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Strengthening Family Planning with Community-Based Nutrition Interventions in Ethiopia:

A Qualitative Study

Daiel Sellen, Sharmin Sharif, Bethlehem Tefera, and Ziauddin Hyder

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Nutrition and Population (HNP) Discussion Paper

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Health, Nutrition and Population (HNP) Discussion Paper

Strengthening Family Planning with Community-based Nutrition Interventions in Ethiopia: *A Qualitative Study*

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Abstract: A small-scale, exploratory, and qualitative operational research study was conducted in early 2011 to capture and examine stakeholder perspectives on integrated family planning (FP) programs implemented through Ethiopia's health extension program (HEP). Qualitative indications are that various stakeholders on both the supply and the demand side perceive that specific community-based nutrition (CBN) activities also delivered within HEP serve to link nutrition, family planning, and other health issues in socially acceptable and qualitatively effective ways. Remarkable concordance of qualitative indicators of service delivery, uptake, and satisfaction was noted on both the supply and demand side of service delivery at the sites studied. Respondent reports suggested the following: (i) active and successful delivery of both CBN and FP activities; (ii) some challenges with record keeping, supervision, and supplies; (iii) strong uptake of services and messages; (iv) a highly positive community-level perception of service quality, even in a partially capacitated kebele (neighborhood); and (v) an engaged response by participants. Qualitative indicators of community-level HEP staff, volunteer performance, and community satisfaction were generally positive. However, gaps and challenges to improving integration and delivery of FP and CBN within HEPs and in achieving sustainability in scale-up of integrated programs include (i) increasing capacity to support implant removal, (ii) maintaining human resources for health within the health extension program, and (iii) addressing the needs of youth in general and out-of-school youth in particular. Recommendations for improved delivery of integrated FP and CBN programs are to explore ways to (i) step up planning and resourcing for contraceptive implant removal, (ii) reduce staff turnover at the health posts and health centers, (iii) strengthen integrative supportive supervision and management of CBN, (iv) enhance recruitment and training of youth as health workers, (v) target adolescents and out-of-school youth for FP and CBN, (vi) harmonize integrated FP and CBN messaging, (vii) harmonize donor support for integration, and (viii) measure the effectiveness of integration.

Keywords: Family planning, community-based nutrition, program integration, stakeholder perspective, service delivery.

Disclaimer: The findings, interpretations, and conclusions expressed in the paper are entirely those of the authors, and do not represent the views of the World Bank, its Executive Directors, or the countries they represent.

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Table of Contents

Table of Contents	v
LIST OF ABBREVIATIONS AND ACRONYMS	viii
ACKNOWLEDGMENTS	ix
PREFACE	x
EXECUTIVE SUMMARY	xi
PART 1. LINKING FAMILY PLANNING AND NUTRITION PROGRAMS	1
1.1. STUDY RATIONALE, AIMS, AND OBJECTIVES	1
1.2. INTEGRATED APPROACHES: A GLOBAL PERSPECTIVE	1
1.2.1. Integrating FP with other services	1
1.2.2. Integrating FP with community-based nutrition (CBN) support services	3
1.2.3. Operational research needs.....	3
1.3. OPERATIONAL CONTEXT IN ETHIOPIA	4
1.3.1. Large unmet needs for family planning	4
1.3.2. Widespread undernutrition.....	5
1.3.3. Ethiopia's health extension program (HEP)	5
1.3.4. Current integration of FP and CBN in Ethiopia	6
1.3.5. Opportunities for operational research in Ethiopia.....	8
PART 2. STUDY DESIGN.....	9
2.1. DATA COLLECTION METHODS.....	9
2.1.1. Study team and activities	9
2.1.2. Tool development.....	9
2.2. SAMPLING	10
2.2.1. In-depth interviews with individual representatives.....	10
2.2.2. Site selection for community-based observation and discussion	10
2.2.3. Observations	11
2.2.4. Focus group discussions.....	11
2.3. ANALYSIS AND REPORTING	12
2.4. STUDY LIMITATIONS	12
2.4.1. Site selection.....	12
2.4.2. Qualitative inference	13
PART 3. RESULTS AND DISCUSSION.....	15
3.1. CHARACTERISTICS OF SELECTED STUDY SITES.....	15
3.1.1. Region selected	15
3.1.2. Kebeles selected.....	15
3.2. QUALITATIVE INDICATORS OF SERVICE DELIVERY (SUPPLY SIDE)	16
3.2.1. Activities and messages delivered	16
3.2.1.1. <i>FP services delivered at monthly growth monitoring and promotion sessions</i>	17
3.2.1.2. <i>FP services delivered at quarterly community health days</i>	17
3.2.1.3. <i>FP services delivered at monthly community conversations and home visits</i>	17
3.2.2. Record keeping	18
3.2.3. Supervision.....	18
3.2.4. Motivation of health extension and volunteer community health workers.....	19
3.2.4.1. <i>Job satisfaction</i>	19
3.2.4.2. <i>On-the-job challenges</i>	19

3.2.4.3. <i>Work time, workload, and incentives for staff retention</i>	20
3.2.5. Supplies	20
3.2.6. Multisectoral coordination.....	21
3.3. QUALITATIVE INDICATORS OF SERVICE DELIVERY (DEMAND SIDE)	21
3.3.1. Community-level support	21
3.3.2. Mobilization of beneficiaries.....	22
3.3.2.1. <i>The health extension program platform</i>	22
3.3.2.2. <i>Observations on gender</i>	22
3.3.2.3. <i>Regularity and quality of CBN activities</i>	23
3.3.3. Acceptance of messages.....	23
3.3.3.1. <i>Cultural acceptability of links between FP and nutrition needs</i>	23
3.3.3.2. <i>FP method mix</i>	24
3.3.3.3. <i>Quality of training</i>	24
3.3.4. Motivation	25
3.4. HOW IS CBN PERCEIVED TO IMPROVE FP SERVICE AND UPTAKE?	26
PART 4. LESSONS LEARNED FOR SCALE-UP	28
4.1. POTENTIAL LIMITING FACTORS AND OBSTACLES	28
4.2. GAPS NOTED	28
4.2.1. Funding.....	28
4.2.2. Transport.....	28
4.2.3. Distribution.....	28
4.2.4. FP service quality	29
4.3. OTHER CHALLENGES IDENTIFIED.....	31
4.3.1. Capacity to support implant removal	31
4.3.2. Maintaining human resources for health.....	31
4.3.3. Addressing FP needs of youth.....	32
4.3.3.1. <i>Existing youth links to health extension program</i>	32
4.3.3.2. <i>Current unmet need expressed</i>	32
4.3.3.3. <i>Weak targeting of youth</i>	32
4.3.3.4. <i>Opportunities for recruitment as health human resources</i>	33
4.4. ONGOING CHANGES WITHIN CBN, FP, AND HEP IN ETHIOPIA	33
PART 5. CONCLUSIONS AND PRACTICAL RECOMMENDATIONS	34
5.1. CONCLUSIONS	34
5.2. RECOMMENDATIONS	35
ANNEXES	42
ANNEX 1. STUDY TIME FRAME, 2011	42
ANNEX 2. THEMES USED TO ORGANIZE DISCUSSION WITH SERVICE PROVIDERS AND USERS	43
ANNEX 3. THEMES USED TO ORGANIZE CONTENT ANALYSIS OF DATA COLLECTED	44
ANNEX 4. EXAMPLE OF AN INTERVIEW GUIDE USED.....	46
ANNEX 5. EXAMPLES OF FOCUS GROUP DISCUSSION GUIDES USED	48
ANNEX 6. OBSERVED ACTIVITIES INTEGRATING FP WITHIN CBN.....	54
ANNEX 7. FP MESSAGES HEALTH EXTENSION WORKER REPORT GIVING DURING CBN ACTIVITIES	56
ANNEX 8. EXAMPLES OF STAKEHOLDER STATEMENTS ON SERVICE DELIVERY, ORGANIZED BY SELECTED THEMES.....	58
Supervision.....	58
Job satisfaction	58
Incentives	58

Coordination	59
Support in the community	59
Mobilization.....	60
How CBN works	61
Why CBN works	62
Weak targeting of youth.....	62
Resource and funding gaps.....	63
ANNEX 9. SUMMARY OF STAKEHOLDER WORKSHOP	64

LIST OF ABBREVIATIONS AND ACRONYMS

BPR	Business process re-engineering
CBN	Community-based nutrition
CC	Community conversation
CHD	Community health days
CPR	Contraceptive prevalent rate
DP	Development partners
EHSP	Essential health service package
FGD	Focus group discussion
FMOH	Federal Ministry of Health
FP	Family planning
GMP	Growth monitoring and promotion
GoE	Government of Ethiopia
GTP	Growth and transformation program
HC	Health center
HEP	Health extension program
HEW	Health extension worker
HFA	Health for all
HP	Health post
HSDP-III	Third Health Sector Development Programme
IDI	In-depth interview
ISS	Integrated supportive supervision
ITN	Insecticide treated net
LAFP	Long-acting family planning
MDG	Millennium Development Goal
MMR	Maternal mortality ratio
MOH	Ministry of Health
MUAC	Mid-upper arm circumference
NNP	National Nutrition Program
NNS	National Nutrition Strategy
NPP	National Population Policy
NSD	Nutrition service delivery
PBS	Protection of Basic Services Programme
PHC	Primary health care
PHCU	Primary health care unit
PLW	Pregnant and lactating women
PSM	Procurement supply management
RHB	Regional health bureau
SAM	Severe acute malnutrition
TF	Therapeutic feeding
TFR	Total fertility rate
TSF	Targeted supplementary food
VCHW	Volunteer community health worker
WoHo	Woreda health office

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PREFACE

Links between population and nutrition are well established; enhancing links associated with desirable human development outcomes is a central component of development efforts. Short previous birth spacing due to unmet needs for family planning (FP), poor family nutrition security,¹ and inadequate feeding and care of infants and young children contribute significantly to early deaths, undernutrition among both women and children, and significant economic losses at all levels of society. Conversely, access to family planning and good nutrition should bring economic and health benefits and serve as effective components of national development plans that respond to challenging and rapidly changing social and economic conditions. Many observers therefore regard integration of family planning service delivery with nutrition and other services as a potentially powerful development strategy in low-income countries. Efforts to address family planning needs within programs aimed at reducing malnutrition make sense because limited availability and use of family planning contribute to child malnutrition.

This report presents the findings of a small-scale, exploratory, and qualitative operational research study that was conducted in early 2011 to identify some of the strengths, opportunities, risks, and challenges of integrated FP and community-based nutrition (CBN) programs implemented in Ethiopia as a component of the national health extension program (HEP). To the best of our knowledge, it may be among the first studies to examine stakeholder perspectives on integrated FP approaches in Ethiopia.

The study was conducted to generate new information on the extent that challenges and successes of integration of FP service provision within CBN would be useful to the government of Ethiopia and relevant development partners in assessing the value added by integrated programming. The findings contribute data to the limited body of evidence to evaluate such programs around the world and should be of direct use to planners aiming to address the large unmet needs for family planning in Ethiopia. At the time of the study, Ethiopia's national FP program was implemented primarily as a component of HEP, a major component of the national health system, particularly in rural areas where 84 percent of Ethiopians live. Ongoing CBN programs also implemented within HEP provided opportunities to gather stakeholder perspectives on whether integration within CBN improves FP uptake, and also to identify opportunities for and constraints to achieving continued or better success in integration.

1. Defined as limited access to and utilization of food and poor access to sanitation and health services that protect against infectious disease.

EXECUTIVE SUMMARY

Continued and rapid population increase and widespread undernutrition hamper progress toward Ethiopia's national development goals. Both family planning and improved nutrition can be effective components of national plans for economic and human development, but there is little data to assess the efficacy of integrated programs aimed at promoting birth spacing and improving child nutrition.

This report summarizes qualitative findings from **operational research conducted at selected sites in Ethiopia** to answer three questions: How do stakeholders perceive the relevance and appropriateness of integrating family planning (FP) and community-based nutrition (CBN) programs? Does CBN programming improve the provision and uptake of FP services; and if so, how? Specific **objectives** were the following:

- Gather new knowledge on current experiences with community-level integrated CBN and FP service delivery system through identification, documentation, analysis, and summary of the enabling and limiting factors, best practices, and lessons learned;
- Obtain qualitative indicators of successes, unintended potential negative effects, and challenges and opportunities for integration, which can inform decisions on whether and how to upscale;
- Generate evidence-based, practical recommendations to overcome obstacles and to improve FP and CBN currently integrated at the community level with respect to institutional capacities and arrangements, policy frameworks, and monitoring and evaluation of process and impact of scaled-up FP interventions delivered;
- Disseminate lessons learned and recommendations to inform efforts to scale-up and scale-out integrated family planning within community-based health and nutrition interventions nationally.

A small-scale, exploratory and qualitative operational research study was conducted between February and June, 2011, to examine the concept that CBN improves FP uptake. A purposive sampling technique was used to select four kebeles (neighborhoods) from within the four regions where the National Nutrition Project (NNP) was implemented at the time of the study.² Kebeles were purposively selected to include a varied range in the level of supervisory oversight, health post infrastructure, and time since rollout of CBN (“model,” “full capacity,” “partial capacity,” and “new CBN”). Individual participants were purposively sampled to include a diversity of individuals from a range of supply-side and demand-side stakeholder groups. A study team conducted: (i) 19 in-depth, structured interviews with selected program administrators within and beyond government; (ii) 8 focus group discussions with stakeholder groups involved in service delivery (health extension workers, volunteer community health workers; 4 focus group discussions with each group), and 10 focus group discussions with intended beneficiaries at community-level uptake (women, men, and youth; 4, 4, and 2 focus group discussions, respectively); (iii) 18 days direct observation in the selected communities, and 4 days attending master trainings for CBN components; and (iv) a program document review. The focus group discussions and observations were conducted at community level.

Thematic analysis of interview and discussion transcripts generated qualitative data on the extent, challenges, and successes of FP service provision in the selected kebeles where CBN is implemented

2. NNP is implemented in Amhara, Oromia, SNNP and Tigray regions, all categorized as food insecure regions where 80 percent of the total population live.

through the national health extension program (HEP). The results were organized by first looking at qualitative indicators of current strengths and weaknesses of integrated FP/CBN service delivery on the supply side (national and local level). Then, qualitative indicators of current strengths and weaknesses of integrated FP/CBN service delivery on the demand side, (that is, at community level) were examined for lessons on what works and what does not from the perspective of intended beneficiaries and frontline health workers. Comparison of the similarities and differences among themes mentioned by different stakeholders allowed insights into whether, how, and why such CBN is perceived to improve FP uptake.

There was remarkable concordance of qualitative indicators of service delivery, uptake, and satisfaction [program] among intended beneficiaries. Specifically, the results suggest (i) active and successful delivery of both CBN and FP activities at the sites studied; (ii) some challenges with record keeping (for example, use of forms), supervision (workload, logistics, supportive feedback), and supplies (stock-outs of FP and other commodities); (iii) strong uptake of FP services and messages; and (iv) a highly positive community-level perception of CBN, FP, and health extension program service quality.

In the kebeles studied, CBN activities enhanced provision and uptake of FP in two main ways. First, CBN activities facilitated a shift from a focus on limiting family size as a goal for couples to a focus on keeping children born alive, well-nourished, growing, and healthy as a goal for families and the wider community. This focus fits better with prevailing cultural models and is suggested as a more powerful concept to achieving social mobilization and individual motivation. The results support the interpretation that direct linkage of FP and CBN messages is culturally acceptable and effective in promoting FP uptake.

Second, CBN activities provided a platform for frequent and varied contact between intended beneficiaries and health extension staff promoting and providing FP. In turn, these influence motivation, access, mobilization, and support of providers or beneficiaries. A positive perception on CBN activities is held by almost all stakeholders consulted and has an apparent positive “spillover” into other health extension program components. Frequent and varied contact with beneficiaries through monthly growth monitoring and community conversations, quarterly child health days, and household visits by health extension workers and volunteer community health workers provide repeated opportunities to discuss the reasons for child malnutrition and promote FP goals such as birth spacing to reduce child malnutrition.

Specific pathways for the **positive effects of CBN** include the appropriateness of mobilization using a platform of regular CBN activities to target FP needs; the support of the health extension program platform and its activities, which are well accepted and endorsed by health workers; good community acceptance linked to positive community perception and high satisfaction with access, availability, and quality of HEP services provided; and good motivation linked to use of local examples and perception of FP as a way to space births and improve mother and child nutrition rather than family size limitation or even birth spacing alone. The first three pathways are likely to be the positive effects of CBN on HEP activities in general, while the last pathway may be a specific positive effect of CBN activities on FP in particular.

Additional lessons were learned about the current strengths of integrated programs. These include the perceived appropriateness of the health extension worker/HEP model among intended beneficiaries at community level; the regularity and quality of CBN activities; and the synergism among health

extension program activities. They also include the addition of long-acting family planning to the “method mix” and the delivery of an improved FP method mix directly to users within the community. Last, they include strong government commitment to both FP and CBN, strong development partner (DP) support for integration, and growing capacity for coordination. Gaps noted (although not specifically investigated) include problems with transport (especially for supervision); distribution of FP commodities, line items, and supplies; limited current use of data systems due to skills gaps; a need for improved training on FP; and gaps in FP service quality at health centers.

Three main **challenges for improving integration** and delivery of FP within CBN were identified as increasing capacity to support implant removal, maintaining human resources for health within HEP, and addressing the needs of youth in general and out-of-school youth in particular. Specifically, resource planning and coordination is needed to avoid a potential “ratchet effect” that may become associated with increasing uptake of ImplanonTM. The special needs emerging from the youth population are only partially served through existing youth links to the HEP; weak targeting of youth contributes to current unmet needs. Human health resources can be protected and increased by maintaining and improving job satisfaction for HEP staff, addressing on-the-job challenges faced by health extension workers and volunteer community health workers, creating better incentives for staff retention and recruiting more youth for the health extension program, CBN, and FP support.

In sum, results of a small-scale operational research study suggest a number of **specific pathways** through which CBN activities provide an effective platform that enhances community-based FP activities and service provision. Provision of FP information and services within a context of broader, substantive, and directly observable community-based activities aimed at a common goal of promoting healthy children and reducing child malnutrition appears to be effective. However, the study did not directly test whether this approach is more effective than promoting family size limitation or whether the integrated approach facilitated peer-to-peer information exchange in the community. These would be useful questions to investigate and verify in future process evaluations.

The interpretation and recommendations take into account several **limitations** of the study. These include nonrandomised, service-based convenience samplings of participants, project staff, volunteers, and managers; lack of a control kebele where CBN was absent; the small number of kebeles included; limited resources for cross-checking translation and transcription; and limited scope and depth of qualitative data resulting from the specific focus and sampling methods used by design.

Although the findings are tentative given the limited scope and qualitative nature of the data collected, they provide potentially useful insights on the strengths and weaknesses of current integration of FP programs with the CBN approach in Ethiopia. They provide support for **eight recommendations** for improved delivery of integrated FP and CBN programs: (i) step up planning and resourcing for implant removal; (ii) reduce staff turnover at the health posts and health centers; (iii) strengthen integrative supportive supervision; (iv) enhance recruitment and training of youth as health workers, (v) target adolescents and out-of-school youth for FP and CBN; (vi) harmonize integrated messaging; (vii) harmonize donor support for integration; and (viii) measure the effects of integration on outcomes.

PART 1. LINKING FAMILY PLANNING AND NUTRITION PROGRAMS

1.1. STUDY RATIONALE, AIMS, AND OBJECTIVES

This report presents findings from a small-scale, exploratory, and qualitative operational research study designed to identify some of the strengths, opportunities, risks, and challenges of integrated family planning (FP) and community-based nutrition (CBN) programs in Ethiopia. The rationale for the study was to respond to a need for increased qualitative understanding of how ongoing, integrated programs are working from the perspective of various stakeholders on both the supply and the delivery side. The study did not aim to evaluate whether FP and CBN integration is more effective in achieving specific population health outcomes than separate delivery. Rather, aims were the following:

- (i) To gather stakeholder perspectives on whether integration within CBN improves FP service;
- (ii) To gather qualitative information on opportunities and challenges to achieve continued or better success in integration.

The main objective was to answer three questions: How do stakeholders perceive the relevance and appropriateness of integrating FP and community-based nutrition programs? Does CBN programming improve the provision and uptake of FP services; and if so, how?

Specific objectives were the following:

- To gather new knowledge on current experiences with community-level integrated CBN and FP service delivery system through identification, documentation, analysis, and summary of the enabling or limiting factors, best practices, and lessons learned;
- To obtain qualitative indicators of successes, unintended potential negative effects, challenges, and opportunities for integration that can inform decisions on whether and how to upscale;
- To generate evidence-based, practical recommendations to overcome obstacles and to improve FP and CBN currently integrated at the community level with respect to institutional capacities and arrangements, policy frameworks, and monitoring and evaluation of process and impact of scaled up FP interventions delivered;
- To disseminate recommendations and lessons learned to inform efforts to scale-up and scale-out integrated family planning within community-based health and nutrition interventions nationally.

The study methods and results are presented in chapters 2 and 3 of this report, respectively. The lessons learned and study limitations are presented in chapter 4. Recommendations are made in chapter 5. The rest of this chapter provides background on integrated programs in Ethiopia, focusing on FP and CBN.

1.2. INTEGRATED APPROACHES: A GLOBAL PERSPECTIVE

1.2.1. Integrating FP with other services

Clear evidence exists that FP is a valuable investment that saves lives by reducing unplanned pregnancies, early motherhood, and short birth intervals, all of which threaten maternal and child survival and health (Smith et al 2009). In response to this evidence, a growing number of international bodies have developed policy plans, guidelines, and best practices for increasing access and uptake by

integrating FP into other health and nonhealth population services as an alternative to traditional, separate approaches. The expected benefits of integration include increased program efficiency, cost-effectiveness, continuity of care among programs, and improved quality of client-centered service and intended outcomes (USAID 2006; Richey and Salem 2008; Ringheim 2009). The underlying mechanisms linking integration to improved FP outcomes are postulated to include synergies achieved during service delivery through efficient use of funds and personnel, integration of different messages, and improved community mobilization.

Experience around the world has demonstrated the feasibility of integrating FP into services that include reproductive health (RH); HIV prevention and treatment services; safe motherhood; and basic primary health services such as maternal, neonatal, and child health and nutrition (USAID 2006, 2011a, 2012a; Richey and Salem 2008; Ringheim 2009; Ringheim, Yeakey et al. 2009; Sebert et al. 2010; Bowen 2010; Foreman 2011; USAID 2012b). Documented pathways to successful integration of FP, as perceived by participants, include integration of messages, improved health worker job aids, and strengthened community linkages (for example, McKaig et al. 2009), and increased program reach to underserved and vulnerable groups (for example, USAID 2012b). Documented challenges to integration include building political support to integrate and coordinate previously separate systems, building capacity to train and support staff, and mobilizing communities (the CATALYST Consortium 2003; Ringheim 2009; Bowen 2010; Foreman 2011; USAID 2012a). However, the full assessment of the success and limitations of integration of FP with other population health programs in different country and program settings is hampered by methodological limitations and a paucity of well-designed studies.

Empirical evaluations of the benefits of integration are relatively few, methodologically discrepant, and hampered by challenges of defining and operationalizing measures of “integration,” developing feasible study designs that can make appropriate comparisons, and possible bias toward publication of only those studies that find positive benefits of linkage. Recent reviews highlight weakness in the evidence supporting integration and call for more evaluation. For example, results of a recent Cochrane Review of 29 interventions integrating maternal, neonatal, and child health and nutrition (MNCHN) and FP services (USAID 2012b) were generally positive, showing that integration was feasible and often successful on the measures employed, but the evidence was limited and uneven in terms of outcomes measured both within and across interventions. Although “most studies reported that FP-MNCH-nutrition integration improved service coverage, quality, and use” and “costs were reduced” when measured, the results on indicators of service effectiveness were mixed or negligible, and many studies lacked rigor and were possibly subject to positive bias (Bain-Brickly, cited in USAID 2011b³). Indications are that more direct comparisons of costs, mortality, and pregnancy-related outcomes across integrated and nonintegrated programs are needed (USAID 2012b). Similarly, a qualitative review by Sebert et al. (2010) concluded that seven of nine studies published between 1994 and 2009 documented improved family planning outcomes and that stakeholder perspectives on integration were positive when investigated, but the authors also noted a lack of studies measuring across-the-board outcomes for all programs implemented and the specific absence of economic analyses.

3. See USAID 2011b, appendix 2: Systematic Review of Integration of Maternal, Neonatal, and Child Health and Nutrition and Family Planning (Cochrane Review).

1.2.2. Integrating FP with community-based nutrition (CBN) support services

Efforts to address FP needs within community-based programs aimed at reducing child malnutrition make particular sense. This is because limited availability and use of FP contribute to undernutrition, illness, death, and economic loss through pathways associated with short birth spacing and child undernutrition. Risk of death of neonates, infants, and children under five years of age increases with shorter previous birth spacing (Brockman, 2004; Rutstein, 2005; Rutstein, 2008), and both gestational and early postnatal undernutrition may mediate this relationship. The risk of child undernutrition increases with shorter preceding birth intervals in most (though not all) low-income countries (Dewey and Cohen 2007; Rutstein 2008).⁴ Globally, children conceived between 12 and 17 months after a previous birth are 25 percent more likely to be stunted or underweight than those conceived after intervals of between 36 and 47 months (Rutstein 2008). Relatively short birth-to-next-pregnancy intervals also increase risk of poor pregnancy outcomes (preterm delivery, low birth weight, and smallness for gestational age) and of neonatal, child, and maternal mortality (Brockman 2004; USAID 2011a). In low-income countries such as Ethiopia, more than half of all deaths among the very young (less than five years) result from undernutrition, and three-quarters of these from mild to moderate undernutrition (Black et al. 2008). Undernutrition also diminishes the health, human capacity, and economic potential of more than half of all surviving children by causing frequent illness, low physical and mental capacity, and economic loss (Ruel and Hoddinott 2008; Alive and Thrive Initiative 2010).

Taken together, these associations provide a strong technical rationale for integrating family planning and nutrition programs at community level because of the potential for gains in breaking the intergenerational cycle of malnutrition and ill health. In addition, any existing similarities between community-based FP and nutrition security programming might offer practical opportunities for integration. Such similarities may include shared target beneficiary groups and a need for both programmatic involvement of health service providers and community mobilization and communication strategies. Integrated programming is likely to achieve better results for both FP and nutrition outcomes at potentially lower transaction, service delivery, human resources, and opportunity costs for intended beneficiaries. However, there have been few evaluations of FP integration within CBN versus other MNCHN programs (USAID 2012b).

1.2.3. Operational research needs

Operational differences between successful family planning and nutrition programs at community level create potential risks for failure of integration efforts. For example, the relative felt needs for FP and CBN will differ among communities; in some it may be a challenge for community members to see the benefits of FP in terms of nutritional improvements, and vice versa. Globally, there is a need for data to evaluate the opportunities, risks, and challenges for integrated FP and CBN to inform decisions about whether and how to scale-up integrated programs. Many key programmatic questions could be addressed. On the service delivery side, does integration of FP and CBN lead to greater efficiency and better quality of services? On the demand side, does integration lead to greater uptake of interventions (effectiveness) and better population outcomes, documented for both FP and CBN? Data to answer such questions are needed because many countries have moved toward integration of family planning within reproductive, maternal, and child health programs.

4. Some studies report undernutrition among women is linked to short previous birth spacing, but more studies with better methods are needed to establish this link (Dewey and Cohen 2007).

1.3. OPERATIONAL CONTEXT IN ETHIOPIA

Ethiopia's national FP program is primarily implemented as a component of the national health extension program (HEP), which is in turn a major component of the health system, particularly in rural areas where 84 percent of Ethiopians live. HEP is aimed at addressing many health-related development needs including large unmet needs for family planning and widespread undernutrition.

1.3.1. Large unmet needs for family planning

Knowledge of family planning (FP) among women is high at 97 percent, and more than one-third of Ethiopian women want to space a future birth (33 percent) or stop childbearing (Central Statistical Agency [CSA] and ICF International 2012). However, contraceptive prevalence rates (CPR) are low, and unmet need for FP is high. The 2011 demographic and health survey (DHS) estimated CPR at about 20 percent of all Ethiopian women age 15 to 49, 29 percent for currently married women, and 57 percent for sexually active unmarried women (Central Statistical Agency and ICF International 2012). Among married women, estimates of total demand for FP are 54 percent, and unmet need is 25.3 percent (Central Statistical Agency and ICF International 2012). Recent estimates are that 41 percent of pregnancies are unintended (Sundaram et al. 2010). Unmet need for FP remains highest among young, less educated, poor rural women (exceeding one-third by various definitions of each of these groups; USAID 2005; Central Statistical Agency and ICF International 2012).

Recent projections on the potential national development gains from meeting this unmet demand for FP highlight potential cost savings, population health benefits, and contributions to reaching MDGs related to child mortality, maternal health, and women's empowerment. Sundaram et al. (2010) estimated that meeting all unmet need for modern methods of contraception in Ethiopia would reduce unplanned births and unsafe abortions by approximately 90 percent and reduce maternal mortality by one-third. Smith et al. (2009) estimated that meeting unmet FP needs in Ethiopia could avert 5.8 million unintended pregnancies, 2 million abortions, 1.1 million deaths among children under five years of age, and 13,000 maternal deaths (Smith et al. 2009, citing data from Moreland and Talbird 2006). Population growth due to a national mean lifetime total fertility rate (TFR) above 5.4 in the decades prior to 2005 challenges all current development efforts to keep pace (Ringheim, Teller, and Sines 2009), and current TFR remains high at 4.8 (Central Statistical Agency and ICF International 2012).

Improved uptake of FP, particularly among the young, could contribute significantly to achieving a healthy and sustainable population through better nutrition in early life and universal achievement of desired family size. National FP targets are to increase contraceptive prevalence from 32 to 65 percent (USAID 2012b). Use of contraceptives among married women has increased, from 8 to 29 percent between 2000–11, primarily through uptake of injectables (Central Statistical Agency and ICF International 2012). Most of the contraceptive users rely on injections and oral contraceptives and 82 percent of them access FP services through the public sector (Central Statistical Agency and ICF International 2012), primarily through government health centers and health posts (47 percent and 23 percent, respectively). Urban-rural gaps in FP access and uptake result in large TFR differences (2.6 versus 5.5; CSA/ICF 2012).

There is a clear need for innovation, new strategies, and additional investments to strengthen coordination and diversify ways to meet FP needs in rural areas, among the poor,⁵ and among out-of-school youth and younger adults (Sundaram et al. 2010; Ringheim, Teller, and Sines 2009). Ethiopia's

5. TFR is significantly lower in the highest quintile income group.

growing and increasingly youthful population now exceeds 79 million, presenting both opportunities and challenges for national development. Almost half of all Ethiopians are under 15 years (47 percent; CSA/ICF 2012), offering a potential “demographic bonus” of skills and markets among youth, and opportunities for investment in national development (World Bank 2007; Ringheim et al. 2009; Gribble 2010). These and other challenges are targeted by the National Adolescent and Youth Reproductive Health Strategy (Federal Ministry of Health [FMOH] 2007), but gaps remain in serving youth not attending school and childless newlyweds because most current FP/RH interventions target women who already have children, or youth who are unmarried and in school. Limited female schooling, early marriage, and motherhood are common. Comparison of data from the 2005 and 2011 Ethiopia DHS indicates the proportion of women married or childbearing by age 15 has decreased slightly, but a majority of women marry before age 17 and give birth before age 20 (CSA/ICF 2012; Central Statistical Agency [Ethiopia] and ORC Macro 2006; World Bank 2005).

1.3.2. Widespread undernutrition

In Ethiopia, widespread undernutrition persists as a major health problem that undermines efforts to achieve national development targets (FMOH 2008; Save the Children UK 2009; Kothari and Nouredine 2010). Recent surveys by several organizations indicate that all the major forms of undernutrition coexist at high prevalence among both young children and women in all parts of the country. The most significant of these for national development are chronic child undernutrition (stunting and wasting), iron deficiency anemia (IDA), vitamin A deficiency (VAD), and iodine deficiency disorder (IDD). Less than a decade ago, measures of children under five indicated more than half of young children were stunted and almost one-third were underweight (Kothari and Nouredine 2010). Current estimates are that the national rate of stunting among children under age five has fallen by 14 percent since 2005, but remains at 44 percent, including 21 percent severely stunted (CSA/ICF 2012). Stunting affects a greater proportion of children in rural areas (46 percent versus 32 percent in urban areas) and children of thinner, poorer, and less educated mothers. Anemia also affects 44 percent of Ethiopian children (CSA/ICF 2012). The percentage of underweight children has also decreased slightly, but remains widespread at 29 percent of under-fives and 34 percent of all two-year-olds (CSA/ICF 2012). Consumption of vitamin A-rich foods and supplementation with iron and vitamin A is far below universal for children of complementary feeding age. Recent estimates are that 27 percent of Ethiopian women are thin or undernourished (Body Mass Index [BMI] less than 18.5 kg/m²) and that overweight and obesity remain uncommon (CSA/ICF 2012). This indicates little change from the 2005 data, which reported that 18 percent and 8.9 percent of women are moderately and severely undernourished, respectively, and that rural women and newly married women between the age of 15 and 19 are most undernourished (Bitew 2010).

1.3.3. Ethiopia’s health extension program (HEP)

The current Federal Ministry of Health, Health Sector Development Program (HSDP III) targets universal coverage for primary health care services through an Essential Health Service Package that includes a health extension program (HEP) as a community-level component (Argaw 2007; Sebhatu 2008; Save the Children/FMOH 2009). HEP is the key program platform for HSDP implementation to achieve health-related national development goals, including MDGs 1 and 4. HEP is designed to deliver 16 health packages focused on promotion, prevention, and selected treatments to target households, women, and children. These packages are aimed at improvements in three major areas (disease prevention and control—three packages; hygiene and environmental sanitation—seven packages; and family health—five packages, including FP and nutrition) and one cross-cutting approach (Sebhatu 2008; Federal Ministry of Health 2008).

At the national level, the FMOH provides financial and technical support for each HEP component through various partnerships with international multilateral and bilateral donors and development partners.⁶ Within FMOH technical working groups (TWGs) convened for each HEP component provide a coordinating framework for implementation. These TWGs involve development partners, local implementing groups, and civil society organizations to form policy, strategies, and implementation guidelines for program design and delivery. As part of an ongoing decentralization process, technical teams are also founded at the regional and *woreda* (district) level to support various components of the HEP program. However, all 16 HEP components are implemented together at the community level and integrated through the work of full-time health extension workers (Giday and Asnake 2008).

HEP is managed by full-time health extension workers (HEWs) with support from voluntary community health workers (VCHWs⁷). Health extension workers are based at a kebele-level health post (HP) linked to a health center (HC) that provides essential curative care for referrals from a cluster of five health posts that together constitute a primary health care unit (PHCU) of health care delivery (Giday 2010). At the time of the study, 30,000 health extension workers (98 percent female; 2 health extension workers in each of the 15,000 kebeles nationwide) had trained in basic curative and preventive health care services. HEWs are expected to spend 75 percent of their time on community outreach, mobilization for health education and communication (community conversations, home and school visits, and recruitment training and supervision of volunteer community health workers) and 25 percent of their time at health posts providing immunization, contraceptives, and antenatal care.

1.3.4. Current integration of FP and CBN in Ethiopia

Several government of Ethiopia (GOE) policy and strategy documents recognize an unmet demand for family planning and better nutrition as key priorities for national development and poverty reduction. Current policy responds to sound evidence that expansion of FP services should bring multiple benefits (for example Sundaram et al. 2010). The National Population Policy (NPP) in place since 1993 aims at equitably balancing population, economic growth, and resources (Ringheim, Teller, and Sines 2009) and guides family planning and reproductive health strategy and policy ((FMOH 2006, 2007, 2010). GOE's second five-year Plan for Accelerated and Sustained Development to End Poverty (PASDEP-II, 2005–10) specifically addresses population. FP is implemented as a component of Ethiopia's health extension program (HEP) at almost all service delivery points (Giday 2010). Currently, long-acting family planning (LAFP) methods are rolled out at the community level in stages through training of HEWs on ImplanonTM⁸ insertion.

Historically, food and nutrition policy and coordination in Ethiopia aimed more at tackling food security than the underlying causes of undernutrition (Linnet 2012), but this is changing. In 2008,

6. Major development partners for FP are the “anonymous partners group” and USAID, UNFPA, Family Health International (FHI), Packard Foundation, and John Snow, Inc. (JSI); and for CBN, they are the World Bank, UNICEF, and Japan International Cooperation Agency (JICA).

7. VCHWs combine roles previously incorporated within a HEP as community-based reproductive health agents (CBRHAs) and VC health posts. VCHWs are elected from the community to assist with health services, health education, and communication at kebele and gotte (50 households) levels.

8. According to the product website, ImplanonTM is a long-acting, reversible hormonal contraceptive subdermal implant that delivers a synthetic hormone (progestin), which prevents ovulation in every cycle for up to three years. One common side effect, among many, is amenorrhea or infrequent bleeding.

FMOH introduced community-based nutrition (CBN) within Ethiopia’s HEP to scale-up current nutrition interventions with a greater focus on community-based and high-impact interventions. CBN is one of four subcomponents of the Nutrition Service Delivery (NSD) of the National Nutrition Program (NNP) (FMOH 2008; FMOH and UNICEF 2009). CBN receives substantial technical support from UNICEF and other development partners as it rolls out nationwide. Shortage of human resources has been identified as a challenge (Ethiopian Health and Nutrition Research Institute 2009), and management is largely provided through the existing HEP staff system. A recent review and analysis of progress indicated that scaling up the community-based nutrition component has been challenging (Save the Children UK / Government of Ethiopia 2009).

Table 1.1. Summary of Activities Implemented under CBN

Intended beneficiaries	Activities
Children under two years of age	<ul style="list-style-type: none"> •Promote full immunization, optimal breastfeeding, and adequate complementary feeding •Identify children who are severely underweight, not gaining weight for two months, or with other health problems and advise or refer to go to HP/health center for treatment or service •Monthly growth monitoring and promotion (GMP) sessions to find out if weight gain is sufficient; if not, take action to improve feeding and caring practices •Provide vitamin A once every six months
Children under five years of age	<ul style="list-style-type: none"> •Quarterly community health day (CHD): Every three months, all children will be screened for mid-upper arm circumference (MUAC) edema •Refer malnourished children (moderate and severe acute malnutrition [SAM]–identified on MUAC) to therapeutic feeding (TF) or targeted supplementary food (TSF) •Vitamin A supplementation every six months (alternating CHDs) •Deworming (alternating CHDs)
Pregnant and lactating women	<ul style="list-style-type: none"> •Mobilize for antenatal care (ANC), safe delivery, postnatal care (PNC), exclusive breastfeeding, and FP services •During CHD: Screening (for weight gain and refer for TSF if weight gain is not adequate) •Provide iron folate supplements for all pregnant women; follow up
All households	<ul style="list-style-type: none"> •Individual and family counseling on improved caring practices during household visits: <ul style="list-style-type: none"> ○ Promote iodized salt when available ○ Monitor ITN use ○ Treatment of water at household level before use ○ Proper hand washing practices ○ Mobilize to improve household sanitation
Community	<ul style="list-style-type: none"> •Community conversations (CC) to assess malnutrition among children, analyze causes, and make plan for action and follow up: <ul style="list-style-type: none"> ○ Monthly at the gotte (50 household) level ○ Quarterly at the kebele level

Source: FMOH 2010.

Current CBN activities primarily target mothers with children aged less than two years and pregnant women for early detection and prevention and for appropriate care for malnourished children (table 1.1). Readers are referred to FMOH/LINKAGES 2005 and Quinn et al. 2006 for lists of the messages.⁹ At the time of the study, health extension workers (HEWs) and their supervisors were implementing these CBN activities with the help of VCHWs, and CBN was rolling out nationwide in phases as the nutrition component within the HEP. Since 2008, CBN had rolled out in 238 woredas with support from the World Bank (144 woredas), UNICEF (86 woredas), and Japan International Cooperation Agency—JICA (10 woredas). Funding for rollout in another 116 woredas was committed by the Spanish government MDG-F (16 woredas) and Canadian International Development Agency—CIDA (100 woredas).

1.3.5. Opportunities for operational research in Ethiopia

To date, little documentation exists on how integration of each HEP component affects the cost-effectiveness, quality, and intended outcomes of other HEP components. Immediate operational research needs are to identify key strengths that can be utilized and further developed and to identify weaknesses in integration, shortfalls in outcomes, and any unintended negative consequences. Specifically, there is a knowledge gap on how integration of FP into CBN activities is working and what else is needed and can be done to strengthen FP in NNP. For example, it is not clearly understood whether integrated programs aimed at improving child nutrition and birth spacing are more effective than stand-alone programs aimed at each outcome separately. The question is highly relevant to contemporary policymakers at the helm of country-led, nationally-coordinated, and intersectoral strategies in Ethiopia and many other countries.

Ongoing programs within the HEP in Ethiopia afford an opportunity for learning lessons about operational synergy and challenges by documenting stakeholder experience of integration of FP and CBN programs. Such information has the potential to inform program planners and managers and improve future integration. The study described in the following chapters was undertaken to evaluate whether improved access and service delivery of integrated FP and CBN at community level contribute to achieving national development goals. Specifically, the study gathered and analyzed stakeholder perspectives on whether and how regularized, structured CBN activities provide a platform upon which culturally meaningful linkage of birth spacing and child nutrition messages and services can be effectively established and practiced.

9. <http://www.linkagesproject.org/publications/EthiopiaKeyMessagesBooklet.pdf>.

PART 2. STUDY DESIGN

The study was designed to assess the experience and perspectives of various stakeholders with regard to integration of FP services and CBN activities and to assess the validity of qualitative indications through triangulation of information reported by different stakeholders, direct and independent observation of selected program activities, and desk review of selected program reports and other relevant policy, planning, and implementation documents.

2.1. DATA COLLECTION METHODS

2.1.1. Study team and activities

Between February and June, 2011, the team conducted (annex 1) (a) a desk review of a range of policy, strategic, program, and research documents (to assess existing policy and implementation frameworks and create qualitative benchmarks against which to evaluate operational research results; (b) individual in-depth interviews with a small sample of purposively selected personnel involved at multiple levels of FP/CBN program delivery in Ethiopia and selected woredas and kebeles; (c) operational focus group discussions with community-level stakeholders (health extension workers, volunteer community health workers, and selected beneficiary groups) in a small sample of purposively selected kebeles; (d) structured and unstructured observations of community health days (CHDs) and community conversations (CC), growth monitoring and promotion (GMP) sessions at each selected kebele and CBN master training sessions; and (e) a stakeholder workshop to disseminate preliminary findings and gather additional opinions and data to generate practical recommendations. Two members of the team, one local and one international consultant, conducted the semistructured, in-depth interviews and focus group discussions with selected stakeholders who had experience in FP/CBN program delivery. In addition, FP/CBN activities were observed at the community level (during activities b, c, and d). A senior consultant oversaw all activities and led the dissemination workshop.

2.1.2. Tool development

Interview guides and checklists were developed after desk review of documents describing aspects of the current health system in the four regions, specifically the HEP, NNP, FP, and CBN programs. Checklists were developed to structure observation of community-based program activities at the HP level. The observation checklist on CHDs was based on the CBN training guide for training of health workers and HEWs (version February 2010). The team developed a set of written guides for semistructured, in-depth individual interviews and focus group discussions through a rapid, formative, operational research process. Guides drafted in English and structured to explore specific relevant topics were revised for face and content validity with selected expert informants. Revised guides were translated into Amharic by one team member and then into Alaba K'abeena and Sidamo¹⁰ by selected HEWs, back-translated, and modified to reduce conceptual mismatch and content ambiguity.

Annex 2 summarizes the topics probed or observed with these tools, and annex 3 summarizes the major themes used to structure the analysis and present the results. Major themes include equipment and supply availability; service delivery, referral, availability, access, and quality; record keeping, training, supervision, and monitoring; various stakeholder experiences with integrated FP and CBN delivery; various stakeholder knowledge, perception, attitudes on FP and nutrition; and youth needs. English

10. In Alaba woreda, HEWs interpreted the questions from Amharic to Alaba (also known as Alaba, Allaaba, and Halaba). In Hawassa Zuriya woreda, HEWs interpreted questions for VCHWs, women, and men in Sidamo (also known as Sidaamu Afoo, Sidaminya, and Sidamo Afo).

translation of examples of in-depth interviews and focus group discussion guides are provided in annexes 4 and 5.

2.2. SAMPLING

Participants in the study were purposively sampled at all levels from grassroots (intended beneficiaries, health extension workers, and volunteer community health workers) to top-level management as follows.

2.2.1. In-depth interviews with individual representatives

Inclusion criteria for selected personnel included having a paid or formal voluntary role within government or civil society directly related to FP/CBN delivery. Nineteen in-depth interviews with representatives from different donor and implementing organizations and officials at federal or national, regional, and *woreda* levels of government were completed. These included ten with government health officials (one with the FMOH, five in-depth interviews with the Regional Health Bureau, and four at *woreda* level), two with officials of donor agencies (USAID, Packard Foundation), and seven with representatives from local implementing NGOs. All in-depth interviews with officials at federal level and representatives of donor agencies were conducted in English, and a mix of English and Amharic was used with regional officials. In-depth interviews with officials at *woreda* level and focus group discussions with health extension workers at *kebele* level were conducted in Amharic.

2.2.2. Site selection for community-based observation and discussion

At the time of the study the National Nutrition Project (NNP) was implemented within four regions of the most populous and food insecure regions of Ethiopia.¹¹ The strategy for site selection aimed at a purposive sample of four *kebeles* drawn from these regions to understand how integrated CBN and FP activities were being implemented at the community level. The study site selection process was based on a desk review of national-, regional-, and *woreda*-level reports and advice obtained during in-depth interviews with the FMOH, the regional health bureau personnel, *woreda* health office officials, and UNICEF officials. Regions, *woredas*, and *kebeles* were purposively selected to allow comparison of qualitative indicators as follows.

First, desk review was conducted to identify regions where NNP and CBN were first rolled out, on the rationale that stakeholders in these regions could offer the greatest depth of experience. Southern Nations, Nationalities, and People's Region (SNNPR) was selected as a region in which CBN was already well established and where a number of *kebeles* with diverse characteristics were potentially accessible to the team given available logistic and time resources.¹² Second, UNICEF personnel and regional-level government personnel were asked to identify within SNNPR two relatively accessible *woredas* with a diversity of *kebeles* in which CBN is implemented. Hawassa Zuriya (northeast of Hawassa) and Alaba (in the south) were selected. Third, within these *woredas*, *woreda* officials were consulted to identify *kebeles*, where collection, summary, and comparison of qualitative indicators of the experience with NPP among different stakeholder groups would be valid and feasible, as indicated by the following inclusion criteria:

11. Amhara, Oromia, SNNP, and Tigray; GoE 2009.

12. Much of this region is within three hours drive from Addis Ababa, weather permitting. An excellent map and information on the region are available at <http://www.ethiodemographyandhealth.org/SNNPR.html>.

- (i) Completed deployment of health extension workers trained on CBN and FP;
- (ii) Feasibility for study given available transport, accommodation, and communication resources.

Fourth, *woreda* officials were consulted to identify kebeles that differed on three indicators of interest: whether or not the kebele was designated as “model” kebele for health extension program, therefore representing a “best case” setting (yes/no); the timing of initial rollout of integrated FP/CBN (recent or established for at least three years); and whether or not a health post was built and operational (yes/no).

2.2.3. Observations

Members of the field team spent 18 days in the selected communities. The field team observed a total of three community conversations (CCs, Kebeles A, B, and C), four community health days (CHDs, all four kebeles), six home visits by a health extension worker or volunteer community health worker (in Kebeles A, C, and D), and one growth monitoring and promotion session (GMP) conducted by VCHWs with health extension worker supervision (Kebele B). The field team spent four days observing two master trainings¹³ for CBN organized by FMOH, UNICEF, and a regional health bureau (RHB) in a regional town and field training of CBN in nearby kebeles. Notes from structured observations were used as tools to verify provision of service, contextualize statements made by participants, and generate insights about the strengths and weaknesses of the programs.

2.2.4. Focus group discussions

Focus group discussions (FGD) were conducted with volunteer community health workers and intended beneficiary groups (women, men, and adolescents) in each of the four kebeles selected. Intended beneficiaries were sampled by gender and life stage (unmarried youth versus adults with children). We also conducted “focused team discussions” with each pair of HEWs. Sampling was not systematic or randomized. It was based on convenience at community level in each *kebele* selected.

- Women (four focus group discussions, all four selected kebeles): A service-based convenience sample of mothers attending a monthly GMP session in each *kebele*. The sample was possibly biased toward regular attendees and women who already have children and we made no effort to assay non-attendees, teens, pre-marital or nulliparous, married women.
- Men (four focus group discussions, all four selected kebele): A service-based convenience sample of men attending a GMP, usually with their partners or a female family member, at the special invitation of male volunteer community health worker. The sample was likely biased toward partners of regular attendees who were acquainted with the volunteer community health worker, available on the day, and motivated to attend.
- Youth (two focus group discussions, two of the selected kebeles, one mixed gender, one males only): A service-based convenience sample of youth aged 15 years and older recruited from the villages by health extension workers and the local youth group president. Only children not attending school at that time participated; of those present, approximately half were in school, and the rest were farming with their fathers.

13. Training of trainers (TOTs) included health officials from regions, woredas, and selected HEWs, and their supervisors, who were expected to go back and train HEWs and supervisors on CBN.

- **Volunteer community health workers** (four focus group discussions, mixed gender): All volunteer community health workers at each kebele were invited; approximately half of those invited were able to attend.
- **Health extension workers** (four “pair” discussions, all female): A focused discussion was conducted with both of the health extension workers at each kebele; all had more than three years experience.

2.3. ANALYSIS AND REPORTING

English transcriptions of the in-depth interviews and focus group discussions were completed within 48 hours of data collection. The content of in-depth interviews collected at federal, regional, and *woreda* levels was organized for qualitative analysis within a matrix of major themes and subthemes defined a priori in the data collection tools (annex 2). The content of focus group discussions and observation checklists collected at the community level was organized using a similar matrix, but separately for each of the four selected kebeles to allow comparisons between them.

Qualitative information collected using interviews and focused discussions was collated, reviewed, and triangulated. A simple type of content analysis was performed by grouping similar and dissimilar responses under each a priori theme and subtheme, tallying frequencies across *kebeles*, participant groups, and type of informant (annex 3). The grouped and tallied information was used to ascertain concordance and discordance across groups and estimate the relative frequency of comments, opinions, and statements (common, uncommon, or rare). The summary information collected was then used to develop qualitative interpretations of the quality of service delivery as perceived and experienced by community-based providers and clients.

2.4. STUDY LIMITATIONS

Several limitations of the study demand careful interpretation of the results. Principal among these are generalizability and validity of the findings, which are potentially limited by selection of limited number of sites and the common problems associated with assessing the validity of qualitative data.

2.4.1. Site selection

The findings are most useful if the conclusions can be generalized beyond the four kebeles included. Any generalizations must be based on an assumption that the relationships between the inputs and outcomes investigated may be similar in other kebeles. It is likely that the results can be generalized to other *kebeles* where NPP was implemented, if they received the similar program inputs. Nevertheless, since the validity of the study was not tested by replicating the methods used across a larger and more systematically selected sample, several limitations may pertain.

First, our use of a service-based convenience sampling for focus group discussion participants and focus discussions and interviews with project staff, volunteers, and managers is likely to exaggerate the positive aspects of the program. Second, the sample did not include a control kebele where CBN was absent. Third, the sample of kebeles selected for inclusion is too small to be representative of the many hundreds of kebeles across a very large and diverse country. Ways in which SNNPR programs may differ from other regions were suggested by key informants and are discussed in section 3.1. Fourth,

qualitative data gathered in this study are not triangulated with quantitative data on utilization rates, immunization rates, or measured or perceived performance because these were not obtained.

2.4.2. Qualitative inference

There are a number of key areas where a more detailed qualitative approach could have yielded information to allow richer interpretations than are possible with the data collected. First, the study focused on FP and CBN integration, trading off clarity against breadth; it gathered no data on other integrated components, for example, reproductive health and community integrated management of childhood illnesses.

Second, although discussion groups were organized by gender, no formal gender analysis was conducted, and the many potential differences in perception, experience, uptake, and satisfaction of male and female intended beneficiaries, and the potential complexity of gendered relations between health extension workers, volunteer community health workers, FP users, and other intended beneficiaries was not explored. Investigation of these gender effects would require a different methodology involving individual interviews and narrative analysis.

Third, the study did not observe and analyze in detail the nature of the interaction between beneficiaries and providers during community-based activities. The social and cultural “negotiations” that play out during such situations or meetings may be very important in strengthening or undermining community and individual responses to the programs. They also warrant further investigation to fully understand the enabling and limiting factors in play in the social environment.

Fourth, it is possible that information and meaning were lost or modified during translation and transcription. Study team members worked together during data collection to improve quality of the transcriptions through cross-checking questions about English transcripts with the translating team member and other key informants. However, study resources for quality assurance did not allow for duplicate transcription and discrepancy checks to better identify misunderstandings or translation errors. One result that is particularly difficult to evaluate is the remarkably low variance among participants in responses to questions raised in FGDs. Most of the FGDs and group discussions led to similar answers with no contradicting responses. During FGDs, the team observed almost no indications of disagreement with points made. If one respondent answered the questions, others either nodded or listened carefully with no sign of disagreement. If a second respondent answered, he or she usually added a point of detail to corroborate the answer of the first respondent.

Fifth, the study did not explore in detail the complex issues around traditional practices known or perceived to be harmful by program delivery staff and volunteers. Indications that this issue is relevant did emerge, however. Health extension workers mentioned that when they advise the community not to practice harmful traditional activities, sometimes people continue them secretly so that the health extension workers cannot find out. If true, this type of community reaction may deeply affect the level of community trust in integrated services and also warrants further investigation.

Sixth, the study did not include a specific focus on gender issues, and methods did not include formal gender analysis. Nevertheless, full attention to potential gendering of perspectives and experiences was given within the methods used, including gender-specific focus group discussion and careful attention to analyzing and reporting any information on gender that emerged. One area where gender is clearly important is in human health resource recruitment and retention.

Last, the qualitative approach used was not appropriate to measure outcomes at a population level, such as population-level coverage rate or estimate the effectiveness of integration of interventions. Rather, the qualitative findings provide some insights on the quality of program delivery, its impact on work routines of health workers, and perceived benefits to members of the communities targeted, and on why and how integration may or may not be working. However, these qualitative findings are not triangulated with quantitative measures of program outcomes because these were not captured. The methods also did not include a systematic literature review or analysis of any quantitative data that may be available from other studies that could be used to triangulate the present findings. There is a rationale for augmenting the present results with quantitative survey data that compare specific indicators of program outcomes using the two approaches (integrated versus vertical FP and CBN).

PART 3. RESULTS AND DISCUSSION

This chapter presents a summary of stakeholder perspectives and study team observations on the specific successes and limitations of CBN and FP program integration. The results are not evaluated against specific benchmarks set a priori. Rather, they are organized according to the focus themes used to organize discussion with service providers and users (annex 3). Taken together, the results increase qualitative understanding of the current strengths, weaknesses, opportunities, and challenges for ongoing integration of FP within CBN and HEP.

3.1. CHARACTERISTICS OF SELECTED STUDY SITES

3.1.1. Region selected

All the woredas and kebeles visited were located in SNNPR within a half-day drive of Addis Ababa or a one and a half-hour drive from Hawassa town. Desk review showed this region had high VCHW regular reporting rate, and a GMP participation rate above 75 percent prior to the study. UNICEF first rolled out CBN in 2007. Key informants identified two particular strengths of CBN program implementation in this region compared to others: (i) better utilization of monitoring and evaluation data at zonal and woreda levels; and (ii) strong support for regular reporting within HMIS. They identified particular challenges of CBN program implementation in SNNPR as (i) attrition of VCHWs; (ii) frequent prioritization of emergency activities over regular ones; (iii) gaps in supervisory and other health human resource capacity, particularly at woreda and kebele levels; and (iv) limited technical support for HEWs. Additional challenges suggested as common to most other regions (but not SNNPR) included weak HMIS database utilization at zonal and woreda levels and gaps in reporting from woredas to the region. Strengths suggested as common to all regions included strong government support for the integration of CBN activities with other health and nutrition activities.

3.1.2. Kebeles selected

Table 3.1 summarizes key characteristics of the kebeles included. Kebele A was a “model” kebele, defined in terms of implementation resources, not performance measures. Kebele A contained over 300 households, a fully capacitated health post, and two model health extension workers who had received their training for CBN in the first tranche in 2008 (three years previously) and been operational for the previous three years. Central officials viewed Kebele B as an average, well-functioning kebele that was fully capacitated with two full-time health extension workers, who had also worked for three years. Kebele C also had two, fully trained, full-time health extension workers, who had worked for three years delivering all 16 health extension program components, but lacked a health post and associated equipment and dispensary supplies; instead, a small office (120 square feet) shared with other local workers served as the kebele committee office, water action office, and agriculture training center. Kebele D had a fully-equipped health post and two full-time health extension workers, but this kebele had started implementing CBN only three months earlier, (HEW were trained on the third tranche early in 2010).

Table 3.1. Characteristics of the Four Kebeles Purposively Selected for Study

	Kebele (descriptor)			
	A (Model)	B (Full capacity)	C (Partial capacity)	D (New CBN)
HEW trained, deployed on CBN	Yes	Yes	Yes	Yes
Years since rollout (tranche #)	3 years (1st)	3 years (1st)	3 years (1st)	0.5 years (3rd)
HP built, stocked	Yes	Yes	No	Yes
Designated health extension program model status	Yes	No	No	No
Distance from Hawassa (km)	85	85	80	35
Reports directly to health office	Regional	Regional	Regional	Zonal
Total population	1,796	3,285	2,547	7,569
Total number of households	367	652	346	1,545
Number of children under 3 years	149	272	212	629
Number of women 15 to 49 years	279	765	493	1,764
Number of health extension workers	2	2	2	2
Number of volunteer community health workers in total	14	17	19	32
Female volunteer community health workers	3	8	3	1
Male volunteer community health workers	11	9	16	31

3.2. QUALITATIVE INDICATORS OF SERVICE DELIVERY (SUPPLY SIDE)

The results were organized by first looking at qualitative indicators of current strengths and weaknesses of integrated FP/CBN service delivery on the supply side (national and local levels).

3.2.1. Activities and messages delivered

Activities delivered were assessed through direct observation of the community-based activities (CCs and GMP sessions, CHDs, and home visits) and content analysis of focus group discussions with service providers (HEWs, volunteer community health workers) and beneficiaries (men, women, and youth). Annex 6 summarizes the observed activities of health extension and volunteer health workers studied, and annex 7 lists health messages extension workers report giving during CBN. Examples of quotations from participants in interviews and focus groups are given in annex 8. Direct observations confirmed that health extension workers in all four kebeles delivered messages on nutrition (infant and young child feeding, balanced diet for the family), sanitation (building and use of latrines), hygiene (both personal and environmental hygiene), malaria prevention (use of insecticide treated nets, ITN), and HIV/AIDS education. In the presence of the field team, health extension workers and VCHWs delivered all intended activities and messages. The team could not verify that all children in need were correctly identified, diagnosed, or referred.

Comments captured during the focused discussions with health extension workers, men, women, and youth also indicated active and successful message delivery. All groups mentioned that both health extension workers and volunteer community health workers delivered messages and information on CBN, FP, immunization, sanitation and hygiene, malaria prevention, testing and treatment, antenatal care services, and HIV/AIDs. Health extension workers described dissemination of FP messages during CBN/HEP activities (annex 8).

The study team did not assess knowledge uptake by individuals, but comments by many men and women participating in focused discussions provided broadly accurate and quite detailed accounts of activities and messages delivered. Transcripts of all the focus group discussions with both men and women contained accurate responses to probes on available FP and nutrition services.

3.2.1.1. FP services delivered at monthly growth monitoring and promotion sessions

The field team observed many community members access FP counseling and other HEP services. Volunteer community health workers and health extension workers were observed as they (i) weighed and identified children as underweight; (ii) counseled mothers of underweight children on breastfeeding techniques and complementary feeding after six months (type of food, preparation and frequency of feeding); and (iii) discussed the reasons for child malnutrition and promoted birth spacing through FP to reduce child malnutrition, using examples of healthy children and mothers.

3.2.1.2. FP services delivered at quarterly community health days

The field team observed VCHWs and HEWs performing CBN activities (arm circumference measurements to identify malnourished women and children under age two) at the same time as vaccination, provision of Depo-Provera and other supplies, referral to antenatal care, and FP advice. In one kebele where the health post and health center were within the same complex, nurses assisted the health extension worker with HIV/AIDS testing and referral for voluntary counseling and testing (VCT).

3.2.1.3. FP services delivered at monthly community conversations and home visits

The field team observed health extension workers conduct CC's at the health post level with assistance from volunteer community health workers; strong community involvement evidenced during discussions on malnutrition, hygiene and sanitation, malaria prevention, and HIV/AIDS was observed and noted. The field team asked the HEWs to carry on their regularly scheduled activities, and it is unlikely that the topics they covered during these observations were biased toward nutrition. During focus team discussions, all health extension workers indicated that they cover one or two topics of the 16 HEP components at each monthly community conversation at the health post level.

Logistical limitations prevented the field team from observing monthly community conversations at 50 household (gotte) level. During focus team discussions, all VCHWs mentioned that they look after 50 households on all 16 HEP components including CBN-related activities. They reported that during their monthly community conversations at this level they teach the community usefulness of FP by referring only to the positive examples of healthy children and families. During this time they are reported (by CBN representatives, master trainings observed) to employ the "but why five times" technique (from CBN training) to guide the community to identify underlying causes of malnutrition and then develop, at household and community levels, a plan of action. The volunteer community health workers also follow up on actions planned in previous community conversations and at household level during their

home visits. Most VCHWs reported promoting improved infant and young child feeding, FP, vaccination, good hygiene practices, construction of latrines, and disposal of waste during home visits.

3.2.2. Record keeping

In all four kebeles the team observed (i) monthly reports prepared by health extension workers for their supervisors, including information on all 16 HEP components; (ii) registrar books for keeping records on the Expanded Programme on Immunization (EPI), malaria, CBN, FP, and ANC; (iii) performance charts that were mostly up to date. Health extension workers mentioned the same materials during focus group discussions; (iv) GMP session slips collected by HEWs from volunteer community health workers recording the number of male and female attendees, the number of children weighed, numbers of children who were underweight and severely underweight; and daily or weekly contact reports completed by the VCHWs that record referral or provision of FP, malnourished children, vaccination, antenatal care, malaria, and HIV/AIDS testing, and sanitation and hygiene. Indications are therefore that records were collected according to program requirement. The field team could not verify the accuracy of these records because it lacked resources for independent collection of data in a sample of the community.

Direct observation revealed health extension workers had prepared handwritten FP and antenatal care registrar books at all sites visited, but also revealed a shortage of these FP and ANC registrar books, referral slips, and FP client record cards. These shortages were also mentioned in focus team discussions with HEWs, with the exception of the FP client cards. A single health extension worker at the model *kebele* mentioned that during FP counseling, HEWs are supposed to fill out an FP client card with client's basic information such as weight, blood pressure, and lactating or nonlactating mother and use these criteria to suggest the best potential FP option.¹⁴ Other HEWs interviewed did not describe criteria for counseling or suggesting best options for interested FP clients.

3.2.3. Supervision

All stakeholders consulted identified supervision as a weak component of health extension program implementation in the locations studied. Although integrated supportive supervision (ISS) is an important component of the HEP that is planned on a quarterly basis with feedback to each level of the health care service delivery system; all federal, regional, and woreda health officials interviewed mentioned that ISS is currently conducted every six months. The reasons are shortage of transport and human resources, and heavy workload of the regional officials, who must fulfill political duties.

Our field team observed supervision of VCHWs by health extension workers during quarterly community health days in three out of the four kebeles visited. We observed supervision and report collection by HEW supervisors. However, we did not collect empirical data on their interactions and ways of working together. Health extension workers and VCHWs in all four kebeles studied mentioned regular interaction and close communication. Health extension workers mentioned bimonthly (three kebeles) or monthly (one kebele) supervision and report collection; supervision during EPI day, house-to-house visits, and when they had questions, concerns, or potential issues with the community. Statements by health extension workers also indicated gaps in supervision (annex 5). In two kebeles, HEWs shared their concerns about some supervisors who collect reports but do not give feedback on improvements or discuss problems.

14. This HEW also described how suggested FP methods should differ between lactating versus nonlactating mothers.

Woreda officials also raised concerns about lack of training of the HEWs' supervisors. Regional program officers of partner organizations and the ex-model health extension workers expressed concerns about poor communications and even mistreatment by supervisors and higher officials. A goal of weekly HEW supervision was mentioned during an in-depth interview with regional and woreda officials in both woredas visited, but described as not possible or often interrupted due to the following:

- **Supervisor workload.** Supervisors have a much larger number of health posts than planned. Currently, most health centers in Ethiopia have many more than the intended five health posts, in part because not all health centers have been constructed. The numbers range between 6 and 24 health posts in the woredas visited as part of this study. One response is to use the woreda health office (WoHo) as a workstation for supervisors to reduce the travel time to distant health centers.
- **Shortage of transport for supervisors,** especially for hard-to-reach and large kebeles.
- **Seasonal inaccessibility** to some health posts during the rainy seasons.
- **General inaccessibility.** Woreda officials described some of the local kebeles as extremely difficult to reach even with a motorbike during dry season. Daily activities by both HEWs and their supervisors are hampered in some geographically large kebeles.

3.2.4. Motivation of health extension and volunteer community health workers

3.2.4.1. Job satisfaction

Health extension workers and volunteer community health workers expressed good job satisfaction universally across the kebeles investigated. All discussion transcripts contain statements that reflect accurate understanding of the intended goals of their work: to increase awareness and knowledge of key health issues such as FP, nutrition (breast feeding, complementary food, balanced diet), vaccination, water, sanitation, and personal and environmental hygiene. Health workers also expressed a sense of satisfaction with their perceived positive effects in their communities, specifically mentioning increased uptake of services such as FP, nutrition, vaccination, antenatal care, and an increased number of community members maintaining personal and environmental hygiene, constructing latrines, and using mosquito nets at night. During observation, the team noted a sense of pride and ownership of the work.

3.2.4.2. On-the-job challenges

Health workers discussed six major challenges of working within their communities:

- Maternal reluctance in allowing child anthropometry
- Religious concerns about FP
- Husbands' resistance to FP
- Water shortages within the kebeles
- Slow pit latrine adoption
- Harmful traditional practices

Many mothers are reluctant to take off children's clothes during weight measurement due to cultural mores, religious beliefs, or inconvenience. Religious perceptions of FP as sinful persist within the community but are eroding, a trend reported as one reason for increased use of FP. Husbands' resistance to FP is commonly understood as based in a fear of sterility. During discussions, VCHWs

requested the investigators to assist them in resolving water shortages and promoting adoption of pit latrines within their kebeles.

HEWs reported various traditional practices that persist within their communities as harmful; these include (i) burning the abdominal skin of infants as treatment for indigestion problems (scars were observed on several infants during site visits); (ii) eating less during pregnancy so that the baby is smaller and labor is easier; (iii) vigorous abdominal massage of pregnant women; (iv) female genital mutilation (FGM); and (v) early marriages. A perception of limited progress in addressing these practices, a lack of drugs to treat basic illnesses at the health post, and lack of transportation to cover geographically larger kebeles were sources of frustration and concern. One HEW linked a feeling of being held responsible and accountable for the health of the entire village with feelings of isolation from the rest of the health system and insufficient support from the health center.

3.2.4.3. Work time, workload, and incentives for staff retention

VCHWs work according to their own availability and schedule after their primary work. VCHWs work by agreement with health extension workers on agreed dates for CCs, CHDs, and GMPs. HEWs mentioned that turnouts tend to be lower during harvesting seasons when it is more difficult for VCHWs to attend. In one kebele studied, the HEWs mentioned that their volunteer community health workers are mostly men (31 out of 32¹⁵), who may stay for up to three months at a time with a second family in another village.

When asked to comment on their work, VCHWs universally mentioned that their workload is high given the demands of their everyday agricultural work and the absence of incentives other than trainings by health extension workers. However, VCHWs' comments on how much time they spend on FP and CBN activities on average varied highly, from two days per week to several hours every day (in the latter cases often for home visits). Volunteer community health workers reported visiting their assigned 50 households at the gotte level between twice and over twenty times per month.¹⁶

Many HEWs expressed a feeling of being underpaid for the work that they do in their community and a perception that their workload is too high. Also mentioned as discouraging were, lack of salary progression for years of experience and a perceived lack of future career prospects, further education, or training.

3.2.5. Supplies

Basic drugs, line items, and necessary equipment were available at all four health posts on all the days visited, but not all four types of FP items (pills, condoms, Depo-Provera, and Implanon™) on each visit day.¹⁷ Vitamin A supplements, iron and folic acid tablets were found in three kebeles but not the model kebele on the first day of our visit. Vitamin A and iron and folic acid supplements were observed to be available on our follow-up visits.

Participants also mentioned several problems with FP and other supplies. HEWs mentioned that the supplies are requested on a need basis (that is, once they run out) but received based on the availability

15. Due to the literacy criteria for VCHW selection.

16. It is possible there was a misunderstanding or translation error.

17. Oral contraceptive pills were missing from the model kebele on the first visit. Interestingly, Kebele C with missing health post had all four FP supplies.

in their catchment health center. Woreda health officials and HEWs mentioned shortage of malaria drugs, vitamin supplements, line items needed for Implanon™, stationary, and cleaning materials. Both woreda health officials and FP representatives from the leading implementing organizations and development partners flagged a shortage of specific line items such as gauze, bandages, iodine solution, and lidocaine as negatively affecting FP service delivery. Woreda and regional health officials mentioned that the flow of supply depends on the availability of commodities, but recently it has been much smoother and less bureaucratic due to business process re-engineering. FMOH representatives recognized maintaining supply as a challenge for integrated FP.

3.2.6. Multisectoral coordination

Program officers from among development partners (DPs) and NGOs mentioned that the technical support for CBN provided by DPs and NGOs from the regional to the health post level was a strength, and such support was observed during site visits. More generally, federal government officials, FP partner representatives, and regional officials mentioned the current governance framework and administrative infrastructure in place from federal to kebele level as key strengths in coordination. Helpful aspects of the new nationally integrated Health Management Information System (HMIS) include improved collaboration, work, and support between federal and regional levels, and utilization for integrated monitoring and evaluation, decision making, planning, policy, and financing. FP representatives highlighted coordination at the regional level with the logistical technical working group.

3.3. QUALITATIVE INDICATORS OF SERVICE DELIVERY (DEMAND SIDE)

The qualitative indicators of current strengths and weaknesses of integrated FP/CBN service delivery on the demand side, that is, at community level, and drawing lessons from what works and what does not from the perspective of intended beneficiaries and frontline health workers were examined.

3.3.1. Community-level support

Results suggested the support for integrated program delivery was strong within the communities studied and linked to positive perceptions on community ownership of human health resources, quality of service delivery, and changes in the community. Beneficiaries perceived many components of the integrated services as satisfactory. Several statements during focus group discussions with men, women, and youth expressed an apparently high satisfaction with the availability, access, and quality of HP, health extension program, and health extension workers. Despite supply problems noted above, responses and statements by women and HEWs during focus group discussions indicated their generally high satisfaction with the availability of drugs, FP line items, and equipment. Health extension workers mentioned that they maintain good support from and relations with the community during all of their activities. Specifically, they work very closely with the community, listen to community members' problems attentively and with respect, and maintain the privacy and confidentiality of beneficiaries. Similar reports from WoHo and HEWs suggest these qualitative indications of positive perception of integrated services among community members are valid.

Many women, men, and HEWs noted that attitudes about FP are improving among women, men, and religious leaders. Participants mentioned as causes the general quality of the services including better counseling techniques involving religious leaders and their wives, community-level dissemination, and

regular community gatherings. Health extension workers commented on how attitudinal change was driving increasing use of FP, often by word of mouth.¹⁸

3.3.2. Mobilization of beneficiaries

A number of factors enabled the mobilization of intended beneficiaries of FP services in the context of CBN delivery.

3.3.2.1. The health extension program platform

Results suggested the health worker model for integrated program delivery strongly enabled mobilization of intended beneficiaries. In all focus discussions community members expressed high satisfaction and familiarity with their health extension workers. Both HEWs and volunteer community health workers expressed a sense of support from their community, perceptions of their high acceptance within their community, and positive change as a result of their services. They clearly linked these positives to the fact that they were chosen by the communities. Higher-level government officials and representatives from NGOs and other DP organizations recognized and acknowledged the HEW model as a significant asset because HEWs are integrated in the community and help bring services closer to the community. Thus, external perspectives on the value of health extension workers matched local ones.

Direct observation indicated that, in all four kebeles visited, HEWs were confident, well known, and accepted by their respective community members. We observed HEWs communicate with intended beneficiaries (mothers as well as men who came to the HP, or during home visits) and with the woreda health officials, program officers, and HEW supervisors with effortlessness and familiarity. All were observed to deliver services with ease and assistance from their trained volunteer community health workers.

3.3.2.2. Observations on gender

Men and women expressed clear preference for using services available at health post versus health center. They flagged four major components of satisfaction with health posts (i) proximity (easy access without transport, when needed); (ii) user-friendly (language, respect, no wait time); (iii) responsiveness (provide advice, care, drugs or referral slip); (iv) generally good availability of supplies;¹⁹ and (v) VCHWs and HEWs are selected and accepted by the community they serve.

The field team observed both strong male participation in community mobilization activities and good attendance by women and children. Our team did not conduct a formal gender analysis but noted that the proportion of male VCHWs approached 80 percent in three out of four of the kebeles visited. The proportion of male VCHWs is high in most kebeles in Ethiopia.²⁰ One reason for the high proportion of males is that CBN activities require literacy among volunteer community health workers, thus the gender inequity in access to this important community role. The study team did not receive any indication that some women may be reluctant to approach male VCHWs, but this potential gender concern was not specifically investigated. Some participants suggested that male volunteer community health workers help to increase male involvement in CBN activities as well as promotion of FP and other components of the HEP.

18. The methods did not include formal participatory assessment of perceived Most Significant Changes, however.

19. Exceptions were reports of no antimalarial treatments in one kebele, and all items at the kebele lacking HP.

20. This is due in part to a requirement for VCHWs to be literate.

The male volunteers were observed to be more involved in the technical aspects of CBN such as weighing children and keeping records. The women volunteers were observed to help HEWs counsel mothers on feeding practices and in crowd control. This is also confirmed by a CBN officer who mentioned that the male volunteers are involved in weighing and report writing whereas the female volunteers mobilize and counsel the women during household visits and community conversations and also during other CBN activities.

3.3.2.3. Regularity and quality of CBN activities

The appropriateness of using a platform of regular CBN activities to target FP needs is apparent from comments by health extension workers in all kebeles investigated (annex 5). Regular contacts established and continued through home visits, community conversations, growth monitoring and promotion sessions, and community health days provide frequent opportunities for intended beneficiaries to hear messages on FP and contact health workers. HEWs highlighted ways that these CBN activities make it easy and advantageous for them to teach mothers and others about FP as they are well attended and allow use of real-life examples. CBN activities provide an appropriate context for mobilizing community members on FP, especially religious leaders and mothers. Subjective assessments by the field team during these CBN activities were that an inviting, friendly, and festive environment involving men, women, and children was successfully fostered.

CBN activities enhance the delivery of FP and other health extension program components by providing individual community members and whole families repeated opportunities to hear messages, discuss health issues, learn about and observe provision of health services, and access available services provided to them. Contact with beneficiaries is frequent and varied. Direct observation revealed a number of ways that CBN activities provide an effective platform to enhance community-based FP activities and service provision. Direct observation and content of in-depth interviews with woreda officials and nutrition program officers suggest that the structure of CBN activities regularizes and increases the frequency of opportunities for contacts between mothers with young children and the health extension workers and volunteer community health workers.

Although the qualitative indications of an effect of CBN on FP were clear, the methods used were not designed to tease out an effect of CBN alone. The team's impression during observations was that there was synergism among multiple components of the health extension program. CBN activities are likely to increase uptake of other services by the community.

3.3.3. Acceptance of messages

3.3.3.1. Cultural acceptability of links between FP and nutrition needs

Promotion of FP through CBN seems well accepted. CBN activities allow health extension workers and volunteer community health workers to promote FP within the context of a shared goal and multiple activities aimed at healthier people. Direct observation and all focus group discussion content from attendees of these activities (both women and men) indicate community members are aware of, understand, accept, and relate to the close link between nutrition and FP. This link between FP use and better nutrition is apparently working as both the intended and the motivated rationale driving FP promotion and provision during all types of CBN activities. Use of local examples during community-based activities creates an enabling environment for community buy-in that is likely reinforced by the positive community perception and high satisfaction with access to, availability, and quality of services

Linkage of FP and CBN messages is culturally acceptable. The regular CBN activities allow HEWs and VCHWs to disseminate information and promote FP within the context of broader, substantive, and directly observable community-based activities aimed at a common goal of child health and understanding how to reduce child malnutrition in the community. Women and men in all four kebeles investigated expressed positive attitudes toward FP messages and services delivered within CBN activities. Intended beneficiaries suggested that targeting mothers for FP through CBN is appropriate and fits well within the prevailing cultural contexts and cultural models for health.

3.3.3.2. FP method mix

Addition of long-acting family planning (LAFP) to the FP method mix improves message acceptance as well as uptake. Many FP representatives interviewed reported a steep increase in community acceptance and use of Implanon™ since it was rolled out in the intervention areas. Two FP representatives cited operational research studies conducted by their organizations. These research studies, according to the two FP representatives, found a quarter of current Implanon™ users are new users of any FP method. This suggests that FP method choices previously available at the community level (pills, condoms, Depo-Provera) were not taken up and that about two-thirds of current Implanon™ users are prior Depo-Provera users. This indicates an improved method mix that narrows the gap in unmet FP need through both new FP uptake and “method shift” among existing FP users.

3.3.3.3. Quality of training

It was observed that the type and quality of training provided within NNP contributed to improved acceptance of messages. The study team observed that master training²¹ includes role-playing and storytelling that is likely to improve behavior change communication (BCC) skills of health extension workers and volunteer community health workers. Each day of training ended with trainees reviewing and discussing what they learned and sharing their experiences with other participants.

The study team observed initial community conversations held as part of two master trainings, which included discussion about identifying underlying reasons for malnutrition and how it could be reduced. Trained HEWs and VCHWs used examples from the community to suggest that having many children frequently is one reason for having malnourished children and that spacing births can help everyone to have healthy children. Consistently, the focus was not family-size limitation as a goal, but rather, birth spacing to achieve healthier children.

The sessions observed were interactive; both male and female community members actively participated in the discussions with the trainees and master trainer and expressed concerns about issues that affect their children. Trainees observed had difficulties explaining two activities to community members: (i) “visioning” change that they seek for the benefit of their children, and (ii) “understanding malnutrition through metaphors.” In both cases, master trainers intervened and facilitated the discussion until community participants came up with a shared vision using metaphors for their children. It is concluded that beginning a discussion with the promise of a positive future (rather than a problem) is a good technique that then allows participatory review of present conditions and how the community can develop action plans to move toward a bright future for their children.

21. Training of trainers (TOTS) of HEWs and VCHWs.

3.3.4. Motivation

FGDs with women and men clearly show that they perceive FP use as a way to space birth for improving mother and child nutrition rather than for family-size limitation or even birth spacing alone. It is likely that this perception fits with an existing cultural model of fertility in which women are expected to have many children, although focused discussions did not explicitly probe this hypothesis. Transcripts of focus discussions of intended beneficiaries (both women and men) in all four *kebeles* indicate the motivation to use FP is based on having healthy, well-nourished children and on reduced child malnutrition. Community members in all four *kebeles* perceived a link between FP use and nutrition; and health workers consistently mentioned and were frequently observed to discuss this link.

Expert perspectives on the causes of a steep increase in Implanon™ uptake matched comments made by HEWs in all *kebeles* investigated. Most health extension workers mentioned that a majority of women using FP in their *kebeles* have chosen Depo-Provera™ because it is “easy,” but that recently many are choosing Implanon™. Health extension workers reported that Implanon™ is attractive because it is used for a long period of time; it is free and easy to use; and its use fits well with the concept of a three-year birth spacing. Health extension workers also mentioned that both Implanon™ users who are new to FP and those who switched from Depo-Provera promote Implanon™ use to their nonuser friends and neighbors. Examples of women in the community becoming pregnant after they stopped using Depo-Provera decrease fears of women becoming permanently sterile and contribute to Implanon’s™ popularity.

All FP representatives interviewed mentioned that bringing FP services into the community and closer to potential users, and delivery of improved FP method mix directly within the community has strengths. They highlighted increased demand for FP already created in the community by health extension program and CBN activities, a general shift toward long acting family planning services, and provision of an improved method mix with long-acting methods such as Implanon™ availability at the health post level and IUCDs at the health center level.

Community-level perspectives were concordant. In all four *kebeles*, men and women in all FGDs mentioned both going to their health post for FP, nutrition, and other services and also a desire for these services to be available within their communities. Health extension workers and volunteer community health workers perceived an increase in both FP method knowledge (including long-acting ones such as, Implanon™), and demand and use (uptake) within the community. Both women and men expressed a need for FP services in their community, mainly in terms of a need to space pregnancy, to prevent harm to the mother and child, to reduce the number of children within families, to get more information on FP, and to receive more services that provide alternatives to permanent methods, said to be feared by men.

One highly negative client experience, reported by HEWs, that could badly undermine motivation of intended beneficiaries and create major implications for program delivery is that some clients using Implanon™ have had difficulties obtaining appointments at the health centers for Implanon™ removal. In several cases clients who had appointments were sent home repeatedly without the procedure, making them extremely frustrated.

Such reports concord with the high dissatisfaction with the poor quality of services in health centers expressed by women and men during focus group discussions. In two *kebeles*, men spoke about poor

services in HCs. Youth in both of the focus group discussions in two *kebeles* mentioned either that they didn't get any services at HC or felt poorly treated by staff.

3.4. HOW IS CBN PERCEIVED TO IMPROVE FP SERVICE AND UPTAKE?

Content analysis of in-depth interview and focus group discussion transcripts suggests that, in the *kebeles* studied, CBN activities are perceived to enhance provision and uptake of FP. Several relevant stakeholder groups on both the service delivery and the demand side share this positive perception. The perceived positive effect is mediated in two main ways. First, CBN activities facilitate a shift from focus on family-size limitation as a goal of couples to one of keeping children born alive, well nourished, growing and healthy as a goal of families and the wider community; this fits better with prevailing cultural models and is therefore a more powerful concept to achieve social mobilization and individual motivation. Second, CBN activities provide a platform for frequent and varied contact between intended beneficiaries and health extension staff able to promote and provide FP. In turn, such contact influences motivation, access, mobilization, and support.

Evidence gathered indicates that positive perceptions on CBN activities spill over to other health extension program components:

- (i) Woreda officials mentioned increased numbers for coverage on FP, EPI, and ANC when *kebeles* with CBN are compared with non-CBN *kebeles* within the same woreda.²²
- (ii) NGO program officers noted increased demand for CBN among the non-CBN *kebeles* (and woredas).
- (iii) All focus group discussions with HEWs, VCHWs, men, and women mentioned an increased awareness of EPI, FP, and nutrition among the women and men in the communities investigated. This concurs with a positive perception of CBN activities expressed by all woreda officials and program officers interviewed.
- (iv) During FGDs, beneficiaries, especially men and youth, expressed a new demand for more types of service (a greater range of drugs, curative care, after-hour service), to be provided through HPs/HEWs. Specifically, men in three of the four *kebeles* studied demanded more supplies; in one of these they demanded after-hour services; in another *kebele* men demanded more training for HEWs and VCHWs; and youth in both group discussions demanded curative care in their HPs as an alternative to HCs.

In all four *kebeles* investigated, both service providers (HEWs and VCHWs) and beneficiaries (men and women) perceived increases of FP knowledge and use, fewer malnourished children, and reduced concerns about and resistance to FP among men and religious leaders. They attributed these changes to

22. The study team did not have access to this data, but reviewed a biannual (six-monthly) performance report that indicated that all clusters with CBN reported higher FP, ANC, and EPI coverage in comparison to the non-CBN clusters included. However, it was not possible to control for many potential confounding factors in an analysis, and the hypothesis warrants empirical testing.

the FP activities conducted during community-based activities and the perception of the value of birth spacing in preventing malnutrition.

PART 4. LESSONS LEARNED FOR SCALE-UP

4.1. POTENTIAL LIMITING FACTORS AND OBSTACLES

The study found qualitative evidence of positive effects of CBN on FP services on the demand side that suggested enabling factors that would be important to replicate and strengthen in any regional or national scale-up activities. The present chapter offers an analysis of some of the potential obstacles and limiting factors that would be important to address as part of efforts to scale-up at the zonal or national level. The analysis is based on interpretation and inferences drawn from the results described in the previous chapter and additional evidence gathered during the study.

4.2. GAPS NOTED

This study was not designed as a gap analysis, but in open-ended response, participants mentioned a number of gaps in program delivery that are noted here.

4.2.1. Funding

All officials and representatives interviewed identified inadequate budgets for FP supplies and consumable line items such as, Lidocaine, iodine solution, and gauze as a major current challenge. FP representatives explained how these are required to provide LAFP and expressed concern about a shortage of funding for procurement to secure FP commodities, contributing to high unmet needs. Several FP representatives suggested that increased knowledge on FP and national scale-up has created imbalance between the amount of commodities needed and the amount purchased. According to one of the FP experts interviewed, GOE was able to fund only 50 percent product availability through Protection of Basic Services (PBS) Fund from 2007–10; current funds for FP commodities fall far short of the estimated requirement.

FP representatives suggested this commodity finance gap is also hampering uptake. Although the long-acting FP commodities are available for free, sometimes women are asked to bring or buy them to receive Implanon™ in the facilities; this is problematic because most are poor. FP representatives suggested this will discourage many interested potential beneficiaries to access those services, and jeopardize results of efforts to add LAFP to the method mix. FP representatives, regional logistics officers, and woreda officials universally identified a need for adequate budget for line items, consumables, and supporting supplies.

4.2.2. Transport

Regional and woreda officials and representatives from local implementing agencies and NGOs working with GOE mentioned shortage of transport vehicles and fuel, which interrupts coordination, supervision, and supply chain at all levels. A regional logistics officer expressed that it is difficult to manage the entire regional supply chain with only three vehicles assigned to bring supplies from the federal office. Although local NGOs may provide transport support during ISS, there is a tendency to work closer to town and a reluctance to allocate transport support for work in distant kebeles.

4.2.3. Distribution

Some representatives reported mismatch between FP supply and demand even when there is no shortage of stock upstream of local demand and said that FP supply is not well distributed across

regions, woredas, health centers, and HPs. For example, FP supplies have been distributed to all regions but without consideration of demand within each region, resulting in overstock and shortage in low and high FP–need regions, respectively. The team observed some mismatch of supplies at the health posts investigated. For instance, during HP visits, the team observed shortages of some vitamin supplements and oral contraceptive pills at one health post and expired oral rehydration solution (ORS) and iodine solution at another, suggesting overstocked supplies. On enquiry, it was reported that supply from the health center was in excess, due to low utilization within the kebele served by this particular HP. Suggestions for addressing distribution challenges included requesting NGOs to assist with transport to move supplies from overstocked low-need regions to understocked high-need regions, and rethinking procedures for base allocation and distribution of existing supply.

4.2.4. FP service quality

FP representatives interviewed mentioned lack of preservice and in-service training on FP,²³ shortage of line items needed for long-term methods²⁴ and commodities,²⁵ lengthy time needed for counseling procedures and sterilization of equipment,²⁶ high turnover of skilled health workers at government facilities,²⁷ and high patient volume²⁸ as negatively affecting FP service quality and creating provider bias toward short-term FP methods.

Three out of eight FP representatives at the national level expressed concerns about lack of both preservice and in-service training on FP for nurses, midwives, and health officers, especially on long-acting method service delivery. Theoretical and practical training of FP is not integrated within the preservice training of health officers in either public or private institutions, and most nurses are given practical training to provide FP services only after graduation. An example given was that many nurses and health workers have never performed any IUCD insertion during their training, and are thus reluctant to provide IUCDs or perform IUCD insertion at their workplace. Another was minimal to no in-service training for Implanon™ insertion for health extension workers. This was confirmed by HEWs, most of whom mentioned feeling that the training on Implanon™ insertion was too short, especially the practical part. They reported the training manual requires each trainee to do at least ten Implanon™ insertions for beneficiaries during training in a health facility but said that it was very difficult to find sufficient numbers of interested Implanon™ users in the facility within the six-day training period for all trainees (for instance, 200 interested persons are needed for 20 trainees).

Quality of provision and care for LAFP methods provided in health centers is contingent on both technical and counseling skills, but the latter is not prioritized as essential. A number of factors may reduce emphasis on training facility-based health workers on counseling techniques and behavior change communication skills that are important in sustaining FP use. First, health officers at health centers must have the technical skills to provide these services. Second, skills in provision of IUCD and Implanon may be prioritized in both training and practice before removal. Third, facility-based health workers must attend to a high number of clients in a short period of time, making it difficult to find sufficient time to counsel them. Fourth, demand is being created by the HEWs and VCHWs at the

23. Three of eight national-level FP experts and one of four woreda health officials.

24. Four out of eight national-level FP experts, one of five regional officers, one of four woreda health officers and HEWs in the model HP.

25. Six of eight national-level FP experts and one of four woreda health officials.

26. Three of eight national-level FP experts.

27. Three of eight national-level FP experts and one of four woreda health officials.

28. Two of seven national-level FP experts questioned.

community level, and counseling techniques are a part of the training for HEWs through HEP and CBN.

4.3. OTHER CHALLENGES IDENTIFIED

The qualitative data indicated a number of challenges for FP services that are not specifically related to the integration of FP and CBN but may limit the quality of FP service provision integrated within HEP.

4.3.1. Capacity to support implant removal

Implanon™ is popular in the kebeles studied, and its use is increasing quite fast. This current success will result in high numbers of Implanon™ users needing removal procedures within approximately two years. As the number of Implanon™ users grows, proper planning and resourcing at the health centers for improved services and strengthening of linkages between community extension services and health centers for removal services and technical support are needed. Otherwise, potential exists for a “ratchet effect,” whereby large numbers of satisfied Implanon™ users are poorly served for timely, convenient, and locally available removal procedures, threatening both their health and continued FP uptake. National capacity necessary to avoid such a ratchet effect will grow as rollout of Implanon™ succeeds. Almost all representatives agreed that longer-acting method services require well-supplied and supported health centers for uninterrupted services; and flagged loss of skilled staff, supply shortages, and high patient load as challenges. The removal procedure requires advanced skills and is therefore available only at health center or clinic level and not part of HEW training.

4.3.2. Maintaining human resources for health

This study generated qualitative data that allow insights into how and why human resources for health (HRH) challenges affect integration of FP and CBN, and suggest potential solutions. Specific findings include generally high satisfaction of HEWs and VCHWs that was tempered by concerns expressed about on-the-job challenges, career development opportunities, and incentives. Poor human health resource retention within public health facilities is problematic because approximately 90 percent of Ethiopians access their health care services through the GOE system. High staff turnover of trained and skilled health care workers was attributed to poor salary and job prospects coupled with poor working environments. High staff turnover disrupts or reduces the quality of services at the health center and health post level needed for comprehensive health care systems at the community level and higher.

The implications of male gender bias among VCHWs against women in the community warrant further investigation. Study teams observed that male volunteers actively participate in the technical part of CBN activities, for example, weighing children, recording data, and reporting and informing the community of CHD, GMP, and CC sessions. Male volunteers increase male involvement in health issues and community ownership and thereby create an enabling environment for all. Study team observations also revealed that HEWs and female volunteers usually perform community outreach, home visits, and counseling.

Although two HEWs are allocated for each *kebele*, the study team noted large discrepancies among *kebeles* in the number of households within each *kebele*, size of geographic area, proximity to a town, and the number of HPs and HCs within the *kebele*. Further assessment of the extent to which human health resource allocation may be disproportionate and contribute to inequity in quality of services is warranted.

4.3.3. Addressing FP needs of youth

The study identified unmarried youth and prepartum women as groups that are not currently well targeted within current integrated FP, whose FP needs are therefore underserved. Almost all FP representatives mentioned a need to prioritize targeting youth (that is, married and unmarried teenagers and young adults) to address health issues because of the current demographic “youth bubble” (46 percent of Ethiopians are below 14 years of age; CSA 2006). Suggestions include reinforcement of activities targeting youth and sensitization of the community, religious leaders, and teachers to youth issues.

4.3.3.1. Existing youth links to health extension program

Content analysis of focus group discussions with youth groups in two kebeles indicates that the youth are familiar with their HEWs and VCHWs, access them for FP and HIV/AIDS information, attend community-based activities, and share information with elders. Health extension workers mentioned that youth are particularly mobilized by HEP home visits. Youth mentioned FP service utilization, some accessed at health posts and others during household visits. Transcripts of focus group discussions with youth groups indicated a different level of knowledge for different components: good knowledge on FP and sanitation, but limited knowledge on nutrition (youth were only able to say that different foods are good for children without actually identifying which foods were beneficial).

4.3.3.2. Current unmet need expressed

Both youth and HEWs reported that no meetings are organized to address and educate the community on the health needs of youth, young adolescents, or nonmothers. Youth groups identified health centers as their health facilities rather than the local HP, and expressed significant dissatisfaction with health center services. Youth group members who went for services at health centers reported that some workers there did not listen to their problems carefully and kept them waiting so long that they decided to travel to another health center, which was further away and in another catchment area.

4.3.3.3. Weak targeting of youth

These local perspectives concord with a concern raised by representatives at the national level and by a woreda official that youth targeting within HEP is currently weak. Existing youth programs are primarily focused in urban areas and target school-going and unmarried adolescents and youth. They rarely target youth living in rural areas or youth not attending school because of early marriage or lack of schools. This reduces outreach, especially among girls. Health extension workers are trained to visit schools to disseminate health information, but most kebeles lack middle schools.

The National Nutrition Program implementation manual describes activities to improve adolescent nutrition by promoting adolescent care and nutrition through interpersonal and group communications under CBN (section 2.3 page 27); and the CBN training manual includes adolescent nutrition and care. However, none of the HEWs and VCHWs mentioned targeting adolescents or youth through group communications for nutrition education, and we observed none of these activities at the community-based activities attended. Health extension workers described how they target youth in three ways (school and home visits,²⁹ and in the community) and teach them about hygiene, FP, and HIV/AIDS.

29. During FGDs young adolescents mentioned that they assist their parents in household activities such as, farming, collecting woods, rearing cattle, and fetching water, as they go to school.

Both the National Adolescent and Youth Reproductive Health Strategy (National AYRH Strategy 2006–15) and the National Reproductive Health Strategy (NRH Strategy 2006–15) provide clear guidelines and strategies to address adolescent and youth RH needs. However, FP representatives raised particular concerns about unmet youth needs for FP. They pointed out that health extension program components including CBN activities and FP advice and service are designed to target mothers with children. Newly married couples and adolescent girls and boys (both school attendees and nonattendees) are weakly targeted for RH or FP and nutrition education. One FP expert explained this as due to strong cultural practices of newlyweds to establish fertility soon after marriage, so that HEWs and VCHWs, who are usually from the same community, tend to focus on the mothers for FP and nutrition services.

4.3.3.4. Opportunities for recruitment as health human resources

Taken together, team observations and content analysis indicate that opportunity exists to plan for managing natural turnover among HEWs and VCHWs by recruiting among the youth. Transcripts from group discussions with youth and observation of community-based activities indicate that youth were keen to become volunteer community health workers for service, skill building, and job options. Many of the VCHWs observed in kebeles investigated were under 30 years old (the youngest was an 18-year-old male). Several HEWs observed were young women who were highly competent and effective in their work. Huge potential exists for creating human health resources for services within the community, sustaining the health extension program platform, and building skills and job options for youth by involving them within their community. One expert stated that a comprehensive package for friendly and confidential provision of FP and reproductive health services for youth is in preparation at the national level. Along with education, training, and employment, such packages have the potential to transform the “youth bubble” into a “demographic bonus” (May et al 2007).

4.4. ONGOING CHANGES WITHIN CBN, FP, AND HEP IN ETHIOPIA

Since the study was conducted in early 2011, ongoing changes to HEP program delivery relevant to the interpretation of findings and development of recommendations include:

- Strengthening of health post and health center referral linkage and supportive supervision
- Integrated refresher training (IRT) in all 16 HEP components for health care staff at all levels
- Provision of a new cadre at the five household levels, called health development army—HDA (to be selected by HEWs and community members to promote health and nutrition messages within five households and refer community members for health services at HP)
- Growth monitoring and promotion (GMP) sessions conducted by HEWs rather than VCHWs
- Health center rather than single supervisor responsibility for five health posts

In addition, a recent human health resource assessment of nutrition highlighted shortage of nutrition staff and made a number of recommendations (Ethiopian Health and Nutrition Research Institute [EHNRI] 2009). A recent USAID Ethiopia Global Health Initiative Strategy document has identified a number of targets and strategies on integrated service delivery framework that are likely to result in changes in FP, CBN, and HEP in Ethiopia (USAID 2012b).

PART 5. CONCLUSIONS AND PRACTICAL RECOMMENDATIONS

5.1. CONCLUSIONS

The results provide preliminary, qualitative evidence that various stakeholders perceive CBN activities to link nutrition and FP and other health issues in socially acceptable and qualitatively effective ways. Remarkable concordance of qualitative indicators of service delivery, uptake, and satisfaction was noted on both the supply and demand sides of service delivery. Taken together, these suggest (i) active and successful delivery of both CBN and FP activities at the sites studied; (ii) some challenges with record keeping, supervision, and supplies; (iii) strong uptake of services and messages; (iv) a highly positive community-level perception of service quality, even in partially capacitated kebeles; and (v) an engaged response by participants.³⁰ The findings highlight opportunities to leverage what works and to offer some tentative recommendations for continued and improved scale-up of integrated programs.

The CBN program has the full support of the HEP platform, and its activities are well accepted and endorsed by health workers. CBN has a well-structured, regular reporting system, well-placed supervision, and good technical support system from UNICEF and the World Bank. Perceived value of CBN spills over into other programs integrated within HEP. Qualitative evidence indicates that FP service delivery was well received by intended beneficiaries in the community, attributed in part to support for the integrated programs and health extension program platform within the community, mobilization of beneficiaries by HEWs and VCHWs through regular CBN activities, acceptance of FP messages at community level within the medium of delivery (integrated CBN and HEP activities) and method mix offered, and strong motivation for FP service use based on positive FP user experience. The study identified generally good qualitative indicators of community-level HEP staff and volunteer performance.

Although most stakeholders perceive CBN as improving FP uptake, a number of gaps and challenges were identified that must be addressed to achieve sustainability in scale-up. These lead to recommendations to further strengthen technical and operational links between FP and CBN programs within HEP. For example, the study identified several opportunities to protect and augment community-level human resources for health. These include development of plans and strategies to strengthen incentives (pay, salary increments with service, and opportunities for career development), supportive supervision (frequency and quality of feedback), and recruitment (targeting women, adolescents, and youth; and improved work conditions). The study also identified opportunities to explore sustainable responses to local demand for basic preventive and (especially) curative services, increased hours of service, and a wider range of drugs and treatments. Although not currently designed to provide curative services, evidence suggests a strong potential platform given the acceptability to the community and new demand generated. Lastly, the study highlighted a need for planning for and coordination of increased Implanon™ removal services, and a demand for improved provision of integrated services to adolescents and out-of-school youth.

In sum, the findings suggest that integration works well and should be continued until and unless other data show otherwise. The results establish proof of concept for the value of community-based FP

30. Community members, officials, and health workers at all levels investigated seemed highly motivated to contribute opinions. The team experienced full cooperation during direct observation and site visits for data collection.

services delivered on the recently established CBN platform and identify ways and means for improvement. Regular CBN activities can serve as an entry point and a strong platform to promote birth spacing.

5.2. RECOMMENDATIONS

Based on the findings, five recommendations for improved delivery and scale-up of integrated FP and CBN are offered:

1. Explore ways to step up planning and resourcing for contraceptive implant removal services

Increased capacity for contraceptive implant removal at the health center level is needed to avoid potential backlash on this increasingly popular method and to avoid a ratchet effect on demand for removal services beginning in about two years time (2013). Assessment and action should focus on four specific difficulties reported: securing appointments for removal, poor quality of health center removal services, health center staff loss, and shortage of supplies and line items.

2. Explore ways to reduce staff turnover at the health posts and health centers

The results identified both evidence of the challenge of high staff turnover, especially the trained and skilled health workers at health center level and above, and specific issues that could be addressed to improve job satisfaction and reduce difficulties faced on the job. For HEWs these include measurement and management of workload and burden of responsibility, and improved opportunities for career development and salary progression based on experience and performance. Since national budget allocation for salaries represents a major challenge, it will be potentially helpful to explore other ways to provide additional compensation. The study did not capture perspectives of health center staff, but strategies to retain and motivate staff are available (for example, Richey and Salem 2008).

3. Explore ways to strengthen integrative supportive supervision and management of CBN

The generally good relationship between HEWs and local volunteers appears to be a key element in the successful mobilization of the community. However, the study also identified potential gains from actions to improve supervision at every level (from health post to federal level) and focus on the hard-to-reach areas. Approaches suggested include (i) use of monthly work plan for each level of health staff; (ii) improving working relationship between HEW supervisors and HEWs with training for health extension workers' supervisors on effective communication and supervision; (iii) equipping supervisors with adequate and reliable transportation, especially for hard-to-reach areas; (iv) strengthening the referral system from health post to health center; and (v) harmonizing workload between health centers with differing number of health posts. In addition, strengthening management capacity for CBN at the health center, woreda, regional, and national levels on nutrition may be helpful to ensure sustainability. It is noted that, since the time data were collected, enhancements in management structures have been implemented; these provide opportunities for assessment of improvements in supervision records and supervisee support.

4. Explore ways to enhance recruitment and training of youth as health workers

The study finds that many youth were keen to become VCHWs to serve their community and to develop skills and create job options in the future. Given ongoing changes in the HEP system (for example, recent rollout of the Health Development Army model), a clearly identified need to anticipate and manage natural HRH turnover of HEWs and volunteers and major challenges to the sustainability of health volunteer models in food insecure communities exists (Maes 2010); this finding suggests

value in exploring all opportunities for recruiting new health worker cadres, especially from adolescents and youth groups at the *kebele* level.

5. Explore ways and means to target adolescents and out-of-school youth for FP and CBN

Ample opportunity exists to extend the documented advantages of integrating FP and CBN through increased efforts to target adolescents (aged 10 to 19) and youth (aged 15 to 24) within the community. Approaches suggested for achieving such multistakeholder engagement include:

- (i) Training and guidelines to HEWs and VCHWs on how to identify and target different groups of adolescents and youth for individual and group communication.
- (ii) Exploring ways to strengthen contacts with and mobilize these groups through home visits, at school, workplace, youth clubs, and through livelihood programs for health education and services.
- (iii) Exploring ways to mobilize and organize regular and structured community youth days/youth health days (similar to CBN); organizing combined multisectoral activities with assistance of these volunteer community health workers, agricultural extension workers, teachers, and community leaders for adolescents and youth should be explored.
- (iv) Designing, implementing, and promoting innovative, (and evidence-based) tailored messages for nutrition and RH/FP, hygiene, and other health components messages such as harmful traditional practices for different adolescents and youth segments or groups (to meet diverse needs of youth) with special focus/target for newly married couples, nonschool-going, new mothers (basically based on marital status, age, school status, residence, and sex).
- (v) Exploring ways to engage out-of-school youth not targeted by existing HEP programs.

6. Explore ways to harmonize FP and nutrition messages in diverse local contexts

Nationwide scaling-up of CBN activities described in this report, particularly messages on birth spacing delivered at monthly GMP sessions—well received by female and male community members—affords an excellent opportunity to promote integrated FP and nutrition messages (healthy birth spacing). Technical working groups and partners of RH/FP and nutrition at the national and regional levels can be encouraged to develop innovative, harmonized behavior change communication (BCC) strategies and messages. They should consult with woreda- and kebele-level health workers to develop IEC and BCC materials and guidelines for HEWs that take local language, culture, and context into consideration. Message harmonization can reduce duplication of materials and training resources.

7. Explore ways to harmonize donor support for integrated programs

To date, different components of HEP including RH/FP and nutrition have been funded and implemented in a vertical way and in accordance with donor policies. Several experts at the national level highlighted the potential gains to integrated HEP from increased harmonization of resources. Opportunities exist to explore all options to further cooperate, collaborate, and coordinate through the established TWGs within and beyond the FMOH to secure successful and sustainable implementation of a comprehensive and integrated HEP.

8. Conduct studies to measure the extent to which integration improves outcomes³¹

31. We are particularly grateful to Anna Herforth and Menno Mulder-Sibanda for challenging our thinking on research needs.

It would benefit future integrated program design to see additional results from empirical studies measuring the impact of CBN in increasing performance and service coverage, contraceptive prevalence rate, decreasing undernutrition, and improving FP and nutrition knowledge and practice using both quantitative and qualitative indicators. It would also be useful to see qualitative and quantitative results from process evaluation studies specifically designed to identify the pathways through which impact has occurred. For example, a more detailed understanding of prevailing cultural contexts and cultural models of health could prove useful for improved design and delivery of the messages and approaches deployed in targeting mothers for FP through CBN. Although broad results from the present study suggest current approaches fit well with cultural norms and expectations, there is little doubt that much detailed information remained undiscovered.

This study generated qualitative evidence to assess how FP is currently delivered in a purposive sample of kebeles with CBN in place, but it did not measure whether FP and nutrition knowledge, adequate nutrition, or CPR improve with integration. It remains unknown whether integrated programs aimed at improving child nutrition and birth spacing together are synergistic in ways many observers have predicted, that is, more effective than stand-alone programs aimed at each outcome separately. The question is highly relevant to contemporary policymakers at the helm of country-led, nationally coordinated, and intersectoral strategies in Ethiopia and in many other countries.

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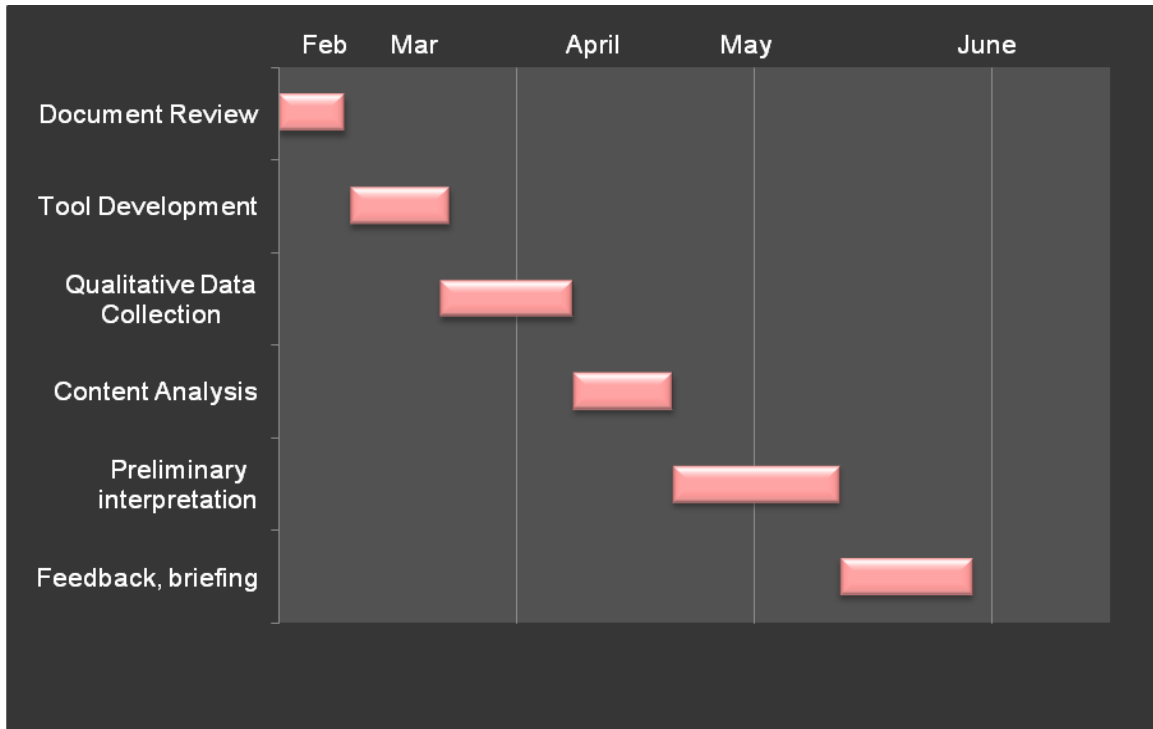
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ANNEXES

ANNEX 1. STUDY TIME FRAME, 2011



ANNEX 2. THEMES USED TO ORGANIZE DISCUSSION WITH SERVICE PROVIDERS AND USERS

Providers (health extension workers—HEWs, community health workers—CHWs)

1. Service delivery mechanism
2. Integrated FP and CBN experience
3. Training, supervision, and refreshers—monitoring and evaluation (M&E)
4. Record-keeping system
5. Equipment supply/availability of FP supplies
6. Referral system
7. Community acceptance
8. FP needs, nutrition activities, and service utilization
9. Male and female involvement in FP
10. Knowledge on linkage between health, nutrition, and FP

Users (women, men, youth)

1. Reason for current service use
2. Access, availability, and quality of health services
3. Supplies
4. Community health day/Community health meetings/Forums
5. Perception on FP services within nutrition service, that is, community health day
6. Perception and attitude on the needs for FP within their communities
7. Knowledge on linkage between health, nutrition, and FP

ANNEX 3. THEMES USED TO ORGANIZE CONTENT ANALYSIS OF DATA COLLECTED

	Qualitative research method						
	IDI	FGD (by stakeholder group)					Observed
Themes		HEW	VCHW	Women	Men	Youth	
Equipment and supply availability	X	X	X	X	X	X	X
Record keeping system	X	X	X				X
Training, supervision, and refreshers, M&E	X	X	X				X
Service delivery system	X	X	X				X
Addressing youth	X	X				X	X
Integrated FP, CBN delivery experience	X	X					X
Referral system		X	X				
Reasons for volunteering			X				
Knowledge, perception, attitude on FP, nutrition		X	X	X	X	X	
Knowledge, perceptions, experiences on links between FP and nutrition			X	X	X	X	
Knowledge on CBN activities				X	X	X	
Knowledge on health extension workers, Volunteer community health workers				X	X	X	
Service availability, access, quality				X	X	X	

ANNEX 4. EXAMPLE OF AN INTERVIEW GUIDE USED

For FP Expert/Official:

1. Identification:

(A) Name of respondent _____

(B) Designation of the respondent _____

Name of Interviewer _____

Day Month Year

2. Demographic Questions:

Gender: M F

Age:

Total time of services at the MoH:

3. Can you explain to us how the current/existing FP program delivery system is laid out?

i. Administrative structure of FP at each level (federal, regional, woreda, and kebele levels established by the FP)

ii. FP delivery process (from top to bottom)

iii. Responsibilities/activities of each staff at each level

iv. Can you tell us about your procurement and supply system—federal, regional, woreda levels? Is it a separate system or integrated system with the rest of the drugs and equipment supplies? 5

v. Please explain how your record-keeping system is structured (what type? How do you collect data with regard to FP activities?). Please provide sample copies of those data/records, if possible.

vi. Do you have a list of equipment/supplements used for the FP program?

vii. How is your supervision, M&E system structured at different levels (collect documents/records)?

viii. Please tell us about the training (and refreshers) system you have in place.

4. FP and NNP integration:

i. What are the FP-related activities/components integrated within the NNP/CBN program?

ii. How/what is the level of coordination between the nutrition wing and your department (FP)?

iii. Can you tell us your view on having integrated FP and nutrition program at the community level?

iv. Can you tell us how it is working in terms of the level at which it is integrated, and at which level it is worked separately?

5. Fund and expenditure structure:

i. What are the factors or criteria that are considered for resource (human, financial, and material) distribution?

ii. Probe: Do you consider the demographics, unmet need of FP, Contraceptive Acceptance Rate/Total Fertility Rate when you decide on the amount of resources distributed in each region? Is it a need-based resource allocation of programs?

iii. Selection decision process

iv. What is your opinion on the fund for FP?

6. Personal view on the existing program:

i. Please tell us what are the strengths of this program or factors that make it successful according to your view.

ii. According to you, can you please tell us factors/areas/things that need to be improved and can add value to the existing program?

iii. Can you comment on the workload at the ministry FP wing?

7. Based on your experience, can you comment on the current views (yours as well as others) on demand of FP services?

8. Any additional comment you would like to add with regard to your FP program.

9. We were informed that there was a pilot project with new guideline for FP activities for the health extension workers in one hundred woredas. We would greatly appreciate if you could give us a copy of the training manual, and tell us which one hundred woredas were selected? Has this new project been rolled out nationally?

ANNEX 5. EXAMPLES OF FOCUS GROUP DISCUSSION GUIDES USED

(A) FGD Guidelines for Health Extension Workers

Date:

Location:

FGD facilitator:

Note taker:

Demographics of the interviewees:

Total number of attendees:

Age range:

Gender:

Total time served as health extension worker:

THEMES

Theme 1: Service delivery mechanism

1.1. What activities do you do on a weekly/monthly basis on FP and Nutrition?

FP

Nutrition

1.2. How do you do each of these activities?

Home visits (what do they do during the home visits)?

Group discussions

Community meetings/community health days

School/workplace

Health posts

1.3. What are the good/best parts of your job?

1.4. What are the difficult parts about your job?

1.5. What would help you to do your job better?

Theme 2: Integrated FP and CBN experience

2.1. Do you do any family planning activities during your CBN activities?

2.2. If yes, what are those activities? Probe: For example, FP activities such as enquire, suggest/give information on FP to the caregivers/attendees.

2.3. What is the benefit/good thing/best part about doing FP activities and CBN activities together?

2.4. How do you find the existing FP services integrated within NNP? What is the worst part about it?

2.5. Do you think it is beneficial to the beneficiaries/community members?

2.6. If yes, please tell us how; if not, please tell us why not?

2.7. Can you share your good and bad experiences during work?

2.8. What can you suggest to improve FP services with CBN?

Theme 3: Training, supervision, and refreshers—M&E

- 3.1. Have you received training for FP and nutrition?
 1. Yes 2. No
- 3.2. If yes, how long was your training for each?
- 3.3. Was the training you received in your catchment area?
- 3.4. Can you please describe the quality of training you received? Probe: Who provided it, frequency, how it was provided/methods, training materials used, content of the training, supportiveness, what's the best and the worst part of the training?
- 3.5. Did you receive any refresher training? When was it?
- 3.6. How many women health troopers/health volunteers/promoters work with you?
- 3.7. Can you tell us how you recruited them?
- 3.8. How do you supervise them? Probe: Frequency of supervision, supervision checklist, feedback system.
- 3.9. Tell us what is the positive side of this supervision.
- 3.10. Comment on how/what to improve on the current supervision system.
- 3.11. Who supervises you for FP and nutrition program? Is it supervised separately or together?
- 3.12. How are you supervised? Probe: Methods, frequency, feedbacks.
- 3.13. What do you think of the current supervision system?
- 3.14. How it can be improved?

Theme 4: Record keeping system/Their workbook
--

- 4.1. What records do you keep for FP and nutrition?
- 4.2. How frequently do you update records?
- 4.3. What data/records do you submit to your supervisor?

Theme 5: Equipment supply/Availability of FP supplies
--

- 5.1. What are the equipment/supplies you have at the HP? Do you have a list?
- 5.2. What do you carry with you during your household visits, community health day activities?
- 5.3. Do you have all the necessary FP- and nutrition-related supplies at the health post at this moment?
- 5.4. How do you request supplies? Whom do you request for supplies?
- 5.5. How frequently do you request supplies?
- 5.6. How long does it take to receive your supplies (from the time your request is made)?
- 5.7. Is the supply chain maintained in a regular/timely manner?
- 5.8. If no, then how do you manage without FP supplies or shortage of supplies? What do you do when you don't have FP supplies?
- 5.9. How does it affect the FP services in your kebele?
- 5.10. How can availability of supplies be improved?

Theme 6: Referral system

- 6.1. How does the referral system work within your kebele?
- 6.2. Do you have referral linkages with other local community-based reproductive health agents (CBRHAs)/NGOs for FP activities?
- 6.3. How is your relationship with them?
- 6.4. What are the strengths of the current referral system?
- 6.5. What are the weaknesses of the current referral system?
- 6.6. What can you suggest to improve the current referral system?

Theme 7: Community acceptance

- 7.1. Who is your main audience for CBN activities and FP group activities?
- 7.2. Do the community members attending the group meetings/activities accept your information easily?
- 7.3. What are the problems you face while performing your CBN and FP activities?

Don't Probe.

Possible answers: Shortage of equipment, supplies, lack of community acceptance, transportation, supervision.

Theme 8: FP Needs, nutrition activities, and service utilization level

- 8.1. What is the FP need level in your kebele? Probe: High need, moderate, low.
- 8.2. Who are your most/regular/frequent clients for family planning? Or, Who mostly comes to you for FP?
- 8.3. What are the most popular choices of FP methods in your kebele?
- 8.4. Tell us why they choose these methods (instead of the other methods you mentioned to them)?
- 8.5. Who comes to you during nutrition activities?
- 8.6. What are the positive sides of providing FP and nutrition services together?
- 8.7. What is the result/impact of your FP activities within CBN? Probe: Improved knowledge, acceptance of FP, reduced birth rate, increased FP use, fewer abortions.
- 8.8. What are the limitations of the current FP and nutrition service?
- 8.9. What can you suggest to improve FP and nutrition services in your kebele?

THEME 9: Male and female involvement in FP

- 9.1. Can you tell us why men in your kebele use FP?
- 9.2. Can you tell us why women in your kebele use FP?
- 9.3. Based on your working experience, tell us who makes the decision to use FP within the family in your kebele and why.
- 9.4. Explain why male members of your kebele DON'T use/want to use FP.
- 9.5. Explain why women of your kebele DON'T use or want to use FP?
- 9.6. What do you do to convince/encourage them to use FP?
- 9.7. What do you suggest to help you to improve/increase FP use within your kebele?

THEME 10: Knowledge on linkage between health, nutrition, and FP

- 10.1. Is there a link between nutrition and FP in health?
- 10.2. If yes, can you tell us how it is linked?

(B) Focus Group Discussions: Guidelines for the Women Attending Community Health Day at the Health Post and/or Health Center/Kebele

Date:

Location:

FGD facilitator:

Note taker:

Demographics of the interviewees:

Total number of attendees:

Age range:

Occupation:

THEMES: (Skip theme 1 when the focus group discussions are at a kebele)

THEME 1: Reason for their visits

- 1.1 Why did you come here today?
- 1.2 Who provides you with these services? Probe: HEWs, WHTs, any other type of health officials.
- 1.3 Can you tell us where and to whom you go to for FP services and nutrition services?
For FP: _____ For nutrition: _____

THEME 2: Access, availability, and quality of health services

- 2.1 What are the health care facilities available in your kebele?
 - 2.2 Which is the closest health care facility for you?
 - 2.3 What could be the approximate distance from your village to the closest health facility?
 - 2.4 How long does it take you to get to the HP?
 - 2.5 Do you take any transportation? If so, how much did it cost you?
 - 2.6 Where do people usually prefer to go when they have a health problem?
 - 2.7 What services can you receive from the health post and health centers? Or, when was your last visit to the health center and for what?
 - 2.8 Have you ever visited the health post/health center?
- If yes, then carry on with the following questions. If no, then skip to theme 4.**
- 2.9 Was there a fee for the services you had? How much was it?
 - 2.10 How long did you have to wait before someone saw you?
 - 2.11 When you visited the health facility, was any one available to attend to you immediately?
 - 2.12 Were you treated with respect when you approached the nurse, doctor, pharmacist, health worker?
 - 2.13 Please describe the behavior of the health care providers. Probe: Did he/she listen to your problem/needs carefully/attentively?

- 2.14 Did he/she explain your issue/solution to you?
- 2.15 Did you understand what she told you?
 Yes No Fully Partially Not at all
- 2.16 Did you feel comfortable talking about your problem with the health care provider (HEW, WHTs)?
- 2.17 Are you satisfied/happy with the health services that are available to you?
- 2.18 If yes, please describe the positive points.
- 2.19 If no, please tell us what you didn't like.
- 2.20 What are the changes you would like to make/suggest to improve the health services?

THEME 3: Supplies

- 3.1 Were you given the drugs/FP materials or supplies as needed?
- 3.2 Was there any time when you needed FP supplies, and these were not available or not given to you?
- 3.3 In your observation, how is the medicine supply in the health center/health post?

THEME 4: Community health day/Community health meetings/Forums

- 4.1 Are any health group meetings/community health days organized in your village?
- 4.2 If yes, who organizes these events in the village?
- 4.3 How frequently are community health days/health meetings held in your village?
- 4.4 Where are the health meetings/community health days usually organized in your village?
- 4.5 If health day is organized, what services are provided during those health days?
- 4.6 Does the health extension worker (or VCHP) come to your home to provide health services?
- 4.7 If yes, what services does he/she provide?
- 4.8 Does HEW (or VCHP) give medicine or FP supplies when he/she comes for home visits?
- 4.9 What does he/she provide?
- 4.10** Did you attend group discussions/meetings or community health days organized by HEWs and VCHWs? **(if say no, skip to the next theme)**
- 4.11 What did he/she (HEW or VCHP) discuss at the meeting?
 Probe: Nutrition of children/women, FP.
- 4.12 Can you tell us what you learned from today's discussion?

THEME 5: Perception about FP services within nutrition service, for example, community health day

- 5.1 Do you receive FP services during community health day?
- 5.2 If yes, what are the positive points about receiving FP services during community health day?

5.3 If no, would you like to receive FP services during community nutrition/health day?

THEME 6: Perception and attitude about the need for FP within their communities

- 6.1 What is your view on the need for FP (met or unmet) within your kebele?
- 6.2 Do you want to have FP services within your kebele/community?
- 6.3 Tell us why you want to have FP services within your kebele? Probe: Birth spacing, limiting the number of children, stopping childbearing for good, STI prevention.
- 6.4 Why do women use FP in your community?
- 6.5 Why do men use FP in your community?
- 6.6 Who makes the decision for FP use within the family?
- 6.7 Why men DON'T use FP in your community?
- 6.8 Tell us why women DON'T use or want to use FP in your community.

THEME 7: Knowledge on linkage between health, nutrition, and FP

- 7.1 Is there a link between health, nutrition, and FP?
- 7.2 If yes, can you tell us how they are linked?

ANNEX 6. OBSERVED ACTIVITIES INTEGRATING FP WITHIN CBN

(A) Observed CBN activities conducted by HEW	Observed additional activities, including FP and MCH activities	Kebele			
		A	B	C	D
During monthly CC		A	B	C	D
Subject covered: Prevention of malaria and HIV/AIDS, promotion of ITN use, sanitation and hygiene	Depo-Provera injection	X	X	X	
	Rapid diagnostic test (RDT) for malaria	X	X		
	Vaccination for children (EPI)	X	X		
During monthly GMP		A	B	C	D
(Under HEW supervision VCHWs work) Weigh children under two years of age, identify moderate malnutrition and severe acute malnutrition (SAM); counsel mothers of moderately malnourished children on exclusive breastfeeding (EBF), CF, and targeted supplementary feeding (TSF) with Plumpy'nut™; and refer children with SAM	ANC		X		
	Vaccination of children (EPI)		X		
	Malaria testing with RDT and promotion of ITN use		X		
	HIV/AIDS testing referrals		X		
During quarterly CHDs		A	B	C	D
MUAC measurements for children under five years, pregnant and lactating women; referral and treatment of children identified as underweight or diagnosed with SAM; counseling of mothers of moderately malnourished children on EBF, CF, and TSF with Plumpy'nut™	Depo-Provera injection	X	X	X	X
	Counseling for Implanon™		X		
	ANC for attending pregnant mothers	X	X	X	X
	Vaccination for children (EPI)	X	X	X	X
	Malaria testing with RDT (adult and children)				X
	HIV testing with RDT	X			
	HIV testing referral				

Note: The blank columns indicate the absence of data from those kebeles on particular CBN activities. Monthly CC sessions were already conducted by the HEWs of Kebele D prior to the data collection time of our study. GMP sessions are conducted by the VCHWs at the gotte (50 household) level, which was (a) not accessible to the research team and also (b) already conducted for that month. Field visits to all four kebeles were scheduled in consultation with the HEWs once the kebeles were selected so that data could be collected during HEWs' regular activities without hampering their (HEWs') work schedule.

(B) Observed CBN Activities Conducted by VCHWs	Kebele			
	A	B	C	D
During CC				
Organize and manage the crowd	X	X	X	
Keep records (EPI card updating)		X	X	
Demonstrate use of ITN		X		
Explain next dates for vaccination		X		
Bring supplies to HEWs	X	X	X	
Clean the HP at the end of CC activities	X	X		
During monthly GMP				
Control the crowd		X		
Set up and calibrate anthropometric equipment		X		
Weigh children		X		
Record measurements of children		X		
During quarterly CHD				
Control the crowd	X	X	X	X
Assist with recording the number of attendees	X	X	X	X
Assist in measuring heights of children under five	X	X	X	X
Prepare mothers with children for vaccination	X	X	X	X
During household visits				
VCHWs to deliver messages on nutrition, sanitation and hygiene, malaria prevention, ANC, and PNC	X		X	X

Note: Observed VCHWs involvement during CBN (triangulated with both service providers [HEWs, VCHWs]) and beneficiaries (women, men, and youth).

ANNEX 7. FP MESSAGES HEALTH EXTENSION WORKER REPORT GIVING DURING CBN ACTIVITIES

For men

During monthly CC:

To allow their wives to use family planning because it is useful to the family in preventing malnutrition both for the mother and the child and also decreases risk of death of the mother and the child.

During household visits:

Use of FP cards with spaced and nonspaced pregnancies comparison: using family planning will prevent malnutrition in the family.

For women

During CCs, GMP, and CHDs:

Use of examples of families using FP (healthy children and mother who is not sterile) and families not using FP (children are malnourished) during CBN activities.

Mothers using FP methods have spaced births and no malnourished children. FP has this advantage: children will be well, and there will be no malnutrition in the family because of spacing of pregnancies

“If mothers have a malnourished child, we tell them that it is because you have increased number of family size, you do not use FP; so you have to use FP to space pregnancy and avoid malnutrition in your family.”

With examples: If you use family planning you will have good and healthy children. And if you do not use family planning, you will have malnourished children.

With examples: Show them malnourished children and tell them, “This is because you have increased number of children and don’t use FP. So if you use FP, you won’t have malnourished children.” (Kebele D)

With examples: Using FP does not cause sterility. For instance, if a woman has been using Depo-Provera, and she stops using it, she becomes pregnant.

Facilitate conversations among women about the usefulness of FP and allow them to come to the solutions themselves. We will also teach them how to prevent malnutrition and other maternal problems that come with giving births to many children.

During CHDs:

After assessment and identification of malnourished children: This is because of having increased family size. Therefore, they have to use FP. We will say, “Thank you” to the

well-nourished children's families and also tell them to provide a balanced diet for their children. (Kebele A)

When religious leaders (and their wives) are present in the community, "It is not sinful to use FP."

ANNEX 8. EXAMPLES OF STAKEHOLDER STATEMENTS ON SERVICE DELIVERY, ORGANIZED BY SELECTED THEMES

Supervision

[Regional officials] get busy with other urgent assignments or other tasks that interrupt the quarterly ISS.

A health official during in-depth interview

The problem about the supervision is that they [HEW supervisors] do not give us time to discuss our problems in detail; instead, they take the report and go.

A health extension worker during focus group discussions

They (HEWs), after a few months, come crying to us for a transfer. No one wants to work on those (hard to reach) kebeles, and supervision is also very difficult.

**Woreda official during in-depth
interview**

Job satisfaction

Serving community, seeing healthy children; people give babies and toddlers a range of food, use of FP, maintaining personal and community hygiene makes us happy. This is our pay.

A volunteer community health worker during focus group discussions

We do our work as volunteer community health workers for the sake and well being of our community. This is our community, so if we don't take care and do what we need to do to be healthy, then who else would?

A volunteer community health worker during focus group discussions

It [workload] is too much and I know, but it's saving lives so it's OK.

There is nothing I don't like about my job. I love my job and my people and this kebele.

HEWs during focus group discussions

Incentives

Workload is too much without pay.

A volunteer community health worker during focus group discussions

Our pay is low for the workload, and there is no increment for experience.

We started two to three years ago as health extension workers, and our salary is still the same salary as any new health extension worker who starts today. There is no value given to our experiences, which is frustrating.

[There is] no upgraded training for us, which is also frustrating given our educational background; we can do more with upgraded training.

Some of us have higher degrees, and can do more work if given training.

HEWs during focus group discussions

No medicines supply, so we can't treat the basic illnesses.

A health extension worker during focus group discussions

Lots of programs are thrown at us from the woreda level; we feel tortured and frustrated sometimes as we are the only people responsible in the kebele.

A health extension worker during focus group discussions

Coordination

We have a very well-structured administrative structure from the national to regional to the community level. We have placements of dedicated people from the national to the community level. We have community presence at the grassroots level. These are all very positive strengths, and we can build on these to improve the system and service delivery.

An expert during in-depth interview

There has been a profound increment on the health budget and consequently on FP, especially within the last two years despite the resource constraint situation of the country.... MNCH is a priority area receiving the 'lion share' of the budget, and consequently FP is given a big share as well. ... So you can see, it's been given due attention with funding, especially now.

An expert during in-depth interview

Support in the community

We don't have to wait for someone to see us, and we are attended immediately by someone when we reach the HP. We are treated with respect. They listen to us attentively; they explain everything—our problem and solutions, and we understand them very well. We are comfortable talking about our problems with the health extension workers, and we are satisfied with it. The positive point is that they (HEWs) tell us about FP in our language.

Man during focus group discussions

Before, we didn't have any HPs, and our community members were dying due to health problems. Now, the health extension workers teach us how to prevent

diseases. So, this is a positive thing for us. And now we know the disease problems, causes, and how to prevent them and what or where to go for help.

A adolescent youth during focus group discussions

We received supplies as needed when we went to the HP. There is not any time when we needed the supply and it was not available. To us, in our observation, there is a full supply of medicine in the HP.

Woman during a focus group discussion

We usually go to the health post for FP and nutrition services. The services we get from the health post are (1) family planning—teaching about use of FP and different methods, (2) nutrition—giving exclusive breast feeding until six months and complementary feeding after six months and giving balanced diet to our children, and (3) malaria testing and treatment distribution of ITN.

Man during focus group discussions

People usually prefer the health post because they get the following services: FP, nutrition, malaria treatment, vaccination, and education.

Woman during focus group discussions

At the start of FP, community acceptance was very low. But after we gave counseling to the wives, and had community conversations with the husbands and religious leaders, we convinced them that FP is good for the family in order to avoid malnutrition for the mothers and their children. The people in our community now have increased awareness about FP and immunizations. They have started to ask about FP to use. Even husbands are bringing their wives to the health post for them to get FP. Religious leaders' wives have started to use FP; they are teaching their community that it is not sinful to use FP.

A health extension worker during focus group discussions

Mobilization

HEWs are live witnesses in FP access increase at the community level and thereby increase in the utilization of services. The community members are taking these services that are being made available to them by the health extension workers.

An expert during in-depth interview

HEWs are integrated within the community they serve; everyone knows her [sic] and goes to her for help.

An expert during in-depth interview

We do not wait for someone to see us. We are attended by someone immediately, and we are treated with respect. They (HEWs) listen to us attentively and explain

our problem and its solutions, and we understand them well. We are comfortable talking about our problems with the health extension workers, and we are satisfied with it. The positive points about them are they (HEWs) give us advice on everything and treat us with respect.

A man during focus group discussions

Before the health extension program, the community people didn't know about FP, EPI, and other programs. Now they all know about all of it. We can see now that the community is changing and the impact is great.

Health extension worker during focus group discussions

How CBN works

Now, with the CBN activities such as community conversation, growth monitoring sessions, and community health days, so many mothers come to these events, so we tell them about FP during these events. And the mothers accept FP messages well because we tell them using examples such as families using FP have healthy children and the mothers are not sterile versus families not using FP have malnourished children.

Health extension worker during focus group discussions

During GMP sessions and CHDs, we get so many mothers; it is easy for us to tell them about family planning. We will also teach them with examples like we will show them malnourished children and tell them this is because they have increased numbers of children and don't use FP. So if you use FP, you won't have malnourished children.

Health extension worker during focus group discussions

Nutrition, FP, and health are linked because those women who do not use FP have malnourished children, and those women who use family planning have good and healthy children.

Woman in focus group discussions

It is very good to give FP during CHDs because so many people come and are changed when they hear teachings (from the health extension workers, volunteer community health workers), and will also tell their neighbors who didn't come.

Man during focus group discussions

Women who do not use FP have malnourished children

Woman during focus group discussions

We tell them (the men and women attending CC, GMP, and CHDs) that if you do not use FP, you will have malnourished children.

Health extension worker during focus group discussions

High access to method mix will help to reduce unmet need.

Expert during in-depth interview

We want to have FP services within our kebele because it is disadvantageous to the mothers, children, and to the economy to have many children, and we want to use FP.

Man during focus group discussions

Why CBN works

So many people come to the meetings [CHDs and GMPs], and they are changed immediately when they see good things about their neighbors and will also tell their neighbors who didn't come.

Men during focus group discussions

The positive point about providing FP during CHDs is so many people are there to hear (listen), and we know so many things and accept so much information when we see our neighbors accepting it.

Women during focus group discussions

When I attend staff performance review meetings at the woredas I visit, seeing how CBN helps other health extension programs, many health extension workers (and even woreda officials) from non-CBN kebeles (and woredas) ask for CBN in their kebeles/woredas.

International agency program officer during in-depth interview

The result of our FP activities given through CBN brought about improved knowledge and increased FP use. It is helpful to provide FP and nutrition services together because we get so many mothers coming for CBN.

Volunteer community health worker during focus group discussions

The good side about our jobs is increased use of family planning—thereby reducing birth rate, preventing malnutrition in the family; use of vaccination—thereby reducing death of children due to preventable illnesses; presence of CC—helping kebele people to talk about their problems and come to solutions for those problems, for example, involving husbands and community religious leaders to talk about the usefulness of family planning and to teach the community about it.

Health extension worker during focus group discussions

Weak targeting of youth

There is a huge problem there [at the health center], they don't respect us. Even if we were to go there by accident, they don't treat us well. We couldn't understand their directions—where we have to go. They sent us to private clinics;

we spent a lot of money there. Generally we are not satisfied with their [health center] services.

An adolescent during focus group discussions

We don't specifically target them or invite them [young adolescents]. Usually during community conversations, they are also invited, and sometimes they also come. But there is no mechanism or activities to reach the adolescents. It is a gap. Usually boys get married at 18 and up, and the girls get married at 14 and up in our kebele. They can come to the health post to take a voluntary HIV test.

Health extension worker during focus group discussions

The health extension workers coming from the same cultural background tend to focus their FP work on older married women who already have three or four children, to counsel them about limiting the number of their children and family size. However, they tend to miss [or] ignore the young, newly married women because culturally the new married women or girls are supposed to show their fertility after their marriage.

National-level expert from an international organization during in-depth interview

Resource and funding gaps

This large gap between the current demand and supply [of FP commodities] must be balanced.

An expert during in-depth interview

ANNEX 9. SUMMARY OF STAKEHOLDER WORKSHOP

Date: May 10, 2011

Time: 2:00 p.m.

Venue: Federal Ministry of Health Conference Hall (back building, first floor)

Topic: Integrating Family Planning with Community-based Health and Nutrition Interventions in Ethiopia

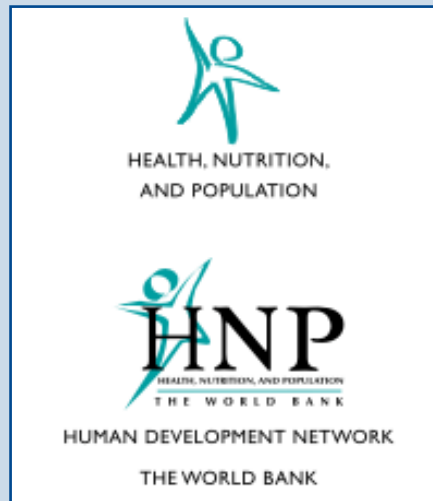
Presenter: Professor Daniel Sellen from University of Toronto

Chairperson: Dr. Amha Kebede, Director General (Acting), EHNRI

Moderator: Mr. Mesfin Gose, National Nutrition Focal Person, FMOH

ABSTRACT

Lack of family planning hampers achievements of all eight Millennium Development Goals. Effective response to documented large unmet needs for family planning is an essential component of national strategies to achieve Ethiopia's development goals. Current maternal mortality, total fertility, and malnutrition rates are high, and contraceptive prevalence rates particularly low among the rural poor in Ethiopia. Reducing Ethiopia's population growth by improving access and increasing uptake of family planning will enable the population to benefit from current economic growth. The consultant team will describe and present preliminary findings from ongoing qualitative process assessment of community-based family planning. The new knowledge on current experiences with community-level integrated nutrition and the FP service delivery system under the health extension program will be reviewed with forum participants, and followed by a discussion of the implications for programming and policy.



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