two day meeting on RH rights and code of ethics. Part of this orientation included value clarification. 250 midwives attended the meeting and endorsed the code of ethics for RH Workers.

7. The code was sent to teaching institutions and is now being taught annually at a one day annual seminar for OB/GYN residents in Addis Ababa. Undergraduates receive training about the code during a one credit hour medical ethics course, where OB/GYN professors discuss this as part of their lecture.

RESULTS:

- The consultative process was effective in raising awareness, obtaining political support, promoting ownership among key stakeholders as they actively contributed to the process, gaining valuable input into the development of the Code of Ethics for RH Workers and facilitating the approval process.

- Ethiopia’s Code of Ethics for Reproductive Health Workers is being used as input to FIGO, as they develop their own code that can then be adapted by others.

- At a recent conference in South Africa, the Ethiopian code and process for drafting and adopting the code was presented as a model.
- The Code of Ethics for RH Workers is being disseminated among OB/GYN residents, medical students and midwives.

LESSONS LEARNED

- A consultative process involving key stakeholders is critical to the development of “owned” and relevant policy, guidelines, and standards.

- Midwives have enormous potential in identifying and caring for victims of sexual abuse so must be well informed about rights and how to best assist the women. Involving them in the process and adoption of the code, 1000 midwives were reached in addition to the approximate 100 OB/GYN physicians.

- There is a need to continue working on reproductive health rights issues as they underlie many of the reproductive problems the country is facing.

AVAILABLE RESOURCES

- http://www.esog.org.et
- http://www.figo.org

CONTACT INFORMATION

Ethiopian society of Obstetricians and Gynecologists (ESOG)
esog@ethionet.et
Tel +251-11-559-60-68/9/70

Documentation: April 2006
Accelerated uptake of the practice for active management of third stage of labor (AMTSL)

NEED:

Maternal mortality is very high in Ethiopia, the Demographic Health Survey conducted in 2000 found 871 maternal deaths per 100,000. Four percent (4%) of maternal mortality is due to post-partum hemorrhage. The incidence is thought to be much higher given that deaths are not captured in institutional service statistics as many women do not make it to the facility given the rapid deterioration and death caused by post-partum hemorrhage.

A baseline assessment of management of third stage of labor practices in 24 health facilities in three regions in Ethiopia: Addis Ababa, Amhara and Oromiya was conducted to develop the training program and for evaluation purposes. A key finding was that only 1% of the facilities were using AMTSL. AMTSL is an intervention which requires a universal administration of Oxytocin (10 International Units intra-muscular) within one minute of delivery, clamping of the cord immediately and controlled umbilical cord traction for all vaginal deliveries.

RESPONSE:

A joint project, implemented by IntraHealth PRIME II, Ethiopian society of Obstetricians and Gynecologists (ESOG) and Ethiopian Nurse Midwives Association (ENMA) aims to reduce maternal deaths from postpartum hemorrhage through introduction of active management of third stage (AMTSL) for all vaginal deliveries.

Key components of the project include:


   National Guidelines, Quick reference materials (job aids), and a training tool on active third stage management were developed by Ministry of Health (MOH), Ethiopian Society of Obstetricians and Gynecologists (ESOG), Ethiopian Nurse Midwife Association (ENMA) and IntraHealth and distributed to institutions of higher education.
2. **Building Capacity of Health Professionals in the Public Healthcare Sector**

Training of trainers was conducted by ESOG. Three-day workshops were then conducted for nurses, health officers, and doctors from 24 hospital and health centers in Amhara, Oromiya and Addis Ababa.

**RESULTS:**

- A rapid transfer of AMSTL knowledge and skill has been observed. Initially it was noted that only 1% of institutions surveyed were instituting active third stage management. Six months after the training, an assessment found that 90% of the survey institutions had instituted the practice.
- Assessment of practitioners found a 60% increase in both their knowledge and practice.
- The practice has cascaded to health workers that have not been directly involved in the training, but who had observed trained providers or had accessed the guidelines or the quick reference aid and subsequently adopted the practice of AMTSL.
- Both providers and administration were positive about adopting the new protocol and change in practices. (Post intervention assessment, 2003)

**LESSONS-LEARNED:**

1. The introductions of these new practices require minimal training; costs for training are low.
2. Challenges to the implementation of AMTSL are: need for cold chain capacity and potential unavailability of Oxytocin. If these challenges are met, AMTSL is quite sustainable and easy to replicate.

**AVAILABLE RESOURCES:**

- Quick reference-AMSTL aids
- Training Guide

**CONTACT INFORMATION:**

esog@ethionet.et

Dr. Ashebir Getachew  ashebirg@ethionet.et
Making Pregnancy Safer (MPS)

NEED:
Maternal Mortality is very high in Ethiopia; the 2000 DHS found 871 maternal deaths per 100,000 births. Common pregnancy-associated complications causing deaths include: prolonged and/or obstructed labor, hemorrhage, and sepsis. Adolescent pregnancy, HIV among pregnant women, malaria, malnutrition, abortions, and the common practice of female genital circumcision contribute to the high rates of pregnancy-related complications.

As may be noted in the following table the utilization of pregnancy-related institutional services in Ethiopia continues to be very low.

<table>
<thead>
<tr>
<th>Indicators</th>
<th>2000 DHS</th>
<th>2005 DHS</th>
<th>Reproductive Health Strategy Targets-MOH</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANC Coverage</td>
<td>27%</td>
<td>28%</td>
<td>70%</td>
</tr>
<tr>
<td>Skilled Delivery</td>
<td>6%</td>
<td>6%</td>
<td>60%</td>
</tr>
<tr>
<td>Maternal Mortality</td>
<td>871/100,000</td>
<td>No data available</td>
<td>350/100,000</td>
</tr>
</tbody>
</table>

There are numerous reasons why women with pregnancy-related complications delay seeking facility care.

- The first delay is at the household level and may be due to: lack of information about services, inadequate knowledge about danger signals during pregnancy and labor, cultural and traditional practices that prevent women from seeking health care, or lack of money for available transport.

- Inability to access health facilities may be because of long distance to the health facilities, poor roads, lack of transportation services, and communication network, and lack of community support mechanisms.

- There may be a delay between arriving and receiving care at the health facility due to omission of appropriate care, delay of interventions or inappropriate interventions due to lack of appropriate theoretical and practical skill, poorly motivated staff, inadequate equipment and supplies or a weak referral system.
A rapid needs assessment was conducted by Family Health Department-Ministry of Health in Arsi Zone (Oromiya Region), Gedeo Zone (SNNPR), Shire Zone (Tigray Region), and South Wollo Zone (Amhara Region). Key findings included:

- Only 4.5% of the deliveries in the zones were attended by a health worker.
- Maternal mortality was 1036 per 100,000 in these catchment areas.
- There was a shortage of maternal and newborn care health professionals.
- Eight percent (8%) of the facilities had Manual Vacuum Aspiration (MVA) equipment.
- Record-keeping was not adequate in 53% of the facilities.

RESPONSE:

Taking the magnitude of the problem into account, Ethiopia was chosen as one of the countries to pilot MPS by WHO and other partners. To address the lack of access to and availability of emergency obstetric care (EmOC), the “Making Pregnancy Safer Initiative” was accepted by the Family Health Department of the Ministry of Health-Ethiopia to be implemented in collaboration with WHO, UNICEF, UNFPA, World Bank, and SIDA. The strategy is to strengthen selected facilities to provide basic and emergency obstetric care (EmOC) through a functioning referral system – from the community to the tertiary level; implementation plan is area based with a systematic phased approach.

Objectives:

- To review national policy and strategy in relation to maternal and child health care and facilitate policy dialogue.
- To improve the quality and quantity of maternal and newborn care in four pilot sites.
- To ensure the provision of skilled attendants at both health facility and household level
- To ensure a functioning health care system and strengthen referral links, especially for complicated obstetric care.
- To improve access and availability to good post-abortion care including family planning counseling and services.
- To improve community awareness on danger signs and complication readiness/birth preparedness and involvement in ensuring access to maternal and newborn care.
• To conduct operational research in order to understand and strengthen further MPS programmatic efforts in the country.

In June 2001, four hospitals and 16 health centers in Amhara, Oromiya, SNNPR and Tigray Regions were selected as pilot sites. Selection criteria for the pilot areas included: poor reproductive health status, large population, available training centers and trainers, adequate level of health infrastructure, relatively accessible and with commitment and interest in participating in the MPS initiative.

The project has since expanded to eight hospitals and 32 health centers over the last two years and is planning additional coverage in the next years.

Key components of MPS:

1. **MOH Capacity-building.** WHO provided a consultant seconded to the FMOH to serve as program officer to work with focal persons assigned from FMOH and Regional Health Bureaus to coordinate the activities. MPS staff are actively involved with other stakeholders within the Ministry of Health, Universities, Reproductive Task Force and professional societies to strengthen the policy environment related to reproductive health.

2. **Training for Health Professionals:** Nurses, midwives, and physicians were provided training on basic and comprehensive EmOC using guidelines and IMPAC tools developed by WHO. The trainers are mainly obstetricians and gynecologists at district hospitals.

3. **Facility System Development.** Assistance was provided to develop a referral system for complicated cases from satellite health centers to the hospitals. By providing an ambulance to each pilot hospital that would be shared with the health centers in their catchment area emergency transport could be provided for more advanced care for major complications. Registration processes were strengthened, otherwise data collection and reporting was through the general MOH reporting system. The health facilities were provided midwifery supplies and obstetric surgical kits as needed for basic as well as comprehensive EmOC.

4. **Community Mobilization.** Community Health Committees were developed at the Kebele level, with the Women’s Affairs Office serving as chairperson. They were provided two-three orientation sessions about danger signs and pregnancy-related complications as well as the need to promote skilled deliveries. Following the orientation, the committees worked with community **idhirs**, local collectives which previously helped only with funerals, to advocate and help for early transportation of
clients and care. Every idbir is now asked to add transport of clients needing emergency obstetric care as part of their assistance.

5. **Facilitative Supervision and Monitoring.** Regular facilitative supervision is provided by the zonal health department (Maternal Child Health (MCH) focal persons) every three months. In addition, regional health bureau focal persons visit every 6 months and national MPS staff monitor at least once a year using various methods: observation, interviews, and review of service delivery reports using supervision check lists.

6. **Annual Review Meeting for experience sharing.** Meetings bring national, regional, zonal and woreda stakeholders together to share accomplishments, problems and to plan necessary actions for the following year.

**RESULTS:**

1. **Increased capacity to provide emergency obstetric care and fuller range of services.**

Ten (10) comprehensive EmOC sites (Health centers) and 40 basic EmOC sites (Zonal/District Hospitals) have been equipped and supplied to provide obstetric care. Eight ambulances were donated to four pilot hospitals and three teaching institutions with medical schools.

2. **Increased knowledge and skills of health professionals at the facilities after training.**

   - Nine trainers (Obstetrician and Gynecologist specialists) were trained on utilization of IMPAC Tools developed by WHO and provided in-service training following these guidelines.
   - Basic and comprehensive training was competency based.
   - 243 Health professionals have been trained in basic emergency obstetric care.
   - Eight (8) teams, each including a General Practitioner or Health Officer to do the surgery and other obstetric care, one nurse to serve as scrub and one nurse to serve as anesthetic, have been trained in comprehensive emergency obstetric care.

3. **Increased utilization of obstetric services.** The number of deliveries at each hospital has increased since the start of the project in 2001.
4. **Increased quality of obstetric care.**
   - The number of C-Sections performed a year has increased from approximately 200 to 950 (totaling all four hospitals) since the beginning 2001.
   - Case fatality rates cannot be calculated given limitations of the HMIS.

5. **Increased awareness of public about danger signs of pregnancy, complications readiness and the importance of hospital deliveries.**
   - Majority of female focus group respondents said that appropriate time for seeking care at facility is the onset of labor.
   - Approximately half of male participants stated onset of labor; an equal number of males stated if problems such as prolonged labor or bleeding.

   *(MPS Evaluation report, FHD, 2006)*

6. **Improved supervision and monitoring.**
   While the number of site visits, use of supervision checklists, review of reports, participation in review meetings, have increased or been established, this component
continues to need strengthening. The current effort to strengthen the HMIS will provide better data quality and increased ability to track results.

7. Improved referral system.

The Kebele committee in Oromiya Region has reported to MPS that the community-based transport assistance by idbir is working well; one idbir is providing 400 birr loans for emergency transport. The loan is then paid back in three months. Anecdotal reports are that this is beneficial as it saves time that previously would be spent to find money or sell cows before going to the hospital.

Focus group discussions in survey communities found that idbir are willing to be involved with facilitation of transport services and community residents express desire for the system; in most places the system is not yet working well as “it still takes long time to access and have to repay quickly.

(MPS Evaluation report, FHD, 2006)

8. Client satisfaction.

- There was a mixed response to the question of satisfaction with obstetric services by the female focus group respondents. While those that were satisfied mentioned the friendliness and support of staff; a significant number said that there is preferential treatment according to social status and residence.

- The great majority of male participants were not satisfied, listing lack of cleanliness, poor handling and approach of staff, lack of privacy for their wives, and lack of supplies and drugs.

(MPS Evaluation report, FHD, 2006)


- Inclusion of Misoprostol in the national drug list for active management of third stage of labor.

- Concept paper on how to avail clean and safe delivery at household level with involvement of Health Extension Workers.

- Inclusion of maternal health program in HHSDP III,

- Adaptation of IMPAC tools to manage common obstetric problems.
• Initiation of Maternal Death Audits (MDA) with Medical Faculty of Addis Ababa University.

• Development of REDUCE model for Ethiopia and its utilization for advocacy at all levels—Parliament to community elders—for bringing maternal health issues high up in the agenda and mobilizing resources and national efforts.

10. Increased funding. Given the advocacy for more services, the great need for increased emergency obstetric care, and the success of the initiative brought additional donors to support the program, e.g. SIDA and EU are now providing funds to expand MPS initiative.

LESSONS LEARNED:

• The plan for the health centers to call the ambulance from the hospital has only been successful in two places. In the other two areas it is not working because health centers are long distances away from the hospital and there is disagreement about who will pay for the maintenance and driver. In one of the areas, this has been solved by giving the ambulance to the furthest health center. Transport continues to be a problem at night given bad road conditions and insecurity (fear of bandits) in some of the project areas.

• It is possible to improve access to EmOC with minor input at the existing government infrastructure, using the government system and adding only what is deficient. Working within the government system will resolve the issue of sustainability. But there are also drawbacks in program implementation because activities must follow the general regulations of the government. For example, training may be compromised by the limits of what can be paid to trainers and trainees.

• Improving the quality and availability of services are critical priorities to increase the utilization of obstetrical health services. Changing the common practice of home births to facility-based assisted deliveries will require behavioral change interventions that address many factors including level of awareness, attitude and beliefs, structural needs (e.g. place to make coffee), costs, transportation, a supportive community and family environment and a well-equipped skilled client and family-focused health care system. Involvement of men is critical to support women to access skilled care. IEC
materials and activities are needed to promote skilled deliveries and early identification/action if pregnancy-related danger signs appear.

- Mechanisms must be created to keep trained and motivated health workers. The high staff turnover requires continual training necessitating adequate budget, planning, and training resources. Low motivation of staff is primarily related to low salaries, lack of clearly defined roles, e.g. the issue of whether general practitioners may conduct surgeries-C-Sections, and inadequate supply and infrastructure issues.

- Ongoing in-service and pre-service trainings are essential to ensure sustainability and quality of services and will help improve not only staff skills but also staff morale.

- Full ownership of programs by Woredas to plan, implement and monitor activities and to oversee and support community mobilization efforts is crucial. The Woreda Health Council can be instrumental in keeping trained staff in place.

- Shared use of the ambulances by referral hospitals and health centers is difficult to manage.

- Integration of ANC-VCT-PMTCT service is lacking at all centers. MPS is planning to partner with NGOs that are supporting the establishment of VCT and PMTCT services to integrate pregnancy, labor and delivery care.

- Supervisory and monitoring visits need to be regular. Increased attention and support is being given to putting supervisory/monitoring systems in place.

- Hospitals, given the higher level of care and serving as a training center, need to be staffed at least by one obstetrician.

- Adequate budget is needed for regular supply of consumables and maintenance of equipment such as steam sterilizers, minor sets, delivery sets, Vacuum extractor, MVA kits, and contraceptive methods. A system to maintain broken instruments and provide regular supplies must be put in place to avoid service interruption.

- Strengthening the training of Health Extension Workers with the community health promoters in community-based safe motherhood promotion activities will help to minimize the first and second phases of delay.

- Building and maintaining strong partnerships at all levels is of great importance for efficient coordination and resource mobilization. The development of the Kebele level committees working with the Woreda Health Council has helped to do this as well as the annual review meetings.
• An attempt should be made to cover the whole zone to bring a palpable difference in coverage/results at zonal level.

AVAILABLE RESOURCES:

• Baseline Assessment
• Five-Year Evaluation Report
• Training Guideline and manuals
• Evaluation and monitoring tool

CONTACT INFORMATION:

Family Health Department
Federal Ministry of Health Ethiopia
Addis Ababa, Ethiopia
Ayele Debebe Gemechu
Obstetrician and Gynaecologist
National Program Officer for MPS
Tell: 251 91 169 79 77
Fax: 251 011 551 40 37
E-mail: Ayeled@et.afro.who.int

WHO/Ethiopian country office-FMOH/FHD
Addis Ababa, Ethiopia
Abonesh H/Miriam, WHO, Kidane Ghebrekidan, UNFPA, and Alemach Teklehaimanot, UNICEF
Save the Mother Initiative

NEED: Refer to need discussed under previous section on MPS.

RESPONSE: From 1998, this initiative was conducted by ESOG in collaboration with International Federation of Gynecology and Obstetrics, (FIGO) Save the Mothers Fund and with support of UNFPA, Pharmacia Corporation, and the World Bank to address the lack of access, availability and utilization of quality obstetric care to reduce maternal mortality caused by unsafe abortions, hemorrhage and other labor/delivery-related complications. The Save the Mother Initiative was launched in West Shoa zone, Oromiya Region. Demonstration sites were established at Ambo Hospital and Shenen and Ejaqi Health Centers. This project area was chosen because of the high number of women being transferred to Addis Ababa with ruptured uteruses and the high maternal mortality rate in the area. Given that Ambo Hospital is approximately 150 kilometers from Addis, the site was easily accessible so close supervision and technical support could be provided.

Key components of the initiative were:

- Networking and consultation with regional, zonal and woreda health personnel to discuss available resources and to plan staff assignment, procurement of equipment and supplies as well as refurbishing infrastructure.
- Initial facility assessment conducted to see what equipment, materials, supplies and other resources were available, in working condition, determine training needs and review the current data collection and recording and record-keeping system.
- Training of general practitioners and other mid level workers who had been selected by regional and zonal offices was done at Ghandi Hospital in Addis for three months and included theoretical and practical experience performing C-Sections, MVA and IUCD insertion, and Norplant procedures
- An experienced OB/GYN physician assigned to the sites to mentor the trainees for a few months upon their return to the workplaces.
- Necessary equipment and medical supplies provided as well as revision of the data management system. The electricity system was improved and the emergency vehicle repaired. Refrigerators were provided to the blood bank.
- A quality assurance/monitoring system was developed that included maternal mortality audits when possible given the improved and available data. Standardized indicators were established and tracked including: number of births attended, number of C-sections performed, number of complications managed, case fatality...
rates, C-section rates using service statistics and international standards for comparative analysis. Case reviews of maternal deaths were conducted on a regular basis led by the project coordinators.

- On-going supervision and technical assistance by the Project Officer on a weekly basis in the beginning and then monthly or more often as needed by a Central Coordinator, both OB/GYN specialists.

- Community Mobilization: Review of service statistics as compared with anticipated births (given the census and demographics of the area) identified the need to address the 1st and 2nd delays; the acceptable formula according to ESOG is that 15% of pregnant women will develop life-threatening complications. Project and hospital staff met with the Woreda Administration, women’s association and other community leaders and did education at the Keble or peasant association level. RH Rights were explained as well as signs of pregnancy and labor complications, and instructions to go to the closest facility if problems or danger signs occur.

RESULTS:

1. **Availability of health professionals trained in emergency obstetric care.**

   - Seven physicians were trained on comprehensive emergency obstetric care and demonstrated competency to perform Cesarean sections, instrument deliveries, and operative deliveries to relieve obstruction, and post-abortion care.

   - 37 midwives, nurses, and health assistants were trained to perform venous delivery, manual removal of placenta, non-surgical management of pregnancy, common medical complications, post-abortion care as well as early identification of potential serious complications and appropriate referrals.

   - General practitioners were enabled to perform c-sections and laparotomies for uterine rupture. E.g. 188 of the 572 C-sections were performed by general practitioners during a specified timeframe within the project.

2. **Availability of emergency obstetric services.**

   - Ambo Hospital had comprehensive emergency obstetric care capacity and basic emergency obstetric care was available at Shenen and Ejaji Health Centers.

   - Decrease in number of referrals to Addis Ababa for advanced care.

   - Round the clock service 7 day a week obstetric services were made available.
3. **Improved quality of emergency care.**
   - Increase in cesarean sections and laparotomies for uterine rupture increased by more than five fold.
   - Decrease in case fatality rates from (6.06 to 2.96)

4. **Information System**
   Revised data collection and record-keeping enabled the project to assess its performance over time. (Source: Interview with ESGP informant from findings published in International Journal of Gynecology and Obstetrics 81(2003)93-102; Project Activity and Monitoring Reports, ESOG)

5. **Replication**
   Save the Mother is being replicated in Lalibella

**LESSONS LEARNED**

- This capacity-building initiative is resource-intensive but can save lives of mothers and infants.
- Motivated providers will assume new responsibilities.
- The quality of training was assured by using a training facility that has a large case load followed by mentoring of newly trained personnel on site.
- There is a need for more attention to creating community awareness, birth preparedness, and danger signs of pregnancy and childbirth; new partnerships and linkage with NGOs are being explored

**ADDITIONAL RESOURCES**

- Study of Under-utilization of Services in West Shoa, ESOG.

**CONTACT INFORMATION**

esog@ethionet.et

web site http://www.esog.org.et
Early Identification and Referral of Pregnancy-Related Emergencies

NEED:

Maternal mortality ratio in Ethiopia is one of the highest in the world with 871 maternal deaths per 100,000 live births (Ethiopia DHS 2000). In the course of their pregnancy approximately 15% of all pregnant women develop some kind of potentially life threatening complication which requires emergency obstetric care. Utilization of obstetric services in Ethiopia was very low with only 5% of births delivered at health institutions and only 6% of births are delivered with the assistance of a trained health professional. Thirty percent (30 %) of births are attended by traditional birth attendants (TBAs). (DHS-Ethiopia 2000).

A baseline assessment conducted by CARE International of three district hospitals in Oromiya Region found: low utilization of obstetric care services; insufficient numbers of health personnel trained in emergency obstetric care (EmOC); medical equipment, drugs and consumable supplies were inadequate to respond to obstetric emergencies; physical structure of the hospitals did not provide adequate privacy for clients during labor and delivery; and water and electric systems at the hospitals were subject to frequent outages.

Focus group discussions in the rural communities indicated that people lacked basic information about obstetric complications.

The community baseline assessment on ‘Health Care Seeking Behavior’ conducted by CARE found that pregnant women do not use facilities because of:

- High cost of treatment largely incurred by unavailability of drugs and supplies at the facility in which case the clients need to buy the necessary materials from private pharmacies,
- Poor client-provider communication,
- Desire for more care and support. “We prefer to deliver at home because in the hospital they will put us in the couch and leave us alone to labor. If I deliver at home the traditional birth attendant (TBA) will hold my back, will talk to me, will tell me what to do” (Mother interviewed by assessment team),
- Unfamiliarity with the hospital environment. “They tell us to go to number so and so to find the doctor. We don’t know where to go. When we reach the room, we will be told ‘the doctor is out’. But the doctor was standing outside without his white coat”
(Husband of woman that had delivered their baby at the facility, interviewed by the assessment team),
- Disrespect shown by staff,
- Lack of available money or any form of assets that can be sold, rented or used for getting loan, willingness of a person to lend money and availability of human power to carry the woman. Therefore, the ability to access health services even after reaching a decision to seek help is also deeply embedded in household livelihood.

For the majority of pregnancy-related complications, the assessment found that the community initially tried traditional medicines and maneuvers before they seek help from a health facility which reduces chance of survival and increases cost of treatment. The sole decision maker in seeking/not seeking help from health facilities is the husband and the trained Traditional Birth Attendants (TTBAs). TTBAs have a crucial role in determining when to take a woman to a facility.

Prior to the project, women with obstetric complications came to the facilities after the TBAs had tried to handle the problems; this often resulting in loss of critical time to save lives of a mother and/or child. TBAs were blamed by the health facilities for the delay and for harmful physical maneuvers. TBAs were not welcomed in the health facilities.

A critical finding in the community assessment was the community’s misperceptions or lack of knowledge on causes of obstetric complications and a belief in certain traditional measures as a treatment. For example, generalized swelling (involving hand, face and feet) that occur during pregnancy is believed to be caused when a certain bird flew around a pregnant woman (‘Alati’). The community understands it is a dangerous disease, but they first try traditional treatments before they take the mother to a facility. They believe that if the woman with that specific problem drinks a mixture of goat blood and goat intestinal content (‘fers’) she can be cured. They also mentioned consulting a religious leader who gives herbal medicine. If there is a problem with retained placenta, the woman is given a drink made with leaf of castoroil (‘gulo’) and the attendant holds the woman’s feet. In two communities in West Harargue Zone a peculiar and potentially dangerous procedure done by TBAs. When the placenta fails to be expelled, they make an incision on the neck of the woman and suck out her blood using a horn. If a blood clot is formed around the incised site, they believed that this is the expelled placenta.
RESPONSE:

To respond to the serious problem of pregnancy-related morbidity and mortality, CARE International’s FEMME (Foundation to Enhance Management of Maternal Emergencies) Project and several other initiatives in Ethiopia including Making Pregnancy Safer and Save the Mothers Projects were designed and supported to increase the access to and availability of quality emergency obstetric care. The FEMME Project was implemented from 2000-2004 with funding by the Bill and Melinda Gates Foundation funded project in collaboration with Columbia University at three district health facilities (Chiro, Gelemsso and Adama Hospitals) in East Shoa and West Harargue Zones. In West Harague Zone, the FEMME Project was linked with the community component of safe motherhood, which was funded by USAID - PVO Networks Project.

The goal of the FEMME project was to: Improve the health status of women of reproductive age by reducing maternal deaths due to major obstetric complications. Project objectives are:

- Increase availability and access of emergency obstetric care services by three zonal hospitals;
- Improve quality of emergency obstetric care services in three zonal hospitals by the year 2003;
- Increase utilization of emergency obstetric care services in three zonal hospitals.

The aim of the Community Safe Motherhood project was to reduce maternal mortality and morbidity by increasing access to quality reproductive health services, with a particular focus on early recognition of obstetric danger signs and complications and referral. The community project was strategically integrated within the facility EmOC project interventions to provide women and families access to a comprehensive package of facility- and community-based EmOC.

At all of the hospitals, general practitioners were trained to provide emergency obstetric care including cesarean sections. Nurses were trained to administer general anesthesia and hospital midwives were provided advance life-saving skill-training. Hospital teams were also trained on interpersonal communication skills that focused on respecting clients' right to competent care, privacy, confidentiality and respecting dignity. Hospital facilities were renovated and equipped; patient care and support systems were strengthened.
To improve utilization of EmOC services, the community intervention initiated in West Harague that involved building capacity of Traditional Birth Attendants (TBAs) to practice basic life-saving skills, to detect early danger signs related to pregnancy and to make referrals and to promote facility-based assisted deliveries. The TBAs that received training were designated as Trained Traditional Birth Attendants (TTBAs).

Key components of the integration of facility and community interventions included:

1. **Capacity-Building for TTBAs and Facility Midwives.**

   The TTBAs were trained on Home Based Life Saving Skills Training (HBLSS) while the facility Midwives was trained on Advanced Life Saving Skills Training (ALSS). Both training curricula were designed by ACNM (American Collage of Nurse-Midwives) and adopted for the local context. The ALSS trained midwives assisted the training of HBLSS training of TBAs fostering a ground for acquaintance and comradeship among the facility staff and the TBAs.

2. **Awareness-raising about signs of complications related to pregnancy, labor and delivery.**

   The TTBAs received basic health information on obstetric danger signs and complications supported with visual aids such as flip charts, posters and models on the causes of obstetric complications. The flipcharts and posters have pictorial diagram of obstetric danger signs with illustrations in Oromiffaa (the local language). The TTBAs used these pictorial messages to educate the community on obstetric complications.

TTBAs were given pictorial diagrams of obstetric complication and a statement when to refer the client to the EmOC facilities (Chiro and Gelemso hospitals) with the newly revised protocol.

To be more client-friendly, the culture of allowing the TTBAs was established in West Harargue Zone Chiro Hospital. TTBAs were encouraged to accompany and stay with their clients at the facilities. The midwives learned to acknowledge the TTBA and communicate with them the management plan for the client. TBAs provided psycho-social support as well as basic care, e.g. rubbing the woman’s back, and encouraging sips of fluid.

4. Establishing Regular Support and Supervision.

Monthly meetings were held with TTBAs and midwives to discuss problems, review cases and provide feedback. These meetings were held at the hospital compound with midwives and CARE staff facilitating the meetings.

RESULTS

An evaluation of the FEMME Project including the community safe motherhood initiative was conducted in 2003 by internal and external evaluators. The evaluation team interviewed managers, staff and service providers. The community group conducted interviews with several women who had recently given birth at the hospitals. They also conducted focus group discussions with prearranged community members to determine community perceptions about services at the hospitals since the start of project interventions. The following results were found during this evaluation or were provided by review of project reports by CARE staff, and a study conducted in 2005 in West Harague where the community component was being implemented.
1. Client Satisfaction with Facility Care

Mothers reported being more comfortable at the hospital when their TTBAs were present during labor and delivery.

After the start up of the monthly meetings in the hospital compound, the project reported that the TTBAs became a major source of information for clients and families and helped to guide the women and their spouses through the facility.

Evaluators found hospital staff to be aware of clients’ rights to quality health care and respectful treatment and community perceptions of the quality of care available at the hospitals to have improved, particularly at Adama and Chiro hospitals.

2. Utilization of obstetric services.

Treatment of complications more than doubled. More patients with complications came to the facilities and more treatment was provided at the facilities instead of referred out to Addis Ababa.

3. Community satisfaction with TTBAs.

In West Harague Zone, where there was a linked community safe motherhood intervention, it was noted that an increased number of home births were attended by the trained TBAs rather than the untrained TBAs in the village.

Focus group discussions with clients found improved satisfaction with the services provided by TTBAs. Thorough focus group discussions held with mothers in Chirro and Habro areas discussed the level of satisfaction by contrasting trained and untrained TBAs. Accordingly, most of the mothers agreed that they were very much delighted and satisfied by the services rendered by TTBAs besides their good behavior and personality. Moreover, women rely on the knowledge and skill of the trained TBAs as compared to untrained ones. The clients perceived that TTBAs are more likely than TBAs to:
Give advice to receive ANC
Advise mothers on nutrition, taking rest, avoiding heavy loads,
Identify high risks earlier such as signs of pre-eclampsia, bleeding after delivery, sepsis, etc.
Manage labor better and arrange referral without delay if prolonged labor

4. Collaboration between TBAs and Facilities

Meetings were held monthly throughout the project at the hospital compound. During these meetings, the TTBAs also deliver their monthly reports to the facility. The meetings provided an opportunity both for facility staff and TTBAs to discuss their concerns from community and facility perspective for improving quality of care. The meetings were reportedly very lively and interactive.

There was 100% attendance by TBAs at the monthly TBA and Midwife Meetings in the 18 months of the project. This was attributed partly to the established good relationship between the midwives and the TTBAs and secondly to the transport and daily allowance of 32 Birr provided to the TTBAs.

The participating TTBAs received monthly supplies including iron tablets for pregnant women.

The comparison study showed marked difference in the relationship where in West Harague the hospital midwives and TTBAs met monthly versus West Shoa where the midwives most often did not know who and how many TBAs were in the area and had never conducted supervision or received reports from them.

From April 2002 to March 2003, 29 TTBAs referred an average of 46 clients with obstetric complications per quarter.

5. Awareness of danger signs and complications related to pregnancy.

During project review meetings and discussions with community leaders, their comments indicated an increased awareness that generalized swelling is a dangerous disease and should be treated by the health facility staff.
Review of the referrals by TTBAs from April 2002 to March 2003 found that the % of clients referred for swelling of hand and face had increased. Of the 35 women referred by TTBAs to West Harague Hospital in the last reporting quarter, 11 women (31%) had problems associated with swelling of hand and face.

6. Replication.

Due to the unavailability of funding, the project has not been replicated elsewhere in Ethiopia.

LESSONS LEARNED:

- TBA/midwife linkage is innovative in Ethiopia.
- The HBLSS training was already known to be effective given the experiences of Save the Children USA in Borena Zone. However, strategically linking TBAs and midwives through training with common objectives of identifying and managing obstetric complications, early referral and supervision and interventions against harmful traditional practices related to pregnancy and labor was an innovative practice and possibly the key to the success of the program.
- Strengthening community components including training of community health workers and traditional birth attendants to promote safe motherhood and early identification of dangers signs related to pregnancy as well as facilitation of linkage between the community workers and health facilities is critical to improving maternal and newborn health.
- Efforts that improve household livelihood or health insurance schemes will also contribute to improving access to obstetric health services as families will be able to better afford transportation and medical costs.

ADDITIONAL RESOURCES

- Final Evaluation of the FEMME (Foundations to Enhance Management of Maternal Emergencies) project in Oromiya region of Ethiopia: Strengthening Emergency
Obstetric Care (EmOC) services. 2004. Addis Ababa. CARE International in Ethiopia.

- Local developed pictorial flip charts and posters with explanation on obstetric danger signs.
- Locally adapted Home Based Life Saving Skills from American College of Nurse Midwives (ACNM)

CONTACT INFORMATION

Muna Abdullah, SRH and HIV/AIDS program manager
CARE International in Ethiopia
Tel. +2511 – 1- 553 80 40
Email munasmh@yahoo.com, MunaA@care.org.et

Documentation: April, 2006
Decentralized On-the-Job Training for Integrated PMTCT Service Providers

NEED:

The “AIDS in Ethiopia 5th Report” reported that the adjusted HIV prevalence rate for Ethiopia was 4.4% and that the highest prevalence continues among the 15-24 age group. It was estimated that there were 128,000 HIV positive pregnancies resulting in 35,000 HIV positive babies being born in 2003. As of June 2004, the country had only 1% coverage for PMTCT services despite estimated HIV prevalence rates of 12% in urban areas and 4% in rural areas among prenatal care attendees.

To address this critical situation, IntraHealth, an international NGO, and partners were tasked through the Hareg Project to assist the Ministry of Health to establish Prevention of Mother to Child Transmission (PMTCT) services in 81 health centers and 55 hospitals.

Targeting health facility-linked prenatal care as an entry point for women to receive services, the project's approach to PMTCT includes offering voluntary counseling and testing, improving obstetrical practices, providing antiretroviral prophylaxis to HIV-positive mothers and their newborn babies, counseling on infant feeding practices and increasing access to family planning services. Community advocacy and sensitization activities raise awareness of PMTCT services (and HIV prevention in general) and foster greater collaboration between health care providers and their communities and among HIV-positive mothers, the health facility and local organizations and community members that can provide care and support. IntraHealth’s aim is to strengthen maternal child health (MCH) services at health facilities by encouraging a 100% integration of PMTCT with antenatal care (ANC), and increasing client flow to MCH services. (IntraHealth website, USAID PMTCT Quarterly Newsletter, vol.1-June, 2005)

To meet the targets required an efficient and effective way to develop the new PMTCT services, train staff and strengthen the supporting systems at the health centers and hospitals.

A centralized model is commonly used to provide extensive training and development of new service delivery skills, but is less than optimal for several reasons:
Health providers are taken from their posts to attend training programs elsewhere affecting the provision of routine services.

- The number of staff persons that can attend from one site is limited.
- Training two persons from one site may result in a struggle for attention and affect skills transfer on return to the facility site.
- To address the lack of existing services, e.g. comprehensive PMTCT and to promote shared responsibility for integrating services, large numbers of facility staff need to be trained.
- The high attrition of professional staff in many areas in Ethiopia requires continuous training programs.
- A problem faced by many centralized training programs is the lack of adequate patients or clients to provide a good practical experience for trainees.

**RESPONSE:**

To address the concerns associated with training as listed above, IntraHealth initiated decentralized on-the-job (OTJ) training programs in December 2004 in the following regions: Addis Ababa, Tigray, Amhara, SNNPR, Oromiya, Afar and Harari Regions in Ethiopia.

Comprehensive care skills-building training was and continues to be done on-site. This practice has been found to be successful in rapid transfer of skills and integration of PMTCT services with existing reproductive health services at governmental health care facilities.

Key components include:

- Consultation with National and Regional Health Authorities.
  
  Meetings were held to discuss the concept of the on-site training model using trainers from the private sector.

- Capacity-building for trainers from private sector.
  
  Senior professionals were selected based on merit and practical experience with special emphasis on those from the region to be trainers. A private institution was contracted to build skills of lead trainers. The training of lead trainers included adult learning skills-building.
• Facility Assessment and Planning.

Needs for renovation and equipping of the facility were assessed and actions planned with the local facility manager and woreda (governmental unit similar to district) health office and the selection of the staff to be trained (based on a selection criteria). Scheduling of training sessions was done to minimize service interruption.

• Community sensitization and mobilization.

Meetings were facilitated with stakeholders at the facility including general staff, community and religious leaders, local woreda and Kebele (community level) officials, Traditional Birth Attendants (TBAs), Community-Based Reproductive Health Agents (CBRHAS), Health Extension Workers, women’s groups, and Persons Living HIV/AIDS (PLWHAs) Associations to help raise awareness in the community about mother to child transmission and to promote the PMTCT services.

• Community Awareness-raising activities.

Community Conversation methodology was used to facilitate dialogue in the community.

• On-the Job Training.

Two (2) trainers were deployed to the Health Centers for three (3) weeks of skill-building on the job for six to eight (6-8) MCH providers.

• Supportive supervision.

Trained regional supervisors visit the PMTCT services to reinforce skills, help with problem-solving, and facilitate cascade training.

• Monitoring.

Regular monitoring is done to assess activity, quality of service and beneficiary satisfaction.
RESULTS:

1. Availability of PMTCT services.
   - 67 health centers have received comprehensive PMTCT training on-site.
   - More than 400 health professionals have been trained. Source: (IntraHealth Reports, 2005)

2. Effectiveness of the practice.
   - Innovative, first time being done to train in PMTCT in Ethiopia.
   - Promotes team learning and peer support. Post-training mentoring and supportive supervision helps to reinforce training objectives.
   - An efficient model for conducting rapid training. IntraHealth with private partner conducted two rounds in 24 facilities in two months.
   - Meeting objectives to build capacity of region to provide training on PMTCT, train adequate number of providers without interrupting PMTCT/MCH services.
   - Effective in teaching problem-solving skills as the training was adapted or harmonized to the actual working environment and local culture.
   - A sense of ownership was promoted through broad-based sensitization to staff and community stakeholders. (Source: IntraHealth Assessment, 2005)

3. Cost-effectiveness of the practice
   - To be comparable to centralized training, the number of OTJ trainees needs to be at least eight (8). (Source: Cost-effectiveness Study, IntraHealth, 2005)

LESSONS-LEARNED:

Decentralized (on-the-job) training works for these reasons:

- Routine facility services are not interrupted as clients work as they learn.
- More clients were available, important to help trainees develop their skills.
- On-the-job training provides more time and an appropriate site for trainees to learn holistic approach to PMTCT integrating ANC, Labor and Delivery, Post-Partum care, and Family Planning.
• Problems with the facility set-up or procedures can be addressed as identified during the training program.
• Health personnel from different departments (ANC, Family Planning, etc) are part of the training program contributing to integration.
• The full package of training materials remains with the facility to promote cascade training, further reference and to increase the sustainability of the services.
• Health care providers are satisfied with the training.
• This public-private interaction works, private sector growth and expertise are used to build public sector capacity.
• Use of regional supervisors promotes closer working relationships between the regions and the facilities.
• The shortage of materials, e.g. HIV test kits or infection prevention materials needed for quality care and for demonstration purposes, lack of water and electricity, and excessive flow of ANC clients in some health centers posed problems to the training process and provision of care, but also provides learning opportunities for trainers and the staff to brainstorm possible solutions. Pre-planning is important to ensure that minimal infrastructure and sufficient necessary supplies and materials are in place or provided.
• Lack of perdiem for stakeholders was a barrier to participation in community stakeholder meetings in some areas; this was addressed successfully linking it to a local administrative meeting.
• Rural areas may not have convenient accommodation for trainers requiring arrangements for local transport.

AVAILABLE RESOURCES:

• Decentralized PMTCT Training Manual (MOH)
• “Joining hands in saving a Generation Report on Decentralized on-the job-training on PMTCT of HIV” (IntraHealth and Bethzatha, March 2006)
CONTACT INFORMATION:

IntraHealth
Cristina Ruden, Country Director
cruden@intrahealth.org
011 663 9241
www.intrahah.org/

Documentation: April, 2006
Comprehensive Care for Rape Victims

NEED:

In Ethiopia, there was known to be a lack of specialized care of patients that were victims of rape. Those that did seek care were treated according to their presenting symptoms, “like any other sexual reproductive problem”. (Family Guidance Association-Ethiopia)

Prevalence of rape data is limited, but studies reflect that this violent crime may be common. In 1998, a school-based study conducted in Addis Ababa and Western Shoa found nine percent of female students age 12-23 reported a history of being raped.5

RESPONSE:

To respond to the lack of comprehensive post-rape services, Family Guidance Association-Ethiopia (FGA-E) established a specialized clinic in Addis Ababa in 2002 to provide care for children, women or men that have been victims of rape.

The following comprehensive services are available at the clinic:

- Examination,
- Treatment of associated injuries,
- Pregnancy testing,
- STI management,
- HIV counseling and testing using rapid test method,
- Referral for HIV/AIDS, treatment, care and support. Repeat testing is recommended to negative clients and provided on return visits,
- Family Planning counseling and methods,
- Medical-legal documentation and certification of findings (including photos),
- On-going counseling and rape crisis management provided by a nurse counselor, who will assist clients to link with police for reporting and will make referrals to safe houses, social services and legal assistance from services provided by the Ethiopian Women’s Lawyer Association and others.

Most clients (85-90%) are provided free services given their socio-economic situation. Clients are generally brought to the clinic or referred by the police, or less frequently by EWLA or other social service agencies. Self referrals are rare.

RESULTS

1. **Utilization of rape care services.**
   
   - 727 victims were cared for in 2002-4.
   - 528 victims received care in 2005, of which 514 were female and 14 were male. (Service Delivery Data provided by FGA-E)

2. **Availability of rape care services.**

   FGA-E has now expanded coverage of comprehensive post-rape care to their clinics in Bahir Dar, Dire Dawa, Awassa, and Adama.

3. **Replication.**

   As mentioned above, clinics have been replicated in Bahir Dar, Dire Dawa, Awassa, and Adama. The Yeketit-12 Hospital in Addis Ababa now has a special child abuse clinic, adapting many practices from FGA-E to meet the needs of children.

LESSONS LEARNED

1. In large urban settings there is a need for free standing clinics to avoid overload for health professionals that are providing primary care services in public health care facilities.

2. To provide quality post-rape care, providers must take sufficient time to take history, examine, document findings and to provide medical counseling in a caring manner. The Addis Ababa service is generally seeing five to six (5-6) clients/day.
CONTACT INFORMATION:

Family Guidance Association of Ethiopia
Ato Amara Bedala, Executive Director
011 151 4111
http://fgae.org/

Documentation: May, 2006
Increasing Access to Comprehensive Post-Abortion Care

NEED:

The penal law on abortion is restrictive in Ethiopia resulting in women with unwanted pregnancies often seeking abortion services from unskilled persons and in unhygienic environments. There are little available data about the prevalence of illegal abortions in Ethiopia. Information from small studies suggests that abortions are common. A 1996 survey conducted in Addis Ababa of in-school adolescents/youth age 10-23 reported that 50% of the respondents had been pregnant in the past; 74% of the pregnancies resulted in abortions.6

Complications from illegal abortions are known to be a major contributor to maternal morbidity and mortality in Ethiopia, accounting for 32% of maternal deaths. (Source: IPAS using REDUCE Model) In 2000, the Ministry of Health –Ethiopia reported that abortion complications are the 5th leading cause of hospital admissions and in 1998, reported that complications from abortions was the 12th leading cause of deaths of hospitalized women. (“Health and Health-Related Indicators”, 2000, 1998, MOH)

Women may be aware of symptoms of complications related to abortions but may delay or avoid seeking care at public health facilities because of the stigma associated with having had an abortion.

“Appropriate and prompt management of abortion and its complication minimizes long-term complications associated with incomplete abortion. These complications which include chronic pelvic pain, chronic pelvic inflammatory disease, dysmenorrheal, loss of the uterus (hysterectomy), and infertility can be disabling and incapacitating.”7

A baseline assessment conducted in 2000 by Ipas found limited private or non-governmental health services providing post-abortion care and that the post-abortion care was being given using sharp metallic curettage which required general anesthesia and at least an overnight stay in a hospital or health centers. There were no linkages with family planning services.

RESPONSE:

Since 2001, Ipas-Ethiopia has joined Marie Stopes International and others are working to increase the ability of women to exercise their sexual and reproductive health rights and to reduce abortion-related morbidity and mortality. Ipas is active in five regions namely Amhara, Addis Ababa, Oromiya and Tigray and SNNPR, working in close collaboration with institutions of higher learning.

Key components include:

- **Collaboration with Institutions of Higher Learning**

  Ipas working with institutions of higher learning, the Ethiopian Public Health Training Initiative, and the Carter Center, developed Post-Abortion Care (PAC) training modules to be integrated into preservice curriculum for medical students or those planning to be attending health officers, midwives, public health and clinical nurses.

- **Facility and Staff Capacity-building**

  These health professionals are trained using the “PAC Training Modules for Health Workers in Ethiopia”. MVA and Infection Prevention equipment and supplies are provided to health centers and hospitals. Ipas works with the facilities to establish or strengthen data collection and record-keeping systems. Supportive supervision is provided by technical staff from Ipas, Regional Health Bureaus and trainers. Periodic meetings are held to do case reviews and to review the assessment findings of the supervisors (standardized checklist is used) regarding quality of services.

- **Community Awareness-Raising**

  Ipas developed training materials on post-abortion care for Community-Based Reproductive Health Agents (CBRHAs) as well as educational materials to help raise public awareness about complications of abortion. Health facility staff are encouraged to work closely with the local CBRHAs to raise the awareness of the dangers of abortions and the need for immediate care of post-abortion complications.
RESULTS

1. Availability of comprehensive post-abortion services.
   - 240 hospitals and health centers equipped with MVA
   - In health centers this was an increase from 3% in 2000 at baseline to 94% noted during the 2004 end-line assessment.
   - Approximately 1000 trainers and service providers have been trained on PAC. In 2000, only 13% of health centers had at least one trained PAC providers; at the end of the project, 87% of health centers had at least one trained provider.

2. Quality of post-abortion care.
   - Facilities providing post-abortion contraceptives increased from 25-73%.
   - Use of MVA for uterine evacuation procedures instead of E&C increased from 17% to 67%, providing safer methodology, less pain for clients, less complications and reduced hospital stays.

3. Institutionalization of Post-Abortion Care Training.
   - Incorporation of PAC training in pre-service core training program through the EPHTI initiative with satellite modules for different levels of health care professionals.
   
   (Source: Ipas Assessment Reports 2000, 2004)

4. Advocacy
   “In May 2005, Ethiopia’s long-awaited new Criminal Code came into effect. With considerable public input, the government revised the code to permit abortion for an expanded range of indications. These include: when the pregnancy results from rape or incest; when the health or life of the woman and the fetus are in danger; in cases of fetal abnormalities; for women with physical or mental disabilities; and for minors who are physically or psychologically unprepared to raise a child. The revised law also notes that poverty and other social factors may be grounds for reducing the criminal penalty for abortion.” (Ipas website)

LESSONS-LEARNED:
• Midwives have enormous potential in effectively managing most post-abortion complications and expand the availability of services where physicians may not be available.

• Training in post-abortion care must include clarifying values and attitudes of health providers in addition to improving their clinical knowledge and skills.

• CBHRAs have proven useful in informing the communities about the dangers of abortions and promoting and providing methods to prevent unwanted pregnancies.

• Pre-service education is an effective way of sustaining health workers clinical skills and addressing the frequent turnover of staff versus providing training in-services.

• To prevent unwanted pregnancies and repeat clients it is important to link emergency treatment of abortion complications with post-abortion family planning counseling and services.

AVAILABLE RESOURCES:

• “Ipas Strategies in Africa”, 2000
• “Responding to unsafe abortion in Ethiopia”, 2002
• Fact sheet: Changes in Ipas intervention facilities
• PAC Training Module for Health Workers in Ethiopia
• Curriculum for training CBRHAs on Post Abortion Care

CONTACT INFORMATION:

Ipas-Ethiopia
Dr. Takele Geressu, Senior Program Advisor
Ipas@ethionet.et
Tel +251-11-663-378

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PRACTICES TO DOCUMENT

The IBP Team gathered information on the following practices but final drafts have not been completed. Brief abstracts are written to highlight these practices.

Improving Information-Gathering Systems to Improve Contraceptive Security In Ethiopia

**Brief Abstract:** A survey of the contraceptive inventory and logistics system (of seventy-six (76) government health facilities) conducted in July 2001 by the Federal Ministry of Health (FMOH), with support by UNFPA, DELIVER, and USAID, found several serious concerns:

- Large quantity of expired or expiring oral contraceptives with estimated value of $1 million.
- High levels of stock outs for all contraceptives
- Lack of information about contraceptive consumption at the lower levels, thus consumption estimate based on demographic data, e.g. Amhara Region has more women so gets more contraceptives. Given the estimated total stock, expected shipments to the FMOH would provide serious oversupply of condoms, light overstocking of IUDs and pills, proper stock of injectable4s, and under-stock of implants. These concerns resulted from a poorly functioning system that included lack of inventory and reporting procedures, collection and management of actual consumption data for forecasting consumption, and transportation and storage issues.
- Given that information about contraceptives stock of NGOs and Social Marketing were not included in the Federal system, there was no complete picture of the total supply of contraceptives available in Ethiopia.

DELIVER, a Project of John Snow Inc. with funding by USAID was initiated to work with the Ministry of Health on a number of key initiatives including the establishment of a comprehensive Ethiopian Contraceptive Logistics System (ECLS) in all regions/cities. Key activities to improve the logistics system at the health facility level have included the development of recording and reporting formats and a three day course, using DELIVER curriculum adapted for Ethiopia, for Pharmacy and Maternal-Child Health Staff.
MCH staff at the Health Clinics and Centers are responsible for recording visits, daily consumption, tallying the number of methods dispensed by type per day, compiling into a monthly Logistics Report (LR) form and using a three to four month average to determine minimal and maximum needs. This is then sent to the woreda level for compilation and then supplies requested from the regional health bureau.

A qualitative and quantitative survey conducted in Addis Ababa found:

- Sixty percent (60%) reported using the Ethiopian Contraceptive Logistic System (ECLS) forms.
- Sixty percent (60%) of the facilities do not use maximum levels.
- Forty-one percent (41%) of all respondents had never received supervision in contraceptive management.
- Inadequate use of stock and bin cards at the health facility level with only 14% of Service Delivery Points (n=58) (Health Posts, Health Centers and Health Clinics) using Stock Card/Bin Cards for all contraceptives they managed in last 6 months, sixty-two percent (62%) of Health Centers kept stock cards on at least 1 product, 54% were accurate. Providers in Addis report that keeping bin cards is seen as a burden, because they usually have only a small amount of commodities.
- It was found that health personnel in facilities the Health Centres were not trained and were not using the Logistic Reports (LRs). These health facilities represent 56% of the total number of the public healthcare sector in Addis Ababa. They use a Ministry of Health form to report quantity dispensed and supply on hand. Health Centers compile the reports of quantity dispensed data from the Health Posts. This is combined with the Health Center’s consumption information and sent to the Sub-City.
- Problems with stock-outs/re-ordering continue with seventy-five (75%) of facilities reporting stock outs before they are re-supplied.
- Fifty-seven percent (57%) of facilities were stocked out on day of survey visit for at least one product – 93% pills, 54% injectables, 30% IUCDs and 52% for implants.
- Facilities deal with stock outs by going to a higher facility for re-supply (59%) or by referring clients to private facilities or to other public facilities or by providing another method. However 51% of the sampled facilities report that it takes only one day to be re-supplied on average and use this to defend not using a formal system for ordering.

(H. Mohammed, DELIVER, 2006)
Integrated Community Clinic Services (Propride)

Brief Abstract: There is a recognized need among reproductive health providers that an integrated approach is needed to promote and facilitate HIV/AIDS prevention, care and support services for their clients given the HIV/AIDS epidemic and the effect of HIV/AIDS on the health of women, their infants and families. Propride, a national NGO has been supporting a community health clinic in Addis Ketema for several years. This is a largely impoverished neighborhood in Addis Ababa with large numbers of unemployed youth, commercial sex workers and mobile families and workers. The health clinic provides primary care, maternal-child health, family planning, sexually transmitted infections (STI) management, and HIV voluntary testing and counseling (VCT) services. Since May, 2005, the staff are working to move from a vertical structure to integration of services/"linked response" to better promote HIV/AIDS prevention, family planning and reproductive health among their clients, many of whom are high-risk (commercial sex workers and their clients) or others moving around the large bus terminal or the nearby Merkato, said to be the largest market in Africa. Structural changes at the clinic have included: establishment of user-friendly registration process and fees, HIV/AIDS information/education through a variety of channels in the waiting room, and change in location of VCT room. All providers are encouraged to promote VCT; VCT services are provided in a more private area of the clinic compound. The VCT counselor refers clients to the family planning services. All services are linked with the HIV/AIDS prevention, care and support services provided through the clinic. The clinic is working to track the internal referrals; providers give the clients a card to take to the VCT room without having to re-register. The problem is that clients often do not go to have VCT services the same day and do not bring the cards with them.

In addition to the general public, the Clinic is serving the area's commercial sex workers (CSWs) with primary care, family planning, and condoms. Family Planning staff state that young unmarried women (non-CSWs) are generally not coming to the clinic given the societal disproval of sex outside of marriage and the continued silence about sexual behavior and issues. The MCH nurse when interviewed states that it is easy to talk with the following groups: pregnant women about the need to be tested because of their concern for their babies, young people planning to marry (pre-marriage VCT testing is becoming a societal norm as in this community many parents, Protestant and Muslim religious leaders and idhirs are making this a requirement) and commercial sex workers given their
awareness/understanding of their high risks. She acknowledges that it is less comfortable to talk with family planning clients that are outside of the above groups about VCT.

Clinic management is happy with the positive attitude of staff toward the concept of integration, but realize that more behavior change training, sensitization about the needs of youth and other high-risk groups is needed as well as improving communication skills to effectively discuss sexual and relationship issues and to promote VCT.

**Mother to Mother (PMTCT Support Group-Addis Ketema Hospital)**

**Brief Abstract:** As has been noted by many PMTCT nurses and VCT counselors, there is a reluctance of HIV+ women to disclose their status to their husbands and therefore there are often high drop-out rates from MCH/PMTCT services. To address the need for greater support to pregnant women that have tested positive for HIV, the Mother to Mother Program, a practice developed by a South African NGO, was initiated at the Addis Ketema Health Center with technical assistance from IntraHealth as a pilot peer to peer intervention. Six mothers were trained to each lead a support group for HIV+ mothers to hold regular group discussions about their situations, needs, and feelings. These meetings are held at the health center with professional counselors and medical staff available to answer questions from the group as needed. This activity is part of the health center’s efforts to provide integrated services for women attending antenatal services including VCT, PMTCT, couple testing and counseling, breast-feeding guidance, family planning counseling and methods, and improved follow-up of infants with HIV-positive mothers.

While quantitative data was not submitted, the Health Center reported to the interviewer that women involved in the Mother to Mother program are more likely: to comply with the PMTCT regimen (neverapine), to disclose to their husbands, and to use family planning services.

**Kangaroo Care Method (EPS and ENMA)**

**Brief Abstract:** Hypothermia is a common cause of mortality of low-birth weight infants. Artificial warming methods e.g. incubators are often not available in rural health facilities given the lack of equipment and/or electricity. And given the high percentage of homebirths, alternative low technical methods are needed. The kangaroo mother care (KMC) method is defined as continual skin to skin contact between a mother and her low birth weight infant immediately after birth; the infant is kept skin to skin between the
mother’s breasts 24 hours a day. This low cost neonatal warming method was introduced by the Ethiopian Pediatric Society after they conducted a one year randomized study in Addis Ababa to study the effectiveness, feasibility, acceptance, and costs related to the use of this method. Given the positive results of the study, physicians and midwives from two regions were trained in counseling mothers of low birth weight infants to use the method. The study as reported in Acta Paediatr 87: 976-85, 1998 and The Journal of Tropical Pediatrics, Vol. 51, No 2 found that use of this practice improved neonatal health and was preferred by mothers over artificial warming methods, and was less expensive than other methods.

Facilitation of NGO Networking and Capacity-Building (CORHA)

**Brief Abstract:** CORHA was started in 1995 to improve coordination, networking, capacity-building, reproductive health advocacy, and resource mobilization in Ethiopia. The Association currently has a membership of 80 NGOs working in the area of reproductive health. Key activities are: development of a website <corha@corhaethopia.org> to keep members up-to-date with new information and issues, development of training curriculum, protocols and supervision/monitoring documents with the Ministry of Health, facilitation of training of trainers programs for NGOs, public and private sector and facilitation of conferences, workshops and other learning opportunities.

Advocating for Legal Protection of Women in Ethiopia (EWLA)

**Brief Abstract:** Historically females in Ethiopia have not been protected from discrimination, traditional practices that have negative consequences, or physical and sexual violence. While quantitative data is not available, a qualitative study conducted by EWLA in 2005, entitled “Violence against Women in Addis Ababa” found that sexual violence is prevalent. Harmful traditional practices such as Female Genital Circumcision/Mutilation are common throughout Ethiopia as are early marriages involving young girls in some regions. The legal system with revision of laws such as family law, penal law, pension law, the maternity leave provision under labor law, as well as accessible legal services were identified as critical needs by the Ethiopian Women Lawyers Association, the National Committee on Harmful Traditional Practices (NCTPE), other NGOs, women’s groups and professional societies. The Ethiopian Women Lawyers Association (EWLA) is a non-profit women’s advocacy group founded in 1996 by a group of women lawyers. Working from their Head
Office in Addis Ababa and branch offices in Bahir Dar, Assosa, Awassa, Nazareth, Dire Dawa and Gambella, this non-governmental organization is working to address discrimination of women and to improve access to legal assistance for females. In addition to the public awareness-raising activities done in partnership with other organizations, EWLA conducts research of and advocacy for law reforms related to women’s rights and provides legal services and assistance for victims of gender-based violence.

In 1999, EWLA initiated an exciting and innovative practice of establishing volunteer para-legal services in communities. Female and/or male volunteers, who have completed grade 12, have an interest on gender and women’s issues and are familiar with the work of EWLA and are dedicated to the cause of women’s rights and are selected by communities to be Para-Legal Workers. Following an EWLA-designed training program, they are able to provide legal counseling related to civil and criminal cases by preparing letters, court briefs (using pre-prepared formats) and make referrals for further legal action. These trained Para-Legal Workers establish committees in each community and are provided an office with stationary and relevant reference materials by EWLA. Supportive supervision and monitoring is provided over the phone and by reviewing quarterly activity reports and site visits by EWLA branch office staff. Every three months, the volunteer Para-Legal Workers are brought together for experience sharing.

**Holistic Services for Fistula Patient (Addis Ababa Fistula Hospital)**

**Brief Abstract:** It is estimated that there are 8000 cases of new fistulas/year in Ethiopia. Women with fistulas are largely hidden from society, because of the stigma associated with the signs and symptoms of disorder. Fistulas are abnormal communication between the vagina and adjoining organs (bladder, rectum, urethra or ureters), caused primarily by unrelieved, prolonged or obstructed labor. The practice of early marriage in Ethiopia resulting in pregnancy during adolescence contributes to the incidence. Prior to 1974, there were no specialized fistula care services in Ethiopia.

Recognizing this unmet need, a private facility, the Addis Ababa Fistula Hospital, was established by Dr. Reginald and Catherine Hamlin with support by the Hamlin Fistula Welfare and Research Trust with the primary objective to provide the best curative care including major and minor surgical treatment, medical treatment, nursing care, and
rehabilitation of clients with stoma therapy, physiotherapy as needed to women with fistulas using a holistic approach. The institution is also involved in fistula prevention, training and research activities. Psycho-social services include: Pre and Post-Treatment Counseling, Client Education and Training in Self-Care, Social and Material Support, literacy classes, instruction on human rights and money management, and education for family members are provided at the facility. Reintegration with Family and Community is done with family counseling at the hospital or as needed. Clients are accompanied by the community and family counseling is provided. Outreach activities include: establishment of new center in Bahir-dar and soon-to-be open centers in Mekelle, Yirga Alem, Metu and Harrar. In Desta Mender there is a center for women with chronic long-term injuries and for those awaiting surgery. Former clients now working as nurses aides conduct social mobilization to raise the awareness of fistulas, to promote prevention measures, and to inform the communities about the fistula care services.

Maternal and Neonatal Tetanus Elimination Campaign Behavior Change Communications (MOH and Save the Children US)

Brief Abstract: Infant mortality continues to be extremely high (DHS data). In Ethiopia, neonatal tetanus is the second most common vaccine-preventable cause of mortality among children under one year of age. It is estimated that 17,900 neonatal tetanus cases with 13,400 infant deaths occur each year (Family Health, MOH 2004). To address the high neonatal mortality due to tetanus, the Family Health Department of the Ministry of Health-Ethiopia in collaboration with UNICEF, Portuguese NATCOM and Save the Children US conducted tetanus toxoid campaigns in pastoral areas in Gugi Zone in Oromiya Region and four woredas in Somali Region to facilitate the social mobilization efforts.

The key components associated with the MNTE monitoring and evaluation plan and campaigns are Inter-agency Coordinating and Planning of budget, supplies logistics and supervision, Training for vaccinators and volunteers who use MOH guidelines, Community Mobilization working with community leaders and women associations and with NGOs and other governmental organizations. Establishment of temporary vaccination sites schools, private health institutions, churches, and mosques in addition to health facilities and development and dissemination of Behavior Change Communications (BCC).

The BCC targeted women of reproductive age use multiple channels: posters, radio and TV spots/ads, films, drama, flipcharts, brochures, stickers, banners, and letters for leaders to
increase awareness about tetanus and the important to get three doses of tetanus toxoid, addressing misconceptions, beliefs and lack of knowledge as identified through formative research findings.

Save the Children US conducted a qualitative study to evaluate the effectiveness of their tetanus toxoid promotion communications in 2005. Findings included:

- Good knowledge (estimated over 90%) about tetanus and tetanus toxoid (TT) immunization among men and women. No evidence of continued misconception that TT is a contraceptive.
- Positive attitude towards tetanus toxoid immunization, “TT is good for the health of mothers and infants”. No discussion of the association of tetanus with evil spirits or anger of God as had been noted during a formative study.
- Behavior change included women and men reporting that eligible women have already received two doses of TT, increased utilization of ANC clinics and assisted birth,
- Use of new razors and thread and improved hand-washing by birth attendants assisting with home births.

During the course of the documentation process, several interesting practices were identified. The team proposes that the following be contacted for information and documentation:

- MOH/RH Task Force-FP Technical Working Group (Forecasting Contraceptive Supply Needs)
- Health Communication Partnership (Youth Action Kit)
- Kembatta (Women Self-Help Groups and Family Planning Promotion)
- PLAN- Family Planning Program in Lalibella
- JSI-ESHE (Community Health Promoters/Role Models).
- Family Health International, Pathfinder, Tulane University etal. (Capacity-Building Work with regional health bureaus governments (coordination and monitoring and evaluation).
- DKT’s Video Vans (HIV/AIDS prevention; Family Planning
- Pathfinder (Private Franchise)
- Engenderhealth and partners (IUD promotion communication strategy)
• JSI (Assessment of Current HMIS).
• Carter Center (Participatory Process for Curriculum Development; Health Officer Training)
• Linkages (LAM Promotion-Development of Interactive Teaching Tools)
• World Learning (Promotion of Continued Education for Married Girls Education in Partnership School Girls Clubs)
• JHPEIGO (Provider-Referrals-VCT)
• Save the Children US (PDQ and Community Action Cycle methodologies)

DISCUSSION

Family Planning

1. The service delivery practices as described and discussed at the IBP meetings are seen as innovative and making a significant contribution to increasing accessibility and availability of a broader method mix that is needed to continue to address the unmet need for spacing and limiting.

2. Community-based Reproductive Health Agents not only promote and distribute oral contraceptives and condoms, but are instrumental in providing guidance and promotion of good reproductive health including instructions about natural family planning methods, referring women to services providing medium, long-term and permanent methods as available, promoting MCH care, educating communities about dangers of abortions, signs of post-abortion complications, and signs of complications related to pregnancy and labor, and working with community committees to prevent early marriages. This community-based family planning promotion/delivery practice was viewed by many as a major contributor to the increase in CPR. Questions and comments raised during this process about the CBRHA program included: concern about the large scope of their work covering many RH issues and if quality of the education and promotion will be impacted; concern about the sustainability of this important program, the potential for conflict of interest or threat to choices of methods if cost-sharing strategies/payments to volunteers are not carefully planned and how the relationship with the health extension program and specifically family planning services can be formalized.
3. The efficiency of reaching large numbers of women with long-term and permanent methods at the training/service events was appreciated by members of the plenary session. Questions raised about the facility service delivery practices include: have the delivery of long-term and permanent methods made a difference (CPR)? Quality concerns raised included: adequacy of education and counseling about methods pre-service delivery event, informed consent, follow-up of clients, level of supervision, level of skills of newly trained staff to perform procedures including removal of IUDs and implants, cascade training given high attrition rates, infection control concerns due to lack of necessary materials and infrastructure, and the lack of stable supply of methods.

4. More information is needed to know who is being reached (and who is not) by all the services (community and facility), requiring more specific information to be collected, recorded and compiled about contraceptive users (age, marital status, rural versus urban, etc.)

5. Are females that are high-risk for unwanted pregnancies and illegal abortions being targeted, being reached with family planning services?

6. How are males that are lacking knowledge or are resistant to family planning being reached? What practices have been successful at reaching males? Anecdotal stories were told to the team about men in communities that have been effective role models, e.g. a Muslim elder had a vasectomy and was influential in promoting others to do so. These stories need to be well documented and the use of role models explored and expanded to work closely with service providers to do community outreach.

7. At both the community and the facility service delivery levels, questions are raised about the quality of the family planning activities. Are the methods working as intended, spacing according to the woman/family’s desires or limiting? What methods are ‘promoted’; are there procedures in place to ensure informed choice? Are there good follow-up systems in place to promote adherence (e.g. correct use of pills, getting Depo-Provera injections on time, using condoms consistently), do women know what to do if they miss a pill or the condom breaks, or to identify and appropriately address side effects or to handle dissatisfaction with the methods? If there are stock-outs of the preferred methods, are women encouraged to use other methods that are available? A
story was told to the team about a woman who could not get her Depo-Provera injection given lack of supplies at the health facility and then returned 10 months later holding out her infant to the family planning staff person saying “here is your baby”.

8. The family planning system seemed fragmented with various supplies and types of methods at different delivery points raising questions about user-friendliness as well as the management of contraceptive supplies. As learned during this documentation process, there is commitment by the governmental and NGO family planning providers and social marketing suppliers working with the RH Task Force Family Planning Technical Group to share information about their contraceptive supplies and consumption and a preference for the “use” approach over service statistics or demographic estimates as it provides the most robust highest quality data for forecasting. As stated in the DELIVER abstract, health posts, where workers are most aware of unmet need and there is generally less attrition, are not using the logistics information system. What is the plan for including them? How are the Woreda Health Councils involved? How will Health Extension Workers as well as other community distributors be integrated into using the logistics information system? Consumption data as well as discontinuation or failure rates would strengthen the “evidence” of the success of services/activities as well as show contribution to CPR (and TFR).

9. The National Goal of 45% CPR by 2015 necessitates concerted actions to secure and maintain an adequate, appropriate, acceptable, and accessible contraceptive method mix. It is reported that there is a large supply of IUCDs now in Ethiopia. What is being done to promote IUCDs? The effectiveness of the IUCD promotion strategy will be interesting to assess and document. The question of why injectables are so popular was raised on several occasions.

10. Evidence of community, client, and staff satisfaction was generally lacking. Methodologies such as Facility-based and Community COPE, Community Feedback, or Performance-Defined Quality would provide useful information monitoring for quality improvement as well as reporting results.
Obstetric Care/Gynecological Services (includes pregnancy, post-abortion complication, and post-rape care services)

1. As was discussed at the consultative meeting, the assisted birth initiatives share major challenges in terms of sustainable effects of the practices: the human resource concerns and need for regulations that clearly delegate level of obstetric/pregnancy-related care that may be provided by specially trained general practitioners, health officers, midwives, nurses and health extension workers, the lack of secure and steady supply/maintenance of necessary inputs that jeopardizes the sustainability of quality emergency obstetric care after the project/donor support ends, the expense of providing quality training, as well as need for further exploration and action to address the social, cultural, and structural barriers to why women are not seeking earlier obstetric care when there are pregnancy-related complications.

2. Stronger linkages with community-based RH promotion interventions including traditional birth attendants as illustrated by the FEMME/Safe Motherhood Initiative are recommended to increase the knowledge of the reproductive age population about “early” danger signs of pregnancy and to promote and facilitate medical care. The practice of linking hospital staff with traditional birth attendants seems critical to increasing utilization of obstetric services given the status of the TBAs in many communities and their role in decision-making at the household level. Further study is needed to explore how they have been used in other countries or can be used in Ethiopia to provide psycho-social support to the client and family as well as assist the over-extended health facility staff with basic nursing care.

3. And as recommended at the IBP consultative meeting, there is a need for all entities involved in improving obstetric care services in Ethiopia to share their lessons-learned, guidelines, results, and to work together to solve the major challenges.

4. An innovative MPS practice that would be interesting to further explore and document is the use of idhirs to resource (and promote) community-based emergency transport for women with pregnancy complications.

5. Gathering data needed to show evidence within the government public health care system and using their HMIS, limited the ability of MPS to obtain sufficient useful information to document results that requires good data about service utilization, morbidity/pregnancy-related complications, treatment provided, or deaths/reason
for death, etc. Further exploration of the HMIS revisions and use of data as mentioned in the Save the Mother document could provide lessons-learned. Establishing good process/output and outcome indicators (preferably meeting international standards) if not already in place, needs to be done soon to ascertain specific data needs, given the reported current revision of the HMIS.

6. It is recommended that COPE or similar participatory internal audit methodology be used to monitor service delivery including inputs, client and staff satisfaction and quality of care. An on-going formalized process for community feed-back about the care, attitudes and condition of the facility with active involvement of males, who are often the primary decision-makers could promote more client-friendly services as well as serve as a monitoring mechanism and provide more evidence about the success of the practices.

7. Given the lack of baseline information about referrals to the facilities by the TTBAs prior to the intervention; it is difficult to know how successful the practice has been in affecting their referral behavior.

8. It would be of interest to know more about the attitudes of the midwives (facility staff in general) towards both clients and TBAs prior to and post-intervention as well as the attitudes of the TBAs towards the midwives and facilities pre and post. CARE provided some data about outcomes of home births attended by TTBAs but without baseline data is hard to analyze.

9. Sustainable effect, in terms of the TTBA participation, was it due to monthly transport allowance, provision of supplies, and/or opportunity to learn (training and monthly meetings)? Knowing the key incentives is important to look at how sustainable this practice could be (without donor support). There was mention that COPE teams were initiated but did not stay functional, so this would be interesting to know more about this process, findings, and barriers.

10. It would be useful to know more about the major issues or content of case reviews done during the monthly visits and to use this to build interest in replicating this activity elsewhere.

11. Questions related to post-rape care include: how can this comprehensive practice be integrated into public sector clinics? How well is the referral system working? If
rape victims do not access the police after being raped, how do they know about the service? Has the evidence that is gathered in the clinics recognized by the courts and has it been used to successfully prosecute rapists? Are there unmet needs for follow-up services (counseling, safe houses, etc.)? What is the mechanism for doing follow-up HIV testing? Do rape victims return for follow-up visits?

12. The Ipas intervention was able to show that they are meeting their objectives and can validate their success with pre and post assessment findings showing increased availability, increased quality of medical practices, and increased link with family planning services.

13. More information about the process and quality of the linked family planning services, the contraceptive utilization rate, the referral to or provision of other RH services including STI treatment as well as the attitude of and emotional support provided by the facility staff is needed.

14. Information from histories taken from clients with post-abortion complications could offer insight into who are the women at high risk for unwanted pregnancies and illegal abortions as well as the barriers to contraceptive use (lack of knowledge, access, availability or attitudes, beliefs of women and their male partners or contraceptive/user failure) as well as who is utilizing the post-abortion services, i.e. are youth coming to the institutions for treatment. The CBRHAs or other community workers could be a great source of knowing who is not accessing the services (following up deaths of women in the community).

15. As with other initiatives to improve obstetric services, sustainability of improved PAC is challenged by the high attrition/turnover rate of trained personnel and the lack of stable supplies of necessary materials, drugs and the costs associated with replacing and maintaining equipment (MVA). The attempt to institutionalize comprehensive PAC into pre-service training is an indicator of success (in terms of sustainability and expansion).

16. The following would be of interest to study, a review of evidence-based community-owned emergency transport practices, formal linkages and partnerships between health facility staff and community-based providers and promoters (including TBAs), study of attitudes of labor and delivery and post-abortion care providers toward
women of different ethnic, religious, socio-economic status, unmarried youth that are pregnant and patients with post-abortion complications.

**Youth Reproductive Health (Promotion and Services)**

1. The INSYGHT project was documented as having valuable lessons-learned to share with others interested in working with governmental agencies to establish youth-friendly reproductive health services and illustrates how practices were modified based on assessment findings.

   - Sustainability of this as has been mentioned of other initiatives to build capacity of governmental health care facilities is challenged by the high turnover/attrition of trained staff, often an inadequate number of staff, and secure steady supplies of materials, drugs including contraceptive methods, in particular Depo-Provera, the method most preferred by youth.

   - This orientation practice is not costly, is done on the job and can be provided by experienced and committed staff for new staff. The regional health bureaus involved are reportedly enthusiastic and supportive of youth-friendly services. There is a need for specialized training of family planning staff to meet the needs of youth: more intensive instruction about correct usage of contraceptives, emergency contraception, dual protection to prevent STIs and HIV, and follow-up to promote adherence as well as to provide counseling about self-risk assessment, VCT, and sexual relationship and other personal issues.

2. The documented Pact youth center practices may be innovative as the centers are providing a wide array of activities and services: RH promotion, HIV/AIDS prevention, livelihoods skills-training and income-generating assistance, library, meeting room, and community service-edutainment.

   - As was commonly found during the IBP documentation process, it would be useful to know more about the “NEED” or the pre-intervention situation with qualitative data about the youth in at least one area or community: what do they know, think, do, what motivates them, what do they want, what makes them vulnerable to risky sexual behavior, and community attitudes toward youth, etc. Formative studies/baseline assessments are critical for designing effective
behavior change interventions as well as to better document success with pre/post intervention and trend data.

- And to know more about how this youth center approach was conceptualized and designed. Was it a practice used elsewhere, if so, was it adapted? The objectives of or targets established for these youth centers were not clearly stated, but may be at the Implementing Agency level.

- There is a need for more quantitative disaggregated data about youth utilization of center activities to know who (age, sex, marital status, in-school/out-of-school and other relevant demographic factors specific to the community, e.g. migrant) is being reached by each service.

- The reported result of an increase in FP utilization in Chimbre Kebele may be evidence of success of the family planning promotion done by the Chimbre Kebele youth center, though would need to explore if other interventions or activities also contributed to this increased utilization.

- It would be interesting to know more about the skills-training program (who is providing the training, what training materials are used). To do livelihoods/income-generating assistance well, good technical assistance, management systems and regular monitoring is required. How this component is being implemented is not clear; perhaps the implementing agencies have the necessary expertise to teach market analysis, business planning, accounting, fund management, and to do regular monitoring.

- Experiences relating to community “ownership”, parent involvement, local leadership, youth management of the centers or mechanisms for on-going inputs (training, classes, and center support) would be of interest to others and also to look at the sustainability of this practice.

- The experience of this author in Ethiopia having listened to the needs of out-of-school youth along the Addis-Djibouti Corridors, is that they want “to learn something that will help us”, not just to be given recreational equipment, balls and games so it is expected that the learning opportunities and income-generating assistance are a major factor in attracting youth to the center.

- It is not clear how RH promotion is being conducted as “peer education” is quite nebulous. Questions were raised about the quality of condom distribution programs managed by youth: the inventory/proper storage system, the education provided about proper usage and if using as a contraceptive, instruction about what to do in case of breakage, and in general how the ABC messages are being communicated and appropriately targeted.
• As youth centers are part of the national RH strategy, it is important to closely follow PACT youth centers as well as those supported by others to identify what is working that is promoting reproductive health of youth and to document lessons-learned. This could perhaps be done as a case study following one or more community youth centers.

3. Sharing of lessons-learned as documented and continued review of evidence-based youth-focused family planning and VCT services (technical expertise in meeting physical, social and emotional needs of youth and delivering quality FP and VCT care) is highly recommended for those involved with or wanting to start youth RH services.

4. Developing a Strategy for Pregnancy Prevention Targeting Girls Most at Risk, including a study of attitudes of health professionals and other significant persons toward unmarried youth that are sexually active.

5. The community-based practice to prevent early marriages is innovative and was reportedly designed as a collaborative effort with various partners including Women's Associations.

• Evidence of Success was reported showing large number of early marriages prevented. It is not clear whether prevented means that parents have canceled the marriages until the girl is older or just for a time given the pressure of the committee or legal system.

• The outcomes of this practice to force parents to change their behavior is less certain and needs to be explored given the anecdotal stories of girls that leave home after the canceled marriages, losing their support system.

• As it is presumed that the goal is to improve the lives or the health of girls, other (short-term) strategies and objectives may need to be explored along while working to discontinue these old traditional practices, e.g. keeping married students in school, delaying first pregnancy, or support groups for newly married couples or young brides. The partnership of World Learning with the community committees to promote married girls staying in school with these early marriage prevention activities is of interest to explore.
• Mobilizing the community to dialogue, organize and act has been successful in the areas of prevention of early marriage as well as raising awareness and changing attitudes related to FGM; it would be of interest to look at the factors for this success: Was it due to the key leadership, the Community Conversation methodology, and or the involvement of youth, e.g. girls clubs?

• The strength and strategy of the movement to abolish early marriages that include advocacy with the legal system, powerful religious groups as well as influential community members (e.g. Kebele administration, women’s associations, teachers and RH workers) is expected to have long-term effect (unless there is negative backlash due to a breakdown in family, kinship and community systems that is attributed to the change in marriage customs). A potential negative consequence could be the increased migration of the young girls with the potential of becoming commercial sex workers and being infected with HIV/AIDS.

Integration of RH and HIV/AIDS Prevention Services

1. There are valuable lessons to learn that were identified during this documentation process. FGA-E’s “one-stop” shopping for RH and VCT services at the youth centers has helped to address the barrier of youth’s concern about privacy and the stigma of being seen accessing VCT or Family Planning services.

• Cross-training of staff allows for integrated service delivery in one room by one staff person (this has been found to be viewed as positive by adult as well as youth clients),

• Having a number of cross-trained staff helps to prevent burnout often experienced by VCT counselors.

• There is a need for more demographic and disaggregated data to know more about who is utilizing what services.

• It is not possible to know the results of the integrated service delivery in terms of utilization, e.g. how many youth received both family planning and VCT services.
• Signage on special (VCT) rooms has been found to be a barrier in both youth and adult clinics.
• Attention is given to special needs of youth, e.g. “girls-only clinics.

2. Other areas to explore with integrated services is to know more about how peer promoters (e.g. are these youth or women that have been tested and have adopted good RH practices) are being used at the health facility and the community level (Mother to Mother Program, Community Health Promoters, Youth Centers, etc.) and how if services are not provided by one provider, communication, record-keeping and tracking of referrals is being done.

3. While several RH programs are using on-the-job training practices (e.g. Pathfinder’s Training-based Service and EngenderHealth’s Family Planning Quality Improvement), the PMTCT Decentralized (On-the-Job) Training Program had already been assessed and was considered by the project to be successful:

• The use of this practice is working to meet IntraHealth’s objectives and targets to rapidly establish a large number of PMTCT services.
• While a comparison of centralized versus decentralized PMTCT training has not been done, it is expected that the quality of the training provided on site is enhanced given that it is reality-based and is incorporated into other activities to establish an integrated system.
• This project has been designed to be sustainable as it focuses on system development and includes building capacity of facilities to provide on-going training for new staff. Sustainability of PMTCT Services will require sufficient inputs (drugs, VCT testing materials, supervision, regular monitoring, and demand).
• Of interest is the cost-effective study. If a minimum of eight trainees is needed to be less costly than central training, this is a factor to consider.

4. VCT services in themselves are complex to manage: Challenges include assuring: clients confidentiality and privacy, sufficient time by over-worked staff at health posts or center level to provide counseling, steady supply of kits, compliance with
testing protocols and guidelines, functional referral systems for care and support, and counselor burn-out. The movement to integrate VCT with RH services will benefit from sharing experiences and lessons-learned with the HIV/AIDS prevention, care and support services and projects in Ethiopia.

RECOMMENDATIONS

It is hoped that both the products and the report of the documentation process will be useful in furthering discussion and assisting the IBP Initiative-Ethiopia to promote evidence-based practices and the sharing of lessons learned among the RH Community.

The following activities are recommended:

- Review of this report with the documented practices and facilitated discussion by MOH, IBP Core Group and RH specialists (as relevant to thematic areas).

- Mechanisms are created to institutionalize the IBP Initiative with support provided for coordination and promotion of implementation of evidenced-based practices, documentation and facilitation of information-sharing.

- Dissemination of lessons-learned from documentation of practices and a process to the wider RH community to involve them in planning implementation of the IBP initiative.

- Development of documentation guide/format, analysis plan and framework for rating practices using a participatory process that is inclusive of regional health bureaus, smaller NGO and/or community-based groups.

- Skills-building workshops: Monitoring and Evaluation; Documentation of Practices

- Promotion of documentation of additional practices.
• Dissemination and analysis of practices as part of issue-based discussions and strategizing at national, regional, and *woreda* levels.

**CONCLUSION**

There are several broad areas that are seen as critical to address in order for reproductive health practices to be strengthened, expanded and more effective.

Strong support, including financial assistance of and by the MOH and all donors that are funding RH programming, is critical to continue promotion of the use and documentation of evidence-based practices and the sharing of lessons-learned within the RH community.

As has been identified through this process, there is a need to build the capacity of the RH community to gather more and better information for use in planning, monitoring process and client satisfaction, modifying or improving services or interventions, evaluating results, effecting policy, as well as reporting to key stakeholders. Assessing data needs for improved monitoring and evaluation of RH programs and services is urgent given the current work being done to revise the HMIS.

Programmatically, there is a need to move beyond the common health education approach to development of interventions to change behaviors that affect personal reproductive and sexual health including the risks of exposure to or transmission of HIV/AIDS. A behavior change approach is needed to be taken as well with initiatives to build capacity and strengthen the reproductive health and HIV/AIDS prevention, care and support services. This will require knowing more about the situation and why people or systems “do as they do” studying a variety of factors: knowledge, beliefs, attitudes, social, religious or cultural factors influencing, behavior, motivators, and structural, economical, environmental, emotional, political, or social barriers to changing behavior. It is certain that much is already known by the reproductive health community about the above factors (though may not be specific enough to be useful at the local level). This information needs to be shared, analyzed and interpreted; decisions can then be made about what needs further qualitative or quantitative study or validation. Multi-
sectoral linkages and partnerships are critical to addressing root causes as well as factors contributing to the serious reproductive health problems, risky behaviors, and lack of resources or quality services.

As has been discussed, the continuation and expansion of effective low-cost community-based RH promotion services to work in coordination with the professional public health system is critical to meeting the needs of hard to reach women and families with good information, early identification of problems, referrals, follow-up and support relating to reproductive health promotion and care.

The work being done by the Family Planning Sub-group of the RH taskforce is exciting as Ministry of Health, donors, NGOs, and other RH professionals join together to improve the contraceptive logistic information system sharing information to better forecast needed supply, plan for procurement of contraceptives, and develop systems that ensure a stable supply of contraceptive methods at the facility level.

To conclude, throughout this process it has been a pleasure to observe: the vitality and high level of reproductive health promotion activity in Ethiopia, the collaborative relationships, the partnerships between national and international NGOs, the existence of an RH task force that facilitates interaction between Ministry of Health, donors, civil society, faith-based organizations, advocacy groups, universities, and professional societies, to celebrate the increase in CPR and other progress that is being made to improve the reproductive health status of women in Ethiopia as well as to be part of this national effort to promote evidenced-based Reproductive Health practices.
REFERENCES

Central Statistical Authority (Ethiopia) and ORC Macro. 2001. *Ethiopia Demographic and Health Survey 2000*. Addis Ababa, Ethiopia and Calverton Maryland, USA.


www.popcouncil.org/

http://www.rhcatalyst.org/


http://www.unaids.org/ UNAIDS Best Practice Collection.

www.unfpa.org/monitoring/toolkit/ “Indicators for RH Program Evaluation”, The Evaluation Project. ...
ANNEX I. List of Agencies and Organizations Interviewed

1. Addis Ababa Fistula Hospital. Dr. Mulu Muleta, Medical Director, 09 11225042 fistulahospital@ethionet.et

2. Addis Ketema Health Center. Dr. Yonas Bekele, Medical Counselor 0911405802.

3. African AIDS Initiative International. Program Coordinator, 011 124 3268 tesfayewd@yahoo.com

4. CARE International-Ethiopia. Muna Abdullah, Program Manager, 011- 553 8040 MunaA@care.org.et

5. Consortium of Reproductive Health Association (CORHA). W/o Tigist Alemu, Executive Director, 011-663-6666 corha@telecom.net.et

6. DELIVER. Ms. Priya Enmart, penmart@jsi.com Bernard Fabre bfabre@healtheth.org.et; 251-11 41 69 416

7. DKT. Andrew Piller, Country Director, Mrs Rahel Belete Marketing General Manager 011-551-9300 dktethiopia@ethionet.et

8. EngenderHealth. Dr. Gelila Kidane, Country Director 011 661 44 74 gkidane@endgenderhealth.org

9. Ethiopian Midwives Association (ENMA). Dr. Kiros Alemayehu, President, 011 663 84 25 enma@ethionet.et

10. Ethiopian Pediatrics Society (EPS) Dr Bogale Worku, President, 011-662-46-99 bogalewo@yahoo.com

11. Ethiopian Society for Obstetricians and Gynecologists (ESOG) Dr. Ashebir Getachew, ashebirg@ethionet.et, Dr. Yirgu G. Hirwot esog@ethionet.et 011 559 60 68/9/70

12. Ethiopian Aid. Ato Yeshiwage Bekele 011 550 44 08

Ethiopian Women’s Lawyer Association (EWLA) Mrs. Mihabare Paulos, Executive Director, Mrs. Helen Seifu, Head of Research 011 550-77-74 ewla@ethionet.et

13. Family Health Department-MOH Mrs Hiwot Mengiste, Acting Head, Dr. Ayele Debebe Gemechu, National Program Officer for MPS 091 169 79 77; Ayeled@et.afro.who.int
14. Family Guidance Association of Ethiopia FGA-E Ato Amara Bedala, Executive Director, 011 151 4111; Ato Sitayehu Dejene, Bahir Dar Clinic 09-18 76 0829, fgaenwb@ethionet.et, Dr. Alemu Ferede, Head of Model Clinic 011 55 288 13, ATo Mollia Zeleke, Youth Officer 09 11 13 48 74.

15. Health Communication Partnership. Mrs. Kokeb Kassa, Country Director 011 416 9212 kkassa@aed.org

16. Intrahealth. Dr. Yetnayet Asfaw, Deputy Country Director 011 66 27480 ydemissie@yahoo.com, Sister Berhne Fekade, Site Coordinator 011 77 3557

17. IPAS-Ethiopia. Dr. Takele Geressu, Senior Program Advisor 011-663-378 Ipas@ethionet.et,

18. Kembbati Menti Gezzima Tope (KMG) Mrs. Bogalech Gebre, Director 011-4670791

19. Linkages/AED. Dr. Agnes Guuyon 011 4168454 agnes.linkages@healtheth.org.et

20. Marie Stopes International, Dr. Beyene Alamadew, Service Delivery Coordinator 11-663-41-51 mne@ethionet.et


22. National Committee on Traditional Practices of Ethiopia (formerly NCHTP, now EGLDM) Ato Abebe Kebede, Executive Director 011-662-45-02

23. Oromiya Development Association. Dr. Mulugeta Hawas 09-11 245 004, Tessema Firdissa, RH Officer. 09 11 43 08 18

24. PACT. Sister Fekete Belete 0116613330 fbelete@pact.org

25. Pathfinder International. 011-661-33-30 Ato Tilahun Giday, Country RepresentativeTgiday@pathfind.org, Dr. Mengistu Asnake, Mrs. Bogalech Alemu251-1-61330 www.pathfinder.org

26. Population Council. Dr. Tekleb Mekbib 011 551 8400 mekibibt@telcom.net.et

27. Propride. Ato Adam Kidane, Director propride@ethionet.et

28. Save The Children/US. Dr. Tedbab Depifie, Tdepifie@savechildren.org.et. Mrs. Yeshmebet G. Giorgis 011-372-84-55

29. UNFPA. Dr. Kidane G. Kidan, 09 11 21 8344 gheberekidane@unfpa.org

30. USAID Mary Ann Abeyta-Behnke, Senior RH Advisor, Mrs. Kidist Lulu, RH Technical Advisor USAID 011- 55 100 88
31. The following agencies were contacted and provided documents or information about potential practices: AMREF, CRDA, Ethiopian Public Health Association (EPHA), Family Health International, John Snow International (JSI), PLAN, UNICEF, UNFPA, and WHO.

ANNEX II. List of Initial Draft Documents

Family Planning

- Training-Service Delivery (Pathfinder)
- Improving Quality of FP Services (EngenderHealth)
- Community-Based Reproductive Health Workers (Pathfinder)
- Marketing Contraceptives (DKT)
- Logistics Information Systems to Contraceptive Security (DELIVER)

Pregnancy and Obstetric Care

- Making Pregnancy Safe (MPS-MOH)
- Save the Mother (STM-ESOG)
- TBAs promoting Assisted Birth (CARE)
- Accelerated uptake of the practice for active management of third stage of labor (ESOG)
- Post-Abortion Care (Ipas)

HIV/AIDS and RH Integration

- Decentralized Training to Integrate PMTCT Services (IntraHealth)
- Integrated VCT/RHG Services for Youth (FGA-E)
- Integrated VCT/RH Services (Propride)

RH Promotion for Youth

- Community-based Youth Centers and Reproductive Health Promotion (PACT)
- Youth-Friendly Facilities (SC/US)

RH Rights/Prevention of Harmful Traditional Practices

- Legal Assistance to Protect the Rights of Women (EWLA)
- Early Marriage Prevention (PATHFINDER)
- Awareness-raising-FGM (NCTPE)
- Code of Ethics for RH Workers (ESOG)
- Comprehensive Care for Rape Victims (FGA-E)
ANNEX III. Interview Guide to Gather Information about Potential Best RH Practices

1. Name of organization, agency, or association: ____________________________
2. Address, phone number, email address: _________________________________
   Name and title of contact: _______________________________________
3. Phone number, email address of contact: _______________________________
4. Name of interviewer: _________________________________________
5. Date of interview: ____________________________
6. Title of practice (project/program/activity/tools/service/policy) relating to reproductive health that has been successful._____________________
7. Tick (x) one or more thematic areas as are relevant:
   a. ___ Family planning: long term/permanent methods
   b. ___ Family Planning: Birth spacing (Community-based, facility-based, social marketing)
   c. ___ Contraceptive security
   d. ___ Adolescent sexual health
   e. ___ Assisted Birth
   f. ___ Neonatal health
   g. ___ Post abortion care
   h. ___ Fistula care
   i. ___ Gender based violence, FGM, Early pregnancy reduction and prevention
   j. ___ HIV/AIDS (VCT and/or PMTCT) and Family Planning
8. What is the overall objective?
9. What are the specific objectives?
10. What problem or issue does this address or resolve?
11. What was the baseline situation like? (if baseline assessment was conducted, provide data)
12. When was this program, practice or service initiated?
13. What is the geographic area of implementation (catchments area) or impact of the project, activity or service? Specify Region, Zone, Woreda, Peasant association(s) or Keble(s)
14. Who is directly implementing this practice?
15. Who (groups, sub-groups) is your targeted population?
16. What number of this group are you hoping to reach this year?
17. How many have you reached (last year, life of project), disaggregated data by woreda, zone, or region and as is possible by sex, age, urban/rural)

18. Describe your practice?

19. What are the key activities?

20. What have been your results or achievements?

21. What evidence do you have to show the success of your results and achievements (include findings of quantitative, qualitative assessments, studies, evaluations, service delivery statistics, or activity or anecdotal reports).

22. Why has this been successful? (list the essential or key components, elements, actions, factors)

23. Has this practice been used elsewhere, is so did you adapt it, or is it innovative?

24. Do you think this practice could be replicated in other parts of Ethiopia? If so, what are the necessary factors in terms of resources: e.g. community participation, leadership, human resources, training, etc?

25. Is this practice sustainable? If so what are the essential or critical elements?

26. What lessons that you have learned from this experience, include obstacles and how you addressed them.

27. What have others done to contribute to the success of this practice (donors, technical consultants, governmental agencies, universities, NGOs, community or faith-based organizations, community groups, or associations?)

ANNEX IV. Interview Guide to Gather Information about Practices That Make Programs Work

1. Name of program that has practices that you would like to share with us.

Tick (x) one or more thematic areas as are relevant:
   ___ Family planning: long term/permanent methods
   ___ Family planning: birth spacing (community-based, facility-based, social marketing)
   ___ Contraceptive security
   ___ Adolescent sexual health
   ___ Assisted birth, pregnancy and delivery
   ___ Neonatal health
___ Post abortion care
___ Fistula
___ Gender based violence, FGM, early pregnancy reduction and prevention
___ HIV/AIDS (VCT and/or PMTCT) and family planning

2. What are the goals, objectives and targets of this program?

3. How did you establish these goal, objectives and targets?

   Probe for:
   a. Situation analysis/baseline assessment
   b. Monitoring and evaluation plan
   c. Problem analysis
   d. Consulted stakeholders
   e. Consulted existing information, research or reports (evaluations, needs assessments)

4. Briefly describe your program or service?

   • When was it initiated?
   • What is the geographic area of implementation (catchment area)?
   • Who (groups, sub-groups) is your targeted population?
   • How do you monitor and evaluate your program or service?

5. List up to three key practices (tools, approaches, systems, actions) that are making the program or service work?

6. For each practice, answer the following questions:

   a. What issue(s) or problem(s) are you addressing or trying to solve?

   b. Please describe:
      • Where the practice is used or done?
      • Activities
      • Steps
      • Resources
      • Implementers
      • Partners
      • Target Groups
      • Necessary Conditions

   c. How did you select or design this practice? Probe for:
      • Imported it because it worked someplace else
      • If you’ve adopted and adapted from someplace else, how did you do it?
      • Tried as innovation based on educated hypothesis
• Adapted from past experience (applying lessons learned)

d. What information and indicators do you have that this practice is working? (Collect documentation)

e. Has this practice been replicated, if so how and where?

f. If not, what would it take (resources, environment or actions) to replicate this practice?

g. Is this practice sustainable? If so, what are the essential or critical elements that make it so?

h. What lessons have you learned from implementing this practice? Include obstacles and how you addressed them.

i. What has been the role of others in the implementation of this practice?

j. What complementary activities (in your program or in a partner’s program) have enhanced the impact of this practice?