

# Integrated Family Health Program End of Program Report

## 2008–2016



**USAID**  
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**E2A** EVIDENCE TO ACTION  
for Strengthened Reproductive Health



**For further information:**

**Integrated Family Health Program**

Tel: +251 11320 3501 Fax: +251 11 320 3572  
 Nefas Silk Lafto Sub City Woreda 03  
 Del Gebeya Area, Addis Ababa, Ethiopia

*This publication is made possible by the generous support of the American people through the United States Agency for International Development (USAID) with a central field support mechanism to the Evidence to Action (E2A) project under a cooperative agreement number of AID-OAA-A-11-00024. The contents are the sole responsibility of IFHP and do not necessarily reflect the views of USAID or the United States Government.*

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## Message from the Chief of Party



After eight and a half years, it gives me great honor and pride to share the Integrated Family Health Program (IFHP) end of program report. The report summarizes the gains we have made through strong, collaborative working relationships with our stakeholders. We are particularly indebted to our partnership with the Federal Ministry of Health (FMOH), whose visionary Health Sector Transformation Plan has helped guide and lead the efforts of IFHP.

As you read through the following pages, you will get to know the full picture of our shared achievements and how they have made a lasting impact on the health of Ethiopian families. The report also highlights the lessons we learned along the way: lessons Ethiopia's health community, led by the FMOH, can apply as it continues to build upon our shared successes.

IFHP fulfilled its mandate to bring siloed health areas together by integrating health services for families. While the report showcases everyday examples of the difference that our work has made in the lives of women, children, youth, and men across the IFHP focal regions, the back story is in how IFHP achieved integrating health services to maximize access to quality health services. Indeed, this report echoes the voices of individuals whose lives have been touched and changed by this truly integrated approach and our collaborative work in diverse communities: family planning acceptors, women delivering babies in health facilities for the first time, the tragic journey of a fistula survivor, and sick children who were reached with the right package of integrated health services at their doorsteps.

IFHP contributed to a stronger health system by using data for decision making. Our continuous use of evidence in program learning was not only crucial in benchmarking our progress, but also in modeling the power of effective routine data use, which is essential for continued health system improvements. Our data show the progress made across IFHP's integrated technical areas, e.g., maternal and newborn health, family planning and reproductive health, and child health.

These positive outcomes would not have been possible without the support of, commitment from, and close working relationships with so many of you at all levels of the health system. I wish to sincerely thank every member of the IFHP team for their dedication and enthusiasm, which enabled us to make a meaningful difference in the lives of so many people.

I also value and appreciate the support of our major donor, USAID, the matching resources from the Korean International Cooperation Agency (KOICA), the World Health Organization's (WHO) country office in Ethiopia, and other partners who worked closely with us to achieve our common goal of improving people's health. Together, we have been able to reach greater achievements and set new milestones for our work.

Thank you!



Mengistu Asnake, MD, MPH  
Chief of Party

## Technical Director's Message



As a public health professional, the opportunity I have had to work with colleagues from Pathfinder International and John Snow, Inc. (JSI) to implement USAID's Integrated Family Health Program (IFHP) has been a dream come true. Since IFHP began in 2008, we have worked in true partnership with the government of Ethiopia (GOE) through the Federal Ministry of Health at every level. This partnership allowed IFHP staff to apply clinical and managerial knowledge to integrate previously disconnected health services in the four focal regions of IFHP, foster innovation, roll out best practices, and maximize the impact of our capacity building efforts.

Together we have instilled sustainable mentoring skills in district staff, who will continue to improve integrated family health services and build local capacity. The results, which are detailed on the following pages, speak for themselves. IFHP does not take credit for the improvements in quality, access, and use of integrated family health services; rather, we share a joint sense of achievement with our public health sector colleagues and communities throughout Ethiopia.

The foundation of our work has been the GOE's clear vision through the health sector development program, strategic decisions to promote family planning and child survival, and, more recently, the launch of the MNH Roadmap (2010). Ethiopia's community health system, encompassing the Health Extension Program, Health Development Army, and primary health center units, leads the way throughout Africa.

Finally, the GOE has demonstrated flexibility to adapt and scale up proven maternal and child health and family planning interventions. Health sector managers at all levels offered IFHP a pathway to contribute to policy development and heard and respected our suggestions and contributions. It is in this context that we have successfully implemented a genuinely integrated approach to family health services and contributed to Ethiopia's remarkable achievements in health.

Our donor, USAID, is a strong and consistent partner. Throughout the life of IFHP, USAID has listened, guided, and advocated for the necessary resources. IFHP also benefited from partnerships with WHO, UNICEF, and other organizations.

This report is a snapshot of IFHP's joint contributions with its donors, government stakeholders, and community beneficiaries. As Pathfinder and JSI continue their partnership together and with the GOE and USAID in the future, we look forward to building upon these results. We also look forward to Ethiopia's continued successes toward universal family health through a well-managed and resilient health system.

Finally, we acknowledge the enormous effort of our IFHP team and the unwavering support accorded to the program from the health sector managers and professionals at all levels of the health system.

Thank you!



Tesfaye Bulto, MD, MPH  
Technical Director

# Changing Lives through Integration

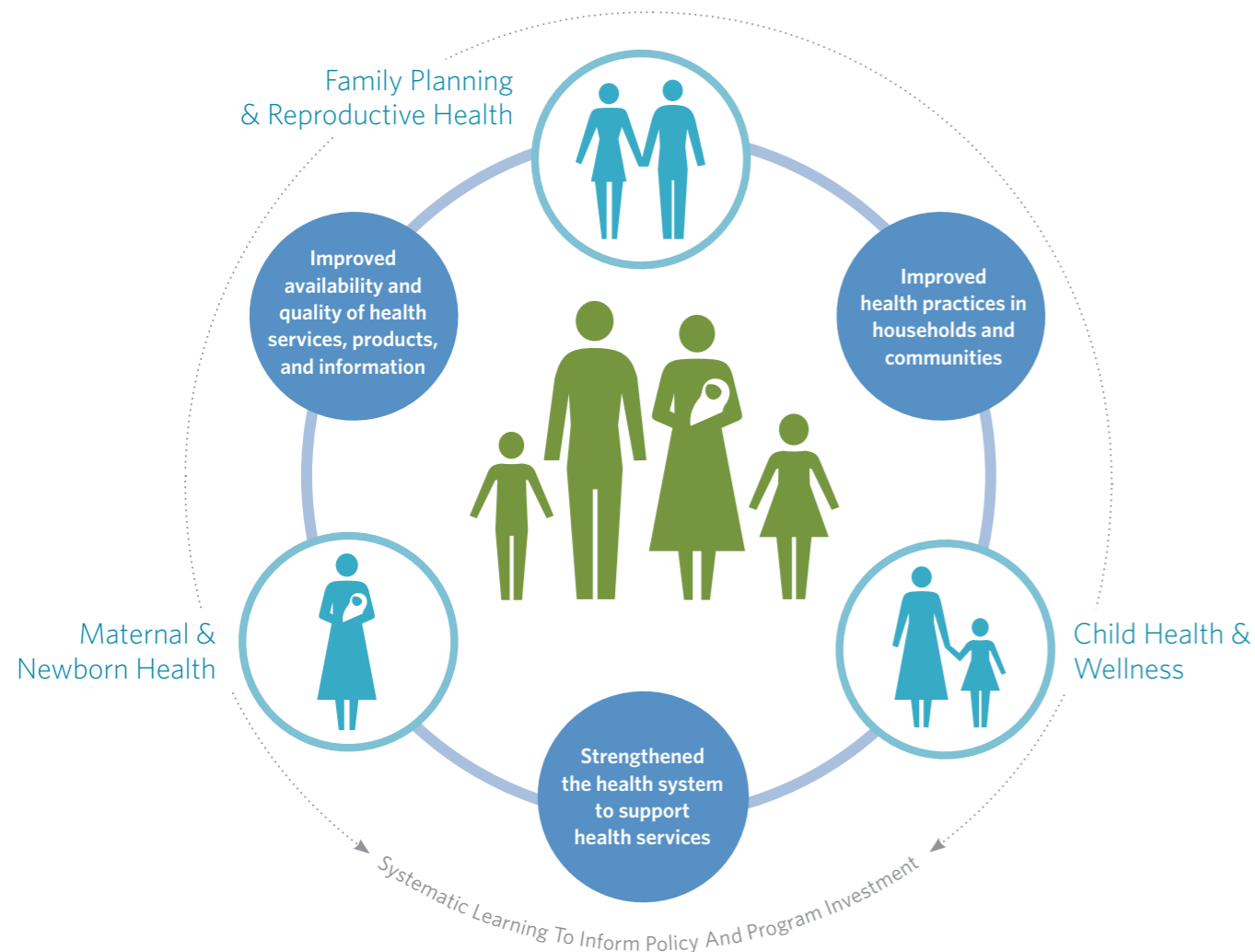
For the past eight years, millions of women, men, and young people throughout Ethiopia have been touched by the Integrated Family Health Program (IFHP), led by Pathfinder International and John Snow, Inc. (JSI), in partnership with the Federal Ministry of Health (FMOH), the Consortium of Reproductive Health Associations (CORHA), and other local partners, and funded by USAID and KOICA.

IFHP fundamentally changed the way families receive health services—moving from a siloed approach to health service delivery to an integrated one. In practice, this means that when one family member receives services, for example a child receives a vaccination, health workers also ensure that accompanying family members are also screened for any health services they might need, for example a mother who might need family planning services, antenatal care, or fistula care.

Integrating health services is easier said than done and requires a truly systemic approach to succeed. The diagram below gives an overview of the approach IFHP used with great success: strengthening the health system to support integrated services; improving the availability of quality integrated health services, products, and information; and improving health practices in households and communities. At every turn, IFHP applied program learning methods to improve and inform policy and program investments.

The following pages describe in detail how IFHP strengthened and integrated family health services by partnering closely with the FMOH, building capacity for a stronger, better trained, and more motivated health workforce, supporting the Health Extension Program, strengthening primary health care units, embracing the Maternal and Newborn Health Roadmap, and more.

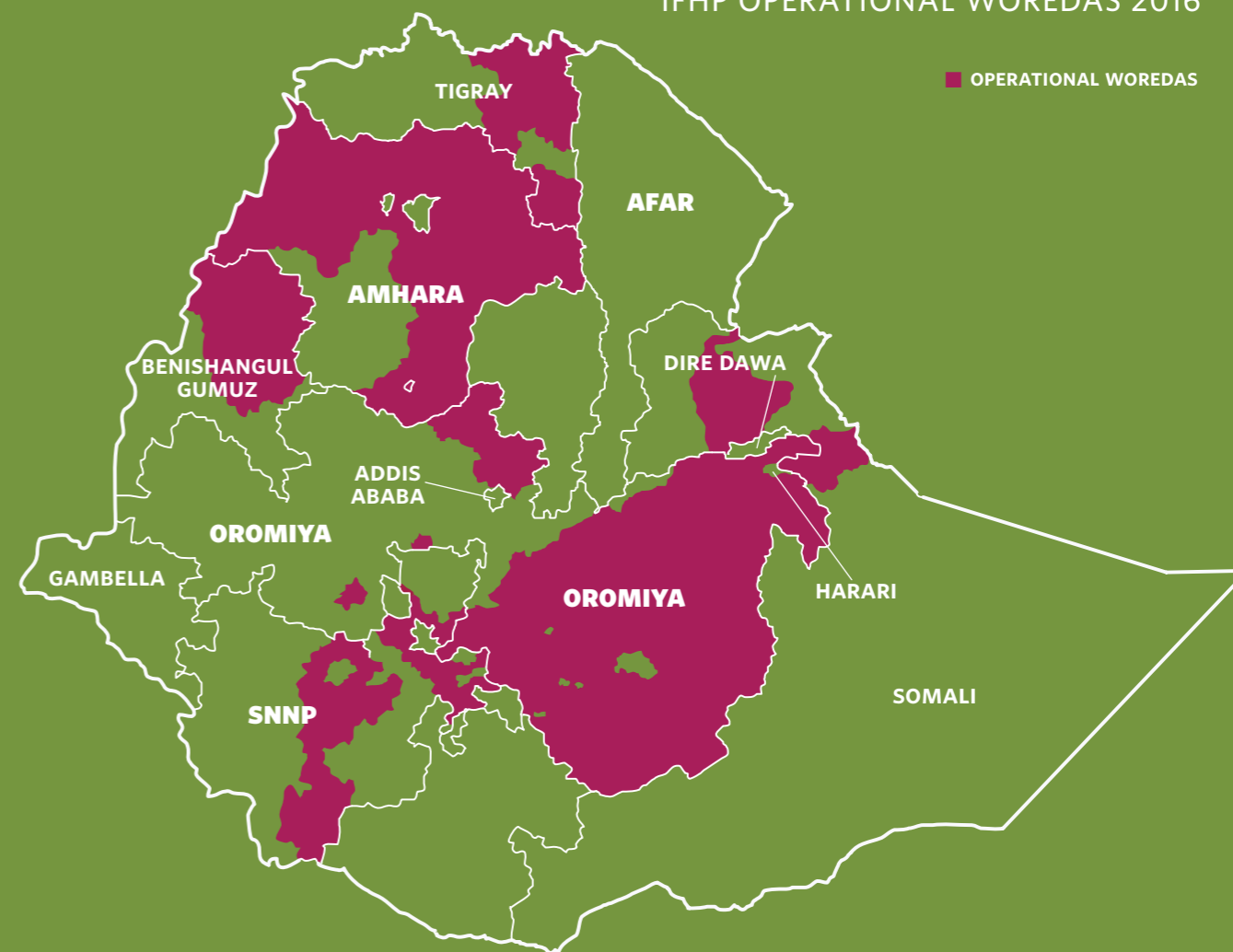
## INTEGRATED FAMILY HEALTH



# Reaching Families across Ethiopia

IFHP's physical reach was very large, operating in 301 woredas of Amhara; Oromia; Southern Nations, Nationalities and Peoples (SNNP); Tigray regions; and a few woredas in Benshangul Gumuz and Somali Regions. In addition to direct impact at the woreda level, through participation in numerous technical working groups and task forces and through planning and capacity building at the regional and national level, IFHP extended its influence and impact beyond specific intervention woredas.

## ETHIOPIA IFHP OPERATIONAL WOREDAS 2016



# The Results of IFHP

The success of IFHP hinged on improving health behaviors and increasing access to quality health services throughout a person's life. Integrated packages of evidence-based interventions were delivered across the continuum of care at family, community, and health facility levels—with amazing success.

At the community, Primary Health Care Unit (PHCU), woreda, and national levels, this program increased community awareness and utilization of family planning and reproductive health as well as maternal, newborn, and child health (MNCH) services and improved overall care.

As a result, communities are now better empowered to demand quality services. The program made significant effort to make the use of family planning a norm in the community—the family planning-focused interventions have generated more than 23 million couple years of protection. In so doing, more than 13 million unwanted pregnancies and nearly 65,000 deaths were averted during the program.

Through the early marriage prevention work, age at first marriage has increased from 16 years in 2009 to nearly 18 years in 2016 in IFHP-assisted areas. In addition, 6,390 women who were debilitated by obstetric fistula were identified, referred, and successfully repaired.

IFHP adolescent- and youth-focused interventions helped increase access to health-related information to more than 14 million young people. With the establishment of 248 youth-friendly services, 80 of which were with matching funds from KOICA, around five million youth and adolescents received sexual and reproductive health and other health services.

During the program period, over 200,000 pregnant women were tested for HIV and those found positive were linked to treatment services. Roughly the same number of women also received family planning services at different HIV service outlets.

Results in skilled maternity service uptake—including antenatal, delivery, and postnatal care—are encouraging. This is a major government priority under the Maternal and Newborn Health Roadmap. In 2008, only 7 percent of births were attended by a skilled provider, and antenatal care and postpartum care were sparse and inconsistent. Since then, more than 7.2 million women delivered with the assistance of skilled birth attendants. Close to four million women received at least one postnatal care visit. Two thirds of women in IFHP areas now seek prenatal care.

IFHP's child health interventions enabled eight million children and six million sick children to receive all doses of pentavalent vaccine, oral rehydration therapy (ORT), and other treatments—huge progress compared to 2008, when nutrition services were scarce at the health facility level. Around 30,000 children with severe acute malnutrition were treated, seven million children with malaria were treated, and 10 percent more children now sleep under insecticide-treated bed nets.

During the course of implementation, a team of multidisciplinary experts, called the Technical Advisory Committee, drawn from various ministries at the federal level and their regional counterparts, partners, and donors, oversaw the implementation of the program. The Committee reviewed and verified reports through regular field visits to health facilities, households, and individual clients. In so doing, IFHP not only harmonized and aligned its plan with government priorities, but also allowed its implementation to be closely monitored by the government. This improved understanding and support of various partners and government ministries. For many senior ministry personnel, Technical Advisory Committee visits are an invaluable opportunity to witness health work from the ground up.

Throughout implementation, IFHP strove to build capacity within the health system to independently plan and execute health programs. This included regular review meetings, development and implementation of integrated supportive supervision, specialized training in management, implementation of health information systems, and data for decision making.

IFHP was organized in a decentralized regional structure similar to that of the Ministry of Health. IFHP was unique in the depth and breadth of its coverage and hands-on technical assistance at the woreda and local levels. Its structure was one of the things which increased impact, because it was able to give ongoing and consistent technical support where it is needed most (i.e. the local level) and where managerial and technical capacity needed the most support. IFHP acknowledges the leading role of the government in these achievements and in their continued implementation. Together, the program's work and shared investments with the Federal Ministry of Health have significantly contributed to healthier Ethiopian families.

**TABLE 1: The following table shows trends of key performance indicators in IFHP-supported areas based on the results of IFHP's random follow-up visits. The visits are an internal program outcome monitoring innovation of IFHP to use with Health Management Information Systems (HMIS) data where possible and to inform timely action.**

KEY PERFORMANCE INDICATORS	2011	2012	2013	2014	2015	2016
<b>Family Planning</b>	<b>%</b>	<b>%</b>	<b>%</b>	<b>%</b>	<b>%</b>	<b>%</b>
Average number of additional children wanted by women of age 15–49 years	2.4	1.2	1.1	1.2	1.2	1.3
Women age 15–49 years who are currently using any family planning method	44.1	53.2	53.9	55.1	54.2	65.2
Women age 15–49 years who are currently using modern family planning method	40.1	50.3	49.7	50.9	53.8	55.6
<b>Maternal and Newborn Health</b>						
Mothers with children 0–11 months who had at least one ANC visit at health facility (Hospital/ HC)	-	39.8	53.8	65.2	75.5	80.2
Mothers with children 0–11 months who had four or more ANC visits at health facility (Hospital/ HC)	-	8.5	11.9	19.2	19.6	28.8
Children 0–11 months whose delivery took place at a health facility (Hospital/ HC)	-	13.3	25.7	50.6	63.1	66.4
<b>Child Health</b>						
Children 12–23 months who received Penta 3 vaccine	-	87.9	92.1	94	93.7	96.9
Children 12–23 months fully vaccinated	77	78.9	86.4	85.3	85.5	90.9
Children 0–23 months who had an illness with a diarrhea/ fever/ cough (incidence of illness)	32.5	29.1	27.3	26.1	29	26
Children 0–23 months who had an illness with a diarrhea/ fever/ cough and sought treatment in the last four weeks	56.6	55.6	58.9	67.3	67.6	74.3
Children 0–23 months who had an illness with a diarrhea/ fever/ cough and received treatment	96.3	97.5	94.4	97	89.8	95.3
<b>Gender</b>						
Mean age at first marriage (in years)	15.7	16.8	17.0	17.6	17.2	17.7
<b>Prevention of Mother to Child Transmission of HIV</b>						
Households whose Head of Household/ Spouse with knowledge of the means of transmission and ways to prevent HIV	91.4	94.8	94.9	96.5	94.0	96.6
Households with a person who was tested for HIV	59.0	75.3	78.2	82.6	79.0	83.3
Households with a pregnant woman in the past one year who tested for HIV during pregnancy	66.7	78.5	87.2	91.8	89.0	95.1
<b>Nutrition</b>						
Infants aged 0–5 months who were exclusively breast fed	57.7	72.7	79.2	84.6	81.0	84.6
Infants aged 0–5 months who started breastfeeding within one hour of birth	70.4	76.1	78.6	86.5	87.7	91.3
Infants aged 0–5 months who were fed the first milk (Colostrum)	77.8	82.5	81.6	89.2	88.1	94.4
Children aged 6–23 months who started complementary feeding at the age of 6 months	60.8	70.9	75.4	78.2	79.0	81.3
<b>Malaria</b>						
Households in malarious areas that have ITNs	80.9	78.7	81.6	73.8	63.3	90.6
Children 0–59 months who slept under a bed net last night (Among all children in malarious areas )	59.7	53.4	57.8	48.4	39.7	62.5
Children 0–59 months who slept under a bed net last night (among children in households found in malarious areas and who have bed nets)	72.9	67.9	71.4	65.2	62.8	68.4

(-) data was not collected during that year

IFHP's implementation had three major components:

- 1 Building human and institutional capacity to promote quality of care through need-based technical assistance, logistics and material support, training, and integrated supportive supervision;
- 2 Promoting positive health seeking behaviors; and
- 3 Working intensively in 11 thematic health areas to promote best practices and increase access and utilization of quality services.

## Implementation Strategies

Building the capacities of health workers and managers was one of IFHP's central activities. For health institutions to function effectively and efficiently, a well-trained and motivated health workforce must be educated, deployed, supervised, and appropriately utilized.

IFHP provided extensive training and training of trainers to health service providers, including health extension workers (HEWs) in the PHCUs supported by the program. IFHP's trainings initiated or expanded family planning and reproductive health and MNCH services, improved service quality and accessibility, and where possible, reduced costs. Over the life of the program, technical trainings improved knowledge, skills, attitude, and confidence of frontline and mid-level health professionals working in PHCUs.

Training and deploying staff is not enough to improve access and quality of services. Trained health workers also need continuous technical updates, a supportive working environment, and the necessary resources in place to deliver quality services. To make this a reality, IFHP supported continuous on-the-job skill and knowledge transfer to health workers; assisted with procurement of necessary materials, equipment, and supplies within PHCUs, woredas, and zones; and built the capacity of health managers and local leadership. This was accomplished through post-training follow-up visits, mentoring, provision of gap-filling start-up kits, materials, equipment and supplies, and regular integrated supportive supervision and performance review meetings.

Under IFHP, integrated supportive supervision became a fixture in areas where it worked, and a main focus for IFHP mentoring. The most important features of IFHP inputs were the use of its program staff for on-site support for continuous learning and quality improvement. Another major innovation was the concept of integrated supportive supervision. Instead of the former costly and time-inefficient system of doing supervision on a single technical area at a time, IFHP worked with the Ministry of Health to introduce integrated supportive supervision, jointly conducted with the public sector staff. Use of checklists ensured coverage of main areas and helped assess health care system bottlenecks, mobilize local resources, and strengthen the buildup of public sector program ownership of IFHP's interventions. Oral and written feedback was an essential part of the supervision, given in a constructive way. Findings from supervision visits were discussed during quarterly performance review meetings.

IFHP and other partners supported quarterly review meetings both technically and financially over the life of the program. Over time, these gatherings became an important capacity building tool for health providers and managers. Performance review meetings, which used data for decision making, served to evaluate performance, share program implementation experience, provide technical updates, and inspire improvements.



*Training and deploying staff is not enough to improve access and quality of services. Trained health workers also need continuous technical updates.*



# Family Planning & Reproductive Health

Women who have access to family planning services are empowered to make lifesaving choices such as delaying motherhood and avoiding unintended pregnancies. IFHP supported the health system in the provision of quality reproductive health and family planning services, with a focus on long-acting reversible contraceptives. Since 2008, there are now more than 17 million new family planning acceptors in IFHP-supported areas.

The Ministry of Health launched their Implanon scale-up program in 2009 to make Implanon, a long-acting family planning method, available at the community level through task shifting by training HEWs. (Before this, HEWs did not provide any long-acting methods.) In 2010, noting the use of the intrauterine contraceptive device (IUCD) was too low despite a high unmet need, the Ministry of Health launched a national initiative to revitalize IUCD as part of a balanced method mix.

As a major family planning partner to the Ministry of Health, IFHP became involved in both the Implanon and IUCD scale-up programs—mainly in the training of HEWs on Implanon insertion,

capacity building of health center staff on IUCD, post-training, and gap-filling provision of supplies and consumables.

IFHP also initiated postpartum IUCD (PP-IUCD) services

in 2012 in 17 health centers already providing IUCD services. Facilitators were trained to roll out the training to health service providers at health centers. Now, more than 70 health facilities provide PP-IUCD in IFHP-supported areas.

IFHP built the capacity of health workers and health facilities through the provision of trainings and gap-filling post-training consumables and supplies. The program uses the Ministry of Health's standard training manuals. Following the trainings, IFHP conducted onsite mentoring and follow-up visits to build the knowledge and skills of PHCU staff. Review meetings, organized by the public sector, were used to review performance, provide updates, and ensure sustainability of the program. The program also used innovative strategies such as the backup support to avail a mix of family planning methods at the community level. Through the backup support, trained health workers stationed at health centers provide long-acting family planning methods at the health post level, which HEWs are not normally trained to do.

## Expanding Options to Meet Demands for Family Planning Services



For more than a decade, Sister Belyu Shale has worked at the Sagure Health Center in Oromia. "I have been providing family services for four years," she reports. "Before I received training from IFHP, no one at the health center had the skills to insert or remove IUCDs." Preventing pregnancy for up to 12 years, the IUCD is an excellent option for many women and girls. "Before my training, we could only provide Implanon, injectables, pills, and condoms," Sister Belyu says.

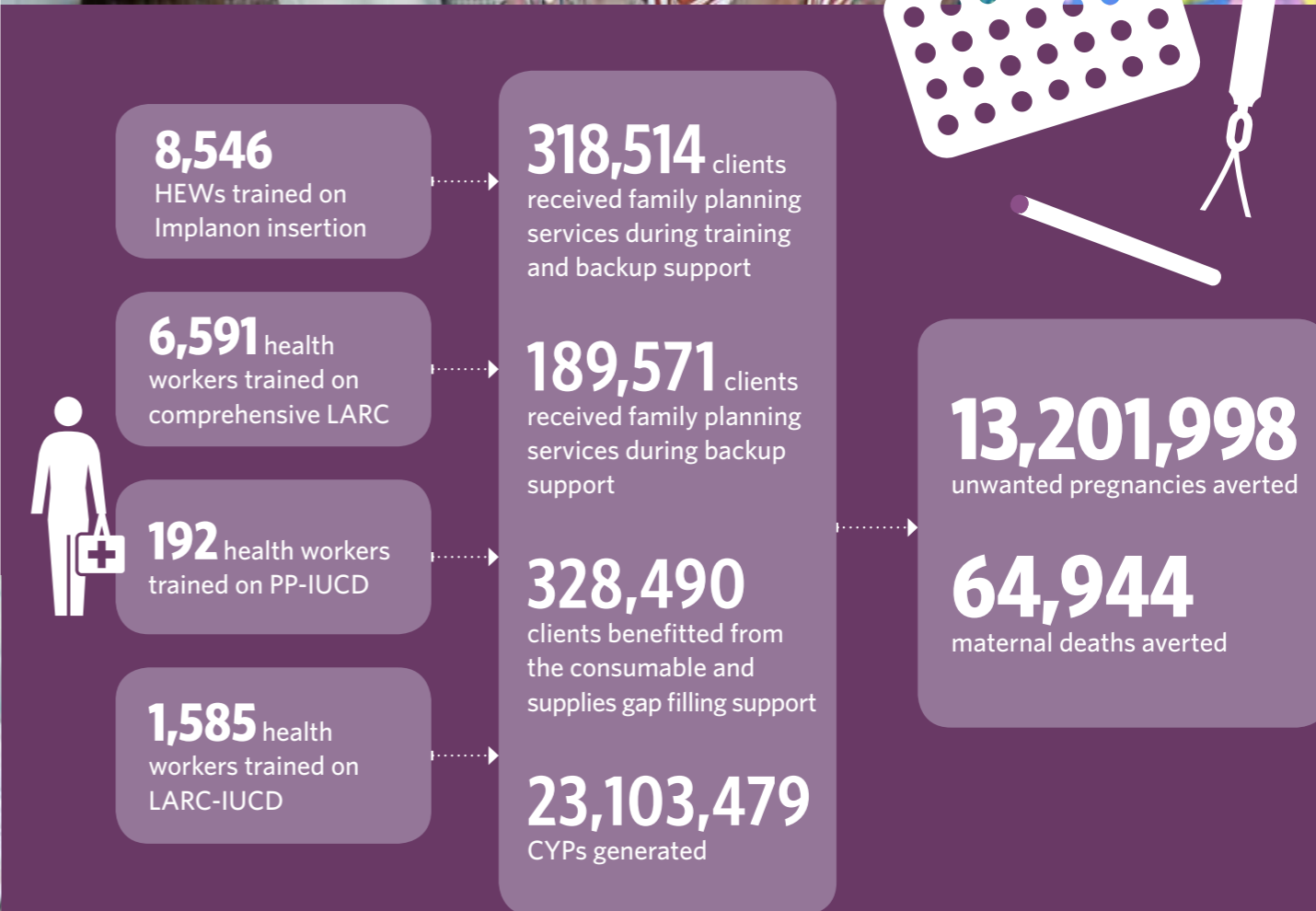
IFHP trained at least two staff at each health center in Digalo Tijo woreda—including Sagure Health Center. The training helped providers expand the reach of family planning beyond the health center. "The health workers are

not limited to facility-based services. They also support health posts to reach women with contraceptives that can't be provided by HEWs," says Abayneh Tesfaye, head of the woreda's health office. "Because of this, use of IUCDs is improving steadily."

In 2010, only 57 clients were using IUCDs—but last year alone, 1,431 women in the woreda received IUCD services.

One of these women is Constable Addis Ashime, a 25-year-old policewoman who received her IUCD from Sister Belyu. "My job as a policewoman puts me on duty during evenings and holidays, and I already have a 1-year-old child," she explains. "My husband, also a policeman, works in another town, 75 kilometers away. Taking care of one child is a challenge already. So, I decided to get an IUCD to delay my next pregnancy."

Across four regions, IFHP has provided IUCD training for more than 2,250 health workers. "We are making a difference," says Sister Belyu, "one woman at a time."



# Maternal & Newborn Health

A major health challenge in Ethiopia—and one of the highest priorities of the government—is reducing maternal and newborn mortality and morbidity. Most maternal and newborn deaths occur during labor, birth, and the first 24 hours following birth. Many of the key interventions known to avert these deaths depend on the availability of a skilled care provider. Skilled care during pregnancy, labor and delivery, and the postnatal period is highly determined by the presence of competent health care workers. Thus, improving the quality of maternity services and increasing skilled delivery has become a cornerstone of the government’s Maternal and Newborn Health (MNH) Roadmap.



The IFHP team joined the Ministry of Health to implement the roadmap. With a central aim of improving access, quality, and utilization of skilled maternity care (antenatal, delivery, and postnatal care), IFHP focused resources on addressing the three delays in: 1) seeking care; 2) reaching point of care; and 3) initiating appropriate and quality treatment.

IFHP’s interventions were implemented in two phases. The first was learning and implementation of interventions in selected woredas; then technical and material support was rapidly expanded to additional woredas. Throughout the two phases, IFHP approached improving maternal and newborn health with a comprehensive, integrated, and evidence-based approach. IFHP played an important role in the Maternal and Newborn Health Task Force and thus evolution and promotion of basic emergency obstetric newborn care (BEmONC), essential newborn care (ENC), community-based newborn care (CBNC), and family-centered maternity care.

A baseline assessment and subsequent assessments in the selected learning woredas informed IFHP’s strategy for maternal and newborn health interventions: training health care providers (e.g., BEmONC); improving health facility readiness (e.g., providing essential equipment, drugs, and supplies); targeted demand creation; and assisting PHCUs to promote respectful maternity care by welcoming families and implementing culturally appropriate care (e.g., with post-delivery coffee ceremonies). Operations research was conducted to test innovative ideas and approaches. One of IFHP’s proudest achievements was the initiation of systematic clinical mentoring following BEmONC training. Experience has shown that this step is essential in cementing knowledge and

## Making the Right Choice

Until just a few years ago, pregnancy in Dejen woreda came with serious risks. The community is located in difficult topography with limited medical care, and women typically delivered at home. Most would only come to the health center if they faced major problems—and by then it was often too late.

After a comprehensive maternal and newborn health intervention that aimed to change the community’s health-seeking behavior and improve providers’ skills and knowledge, the situation is changing: more women are seeking care for themselves and their newborns.

Semegn Shiferaw, 24, has experienced the comprehensive maternal and newborn health approach first-hand. She received antenatal care during her pregnancy and was attended by a skilled birth attendant at Woyra Health Center during her delivery—and she made these choices after talking with HEWs at her local health post.

“I decided to deliver at the health center because the traditional birth attendants do not wear gloves and I feared I might contract HIV,” Semegn explains. “I am happy that I went to the health center. The midwives are very kind. When I told them I did not want to deliver on the delivery couch, they assisted me in a squatting position. My baby and I are very healthy and I know I made the right decision.”

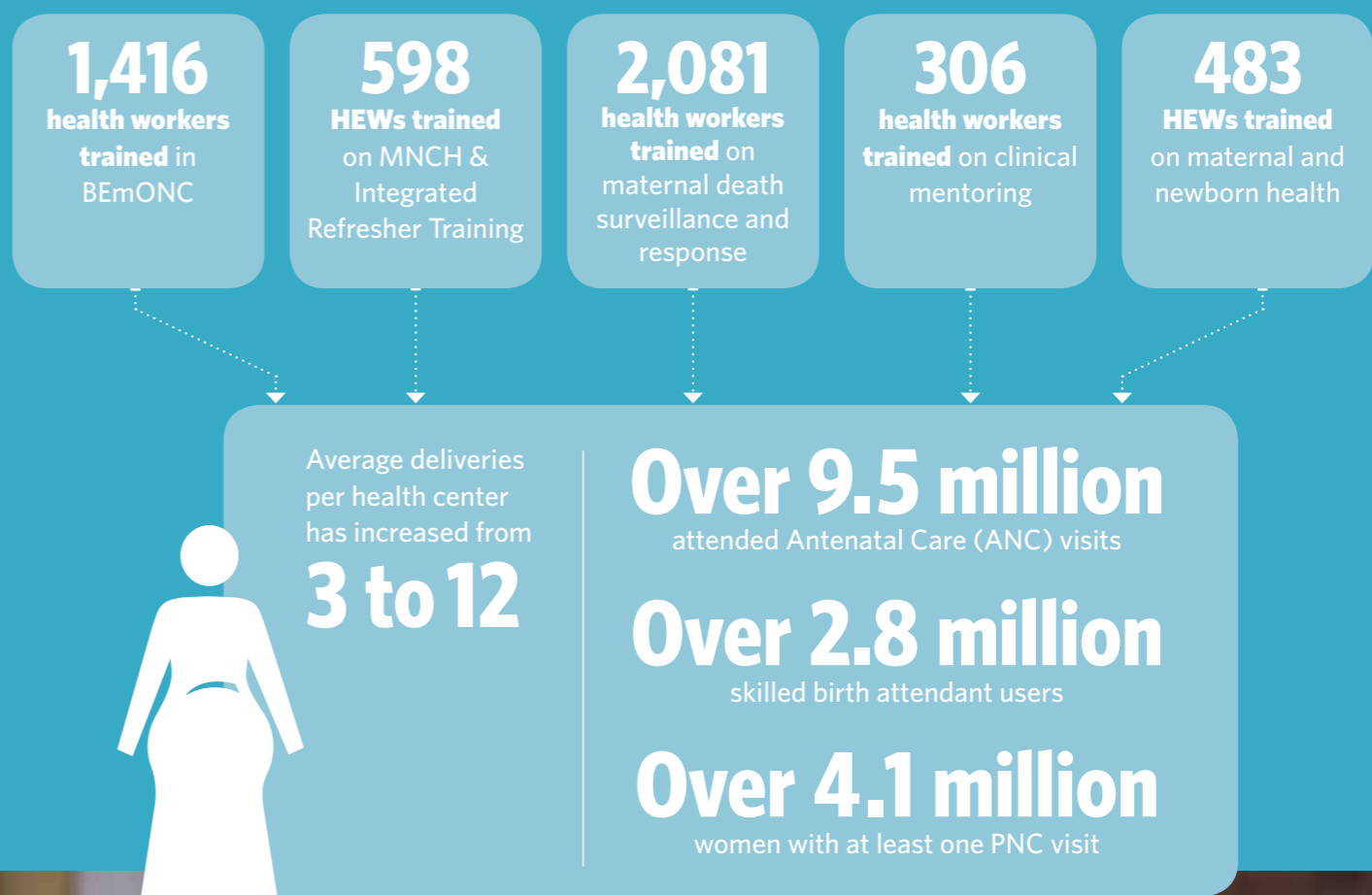
Since giving birth, Semegn has become involved in community health through the women’s meetings in her kebele. The women gather to observe religious holidays and to discuss skilled birth attendance, birth preparedness, and issues related to pregnancy. The women also contribute five birr each per month to assist pregnant women in their community.

“We can play a role in the health of women in Dejen woreda by sharing our knowledge,” says Semegn. “We can help them protect themselves and their children.”

mentoring newly-trained PCHU staff to apply experience in attending to complicated cases.

The IFHP team worked with other Maternal and Newborn Health Task Force Members and the Ministry of Health to introduce and subsequently improve its BEmONC training model, which was the basis for expansion to scale. Subsequently, IFHP has informed recommendations on shorter training, and more efficient and cost-effective care.

IFHP also participated in country-wide efforts to improve CBNC through the Health Extension Program and utilizing HEWs and the Health Development Army to make timely postnatal care visits and initiate rapid care when needed.





# Child Health and Expanded Program of Immunization

IFHP joins the Ethiopian government in celebrating reduced child mortality in Ethiopia and supports making child survival interventions sustainable.

Integrated Management of Neonatal and Childhood Illnesses (IMNCI) was a key intervention for IFHP which, if well implemented, ensures the greatest reduction of mortality in children. In 2009, as part of a comprehensive IMNCI approach, integrated community case management (iCCM) of childhood illnesses was introduced. iCCM extends treatment to the health post level through trained HEWs. IFHP responded to the Ministry of Health's request for rapid expansion of iCCM by providing training and other support to HEWs in 300 focus woredas.

Roll-out of iCCM presented challenges, particularly low uptake at the beginning. Throughout the life of the program, IFHP monitored and refocused efforts. When data showed ORT use was low, staff worked with woreda management to improve supply chain and with HEWs to promote ORT corner use. IFHP learned that child

survival interventions, though evidence-based and simple, take constant vigilance to achieve the desired results. Newborn deaths now contribute to the majority of under-five mortality in Ethiopia. A Community-based Newborn Care (CNBC) program was initiated by the government, and

IFHP took part in training of HEWs to treat newborn sepsis within their communities.

Immunization is another area where constant vigilance is needed to see progress. IFHP undertook capacity building of expanded program of immunization (EPI) managers, health workers, and HEWs. IFHP collaborated with UNICEF and other partners to develop EPI in-service training materials and trained health workers in basic EPI services. Preventive refrigerator maintenance training was also undertaken, and even IFHP drivers were trained to do their part. The program has also participated in national immunization campaigns, including measles supplementary immunization activities, polio, routine immunization activity, and enhanced outreach strategy. Country-, regional-, and cluster-level IFHP offices provided technical and logistic support to the campaigns. IFHP worked with woredas to monitor vaccination rates.



## Saving Children's Lives: Making Services Available at a Walking Distance

For most of Ayelech Kakabo's life, she's seen her neighbors in Walana village face many hardships. "When a child got sick we would put him on a wooden cot and carry him on our shoulders," she recalls. "It is a day's journey by foot to reach Hosanna Health Center. We would have to stay at a relative's house for days until the child finished treatment." Because the journey was so difficult, she explains, the villagers would often try to treat sick children at home instead. "We tried to help them with what we learned from our forefathers."

Degefech Ayana and Tigist Abuha are HEWs at Walana Health Post. They have been helping the community for the last five years. But until this year, they didn't have the training or medicine to treat serious illnesses like malaria and pneumonia. "It was terrible to be able to do nothing for a desperate mother with a sick child," says Degefech. "When we couldn't help the sick child other than referring them to distant health centers, the community could not trust us."

Those days are over. A year ago, IFHP organized training for HEWs in collaboration with Kembata Tembaro Zonal Health Department and woreda health offices. During the training, the HEWs learned how to identify, classify, and treat sick children with symptoms of malaria, pneumonia, diarrhea, and malnutrition.

Frenesh Meseret, 25, has two children. "Two months ago, my daughter Eyerusalem was very sick; she had fever and was not eating anything," Frenesh says. "I took her to the health post; the health extension worker told me it was malaria. She gave me medicines and explained to me how to give the medicine to my daughter. By the time I went for the second appointment, my daughter had already recovered from her illness. She was eating, playing, and laughing."

Ayelech Kakabo knows that until this year, such a happy ending for Frenesh and Eyerusalem might not have been possible. "Because help is closer to home now, things are easier," Ayelech says. "In the old days, it would have been very difficult and the outcome could have been different."



IMNCI:  
**4,193**  
health workers  
trained

iCCM:  
**17,575**  
HEWs and health  
workers trained



EPI:  
**7,172**  
people trained

CBNC:  
**4,305**  
HEWs trained

**2,780**  
refrigerators  
repaired

**14,250**  
foam pads  
distributed

**2,725**  
sets of ORT corner  
materials distributed

### CLASSIFIED AND TREATED

**293,548** children with pneumonia

**479,360** with diarrhea

**167,136** with malaria

**31,804** sick young infants

**2,096** cases of newborn sepsis

### VACCINATED

**9,014,341** children with Penta 1

**8,480,716** children with Penta 3

**8,390,157** with measles

### CHILDREN FULLY VACCINATED

**7,695,838**

### CHILDREN PROTECTED AT BIRTH

**5,927,979**



# Adolescent & Youth Reproductive Health

A third of Ethiopia's population is young. As adolescents transition from childhood to adulthood, they enter a pivotal development period. Their decisions and the decisions made for them by others substantially influence their well-being and future life. Stigma associated with sexual and reproductive health, providers who refuse to offer those services to young people due to their age or marital status, and services that fail to provide privacy and confidentiality to adolescents often result in poor sexual and reproductive health service uptake among young people. This in turn contributes to poor sexual and reproductive health outcomes.

Since 2008, IFHP has been working to improve the ability of youth to make informed reproductive health decisions by providing enhanced information, education, and behavior change communication interventions. The program, together with the Ministry of Health, established and supported the functionality of youth-friendly services (YFS) within the public health facilities and university clinics. Moreover, IFHP worked to improve the policy environment and the capacity of the youth and youth associations to plan, implement, and evaluate youth programs.

The approach applies an ecological model, addressing the individual, societal, and structural determinants of adolescent and youth sexual and reproductive health service utilization. At the individual level, the YFS approach increases knowledge and skills among young people through training peer educators. The trained peer educators provide sexual and reproductive health information to their peers. In addition, YFS providers are trained to provide comprehensive information during clinic visits. At the societal level, the approach emphasizes fostering an enabling environment for young people by sensitizing community members and health facility staff—including guards, receptionists, and health facility heads—on the importance of YFS in improving sexual and reproductive health service utilization among young people. The establishment and provision of YFS through public health facilities addresses the structural component of the ecological model. In order to position YFS for scale-up and increase sustainability, IFHP's YFS have been implemented in close cooperation with the Ministry of Health and its regional structures.

## Reaching Young People with Youth-Friendly Services

If you're a teenager in Kombolcha, chances are you know Solomon and Hirut—and you love them.

In this rural town 548 kilometers east of Addis Ababa, talking about sex is taboo. Since parents won't discuss it, young people are left uninformed. As a result, many teenagers become unintentionally pregnant or contract sexually transmitted infections, including HIV.

But this has begun to change. At the newly-established YFS unit at Melka Fura Health Center, nurses Solomon and Hirut provide sexual and reproductive health information and services to

suicide.' Luckily, the laboratory test was negative—she was not pregnant! I counseled her and gave her contraceptives."

These days, teenage girls are no longer afraid to come to the health center. "Young people come straight to the YFS and get the services they want without fear. They also get information about the YFS from peer educators," says Hirut, who was trained through IFHP.

Before the project, most health facilities treated young people like adults, and services were not sensitive to their needs. Providers weren't trained in working with youth, and young people were afraid of the stigma they would face if they sought information or services.

"Unless you handle young clients in a friendly manner and with the assurance of confidentiality, you cannot tackle their problems," says Solomon. "IFHP's training has helped me a lot in this regard."



young people. They also recruit, train, and deploy peer educators.

"One day, before the YFS was established, a 16-year-old girl burst into my office and whispered that she wanted to talk to me in private," Hirut remembers. "She was almost too afraid to speak. She told me she was pregnant, and she pleaded for termination. If I wouldn't help her, she said, 'I will commit

In collaboration with the public health system, IFHP has established 248 YFS facilities in the Amhara, Tigray, Oromia, SNNP, Beneshangul, and Somali regions of Ethiopia. This has increased access to sexual and reproductive health services for millions of young Ethiopians.

For Solomon and Hirut, every day brings new opportunities. Together, they're helping the young people of Kombolcha break down taboos and make informed choices for a healthier future.



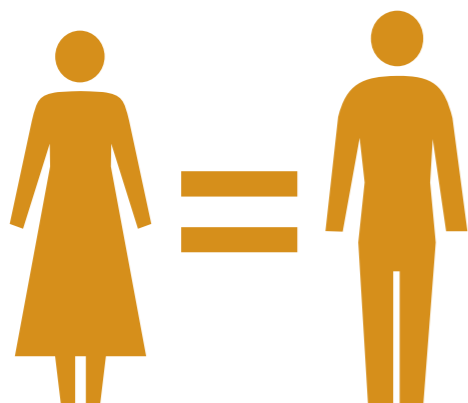
# Gender

Gender is recognized as one of the key social determinants of health. Evidence consistently shows that socially constructed values, norms, attitudes, and practices related to gender determine positive or negative health outcomes. Ethiopia displays relative gender disparities in access and utilization of health, education, and other services. Women and girls—because of their relatively low social and economic status—are vulnerable to different health problems throughout their lives. Among other things, harmful traditional practices like female genital cutting and child marriage significantly affect women's and girls' health and overall wellbeing.

IFHP has been supporting gender mainstreaming across all of its thematic area interventions. It has worked with the Ministry of Health in the development of a national gender mainstreaming manual and trained health service providers in gender mainstreaming. The program has also been supporting the health sector to provide gender responsive services.

IFHP's gender work focused on training health workers and health managers on gender mainstreaming at all levels of the health system. The program's gender activities also included sensitization of HEWs and religious and community leaders on gender and harmful traditional practices. In addition to providing technical support to the Ministry of Health and the Ministry of Women, Children, and Youth Affairs, IFHP supported and strengthened early marriage cancellation committees at zonal, woreda, and lower levels.

One of the maternal health problems that manifests as a result of gender disparities is obstetric fistula. IFHP has technically and financially supported the identification, referral, and transportation of women with obstetric fistula to repair centers, and their reintegration back into their families and communities. IFHP has also trained health care providers at health centers in fistula diagnosis as a strategy to decrease non-relevant referral to fistula treatment centers. Additionally, as a member of the National Fistula Taskforce, IFHP has contributed to the development, launching, and dissemination of the Plan of Action to Eliminate Fistula by 2020.



## Ending Fistula and Transforming Lives: Restoring the Health and Dignity of Women Devastatingly Injured in Childbirth



Neges Mesfin's eyes tell her story: a story of pain and sorrow endured for years. When she was just three years old, her parents pre-arranged her marriage, in accordance with the culture of her village in the Amhara region. But as she grew up, Neges knew she wanted to finish her schooling. She wanted to delay her marriage.

To her community, Neges's rebellion was seen as disrespectful. Her parents began to mistreat her, and beating became a daily experience. "Eventually, I was unable to resist the pressure. I discontinued my education and submitted to their will," remembers Neges.

At 15, Neges married according to her parents' arrangement, and she immediately became pregnant. "When the time came, I labored at home for three days," she tells us.

Although she delivered a healthy baby, Neges passed out and awoke in terrible pain, sick and with an unpleasant discharge leaking from her birth canal.

"My mother and my father were wretched when they saw what had happened to my body," says Neges. "At first, I totally excluded myself

from social life. Some people talked about me in the village, saying 'she stays in bed most of the time and pees on her bed like a baby.'"

With tears in her eyes, Neges says, "I lived with this problem for 28 years until one day I heard life changing news. I saw a film in our kebele about women who had problems exactly like mine. I was happy to see women like me and above all to learn that the problem could be treated. I also learned then that the problem is called 'fistula.' I contacted the people who showed the film and with their support travelled to Gondar Referral Hospital for treatment."

IFHP has provided training on gender issues, harmful traditional practices, and obstetric fistula to Women, Children, and Youth Affairs Office's staff—and conducted workshops for community leaders. The workshops dispel stigmatizing beliefs and help participants identify and refer suspected cases for treatment.

Now 49, Neges has become a fistula ambassador. "So far, I have identified and accompanied eight suspected fistula cases to Gondar Referral Hospital. Five were diagnosed as having fistula and successfully repaired. Recently I identified another four women that I will soon accompany to hospital," she says proudly. "I thank my husband who has been with me during those trying times. He equally suffered the pain I went through. It is now four years since I got my problem solved and I feel as if I have been reborn."

Thanks to Neges, many more women will have that chance, too.



**ACHIEVEMENTS:**  
**6,738** obstetric fistula cases identified and referred

**823** legal bodies and practitioners **trained on gender, gender-based violence, and harmful traditional practices**

**21,512** early marriages deferred or cancelled

**2,768** health service providers **trained on gender mainstreaming** in health

**8,518** religious and community leaders **trained on gender, harmful traditional practices, and gender-based violence**





## HIV & AIDS

### Ensuring Access to Contraception for Women Living with HIV: A “One-Window” Service Approach

Abebech Reta was a 20-year-old newlywed when she and her husband, a widower named Tesfaye, both got sick. “At first I thought it would pass. Then I started to worry that I was bewitched,” she remembers. “None of the traditional healers could help me, so I went to the Fiche hospital.”

The nurse gave her devastating news: she was HIV positive. “I was shocked,” says Abebech. “I lost hope.”

Abebech had always dreamed of being a mother. “But the nurse told me that my health status was not good enough to become pregnant,” she recalls. “She advised me to delay the pregnancy until I got my health back.”

Abebech began HIV treatment at the hospital and was referred

transmission of HIV. To date, IFHP has trained more than 1,500 health professionals and helped over 250 health centers provide integrated services. Debretsigie is one of them.

While her health improved, Abebech chose to use injectable contraceptives and condoms. Then, with support from facility staff, she was able to proceed with her plans for pregnancy. Today, she is the proud mother of an 18-month-old boy. He is free from HIV.

“I am so happy to have a child,” says Abebech, smiling. It’s been six years since her diagnosis. “We do not plan to have any more children for the time being. I am using injectable contraceptive and condoms to delay my next pregnancy, as I did before the first one.”

IFHP ensures that women like Abebech can access equitable, efficient, stigma-free, and sustainable healthcare. “We have benefited from this very important intervention,” says Dr. Shemelis, the director of Debretsigie. “Our health providers received training; our health center has also received job aids and family planning commodities. We are now able to provide family planning and HIV services together for our clients.”

For Abebech, the integrated program has made all the difference in the world. “I know I have a future, and I can watch my son grow up healthy,” she says. “My hope has returned.”

One of the strategies to ensure the achievement of ending mother-to-child transmission of HIV by the year 2015 is implementation of Option B plus approach: test and treat all pregnant mothers.

IFHP supported this strategy by implementing prevention of mother-to-child transmission of HIV (PMTCT) in 82 facilities and family planning-HIV integration in about 200 health facilities in line with the government’s guidelines and strategies. In addition to participating in national PMTCT-related activities, IFHP’s support focused on strengthening the capacity of staff in regional health bureaus, zonal health departments, woreda health offices, and health care providers including HEWs. IFHP also supports clinical mentorship, PMTCT outreach services, technical assistance to catchment area review meetings, and gap-filling commodity and consumable support. The program supported the integration of family planning in HIV service delivery points and at voluntary testing and counseling (VCT), PMTCT, and antiretroviral therapy (ART) clinics.

IFHP focused on strengthening and consolidating the integration of family planning into HIV service delivery points through training health care providers on family planning counseling, service provision, and referral to reach HIV positive people with contraception. Health service providers were trained to provide PMTCT services. The program supported health centers to provide backup PMTCT services, rendered by health center staff at the health post level, enabling pregnant women in rural areas to access PMTCT service within their reach. In addition, IFHP provided mentoring, post-training follow-up, and review meetings to ensure service quality and continuity.



for further treatment at the Debretsigie Health Center.

In 2009, IFHP began establishing programs that could provide HIV and family planning services under one roof. These programs empower women to prevent unintended pregnancy and prevent mother-to-child

**212,609**  
pregnant women tested for HIV during ANC



**214,944**  
women and men received FP methods at VCT and ART clinics. 122,334 (57%) of them were HIV negative

**64,940**  
partners of tested women were counseled

**63,820**  
partners of tested women were counseled and tested



**1,630**  
health workers trained on FP/HIV integration

**1,373**  
health workers trained on PMTCT



# Reducing the Burden of Malaria

Malaria is a leading cause of morbidity and mortality in many developing countries. In recent years, Ethiopia has witnessed a significant reduction in the number of malaria cases, mainly because of the prevention and control measures taken at the community level. IFHP, as a key partner of the Ministry of Health, supported scale-up of proven approaches in malaria control since 2008.

The major strategy of IFHP has been building the skills of health workers and HEWs in malaria case management and epidemic detection and response. Activities included integration of malaria prevention and case management into MNCH; community mobilization; building the technical competency of frontline health workers—particularly HEWs—through training on iCCM; and epidemic monitoring. The program also supported the public sector in the distribution of long-lasting insecticide-treated bed nets and indoor residual spraying to control malaria.



## Keeping the Insects Off: Using Insecticide-Treated Nets and Managing the Environment to Stay Healthy

Workiye Mihiret and Tenaw Teshome are a young married couple in Abaye Terra kebele in Amhara. As with most recently married couples, they want to have children—but they worry deeply about malaria.

Workiye herself survived repeated episodes of malaria: “When I had fever, I used to go to Arbaya Health Center or Abaye Terra Health Post for treatment.”



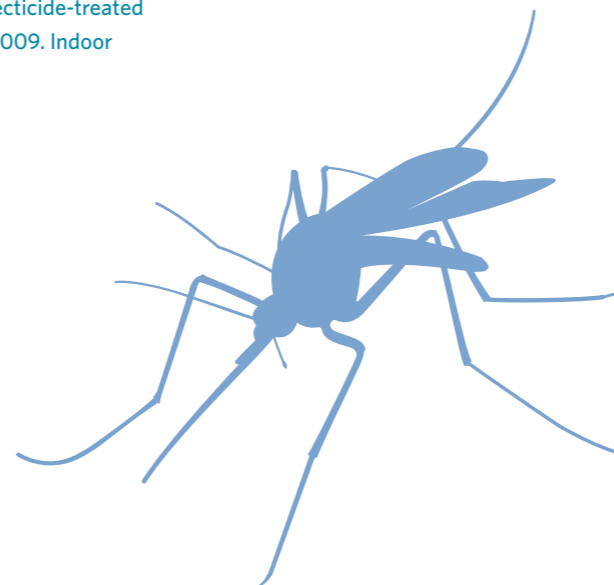
IFHP trained HEWs and health center staff in this woreda on how to test malaria and treat positive cases, as well as the prevention and management of malaria as part of the training on case management of childhood diseases. Start-up kits including anti-malaria drugs and consumables were provided following training.

“For many years, malaria was the number one killer in our woreda,” says Ato Tigabu Melkam, a nutrition and child health service officer and former head of the woreda health office. “We have distributed over 140,000 long-lasting insecticide-treated bed nets since 2009. Indoor

residual spray is now used and water pockets are drained in the malarious kebeles in the woreda.”

Looking at the malaria monitoring chart on the walls of the woreda health office tells the story. One can see a sharp decline in the number of malaria cases over the years.

“Since I started to use a bed net, I neither had illness due to malaria nor heard a person die of the same cause,” says Workiye.



## ACHIEVEMENTS

**34,433**

health workers and HEWs trained on malaria prevention and case management

**27,011**

health workers and HEWs trained on community mobilization and behavior change

**1,572,697**

children under five received artemisinin-based combination treatment

**6,865,788**

people 5 years of age and older received artemisinin-based combination treatment





## Nutrition

IFHP is a leader in promoting improved maternal and child nutrition, mainly through behavior change interventions. IFHP has worked closely with the Ministry of Health in developing capacity in nutrition, which includes nutrition education materials used for achieving the national nutrition program targets. The first National Nutrition Strategy was launched in 2008 and the second in 2015. The main focus of the strategy is the integration of nutrition education into the Health Extension Program. Accordingly, the major entry point for IFHP has been to work with HEWs to strengthen MIYCF. Because they work at the community level, the Health Extension Program and Health Development Armies represent a unique opportunity for nutrition messages to reach each and every household in the country.

Since 2010, IFHP collaborated with the Alive & Thrive project, funded by the Gates Foundation. This collaboration focused on stunting reduction through the promotion of appropriate community-level MIYCF practices. Behavioral change communications in nutrition heavily emphasized the promotion of complementary feeding. Demonstration of complimentary food preparation at community and household levels was heavily promoted. At the same time, IFHP and Alive & Thrive conducted sensitization sessions and trained health managers.

Through a WHO-funded project called Accelerating Nutrition Improvements, IFHP worked on the reduction of stunting among children under five and iron-deficiency anemia among adolescent girls. Accelerating Nutrition Improvements activities underscored the fact that adolescent nutrition is a neglected area which needs more emphasis.

### Seeing is Believing: Demonstrating Complementary Food Preparation to Reduce Child Malnutrition

In Dilla Zuria woreda in SNNP, children often suffered from malnutrition—but the problem was not lack of food.

Mothers in the woreda would often transition their babies to solid foods before they were six months old. With families selling most of their produce at the nearby market, their diets lacked variety—and for babies, there simply weren't enough nutrients for them to grow and thrive. "In 2012 alone," reports Andualem Mamo, head of Chichu Health Center in Dilla, "15 children, on average, were admitted every quarter for intensive care and rehabilitation."

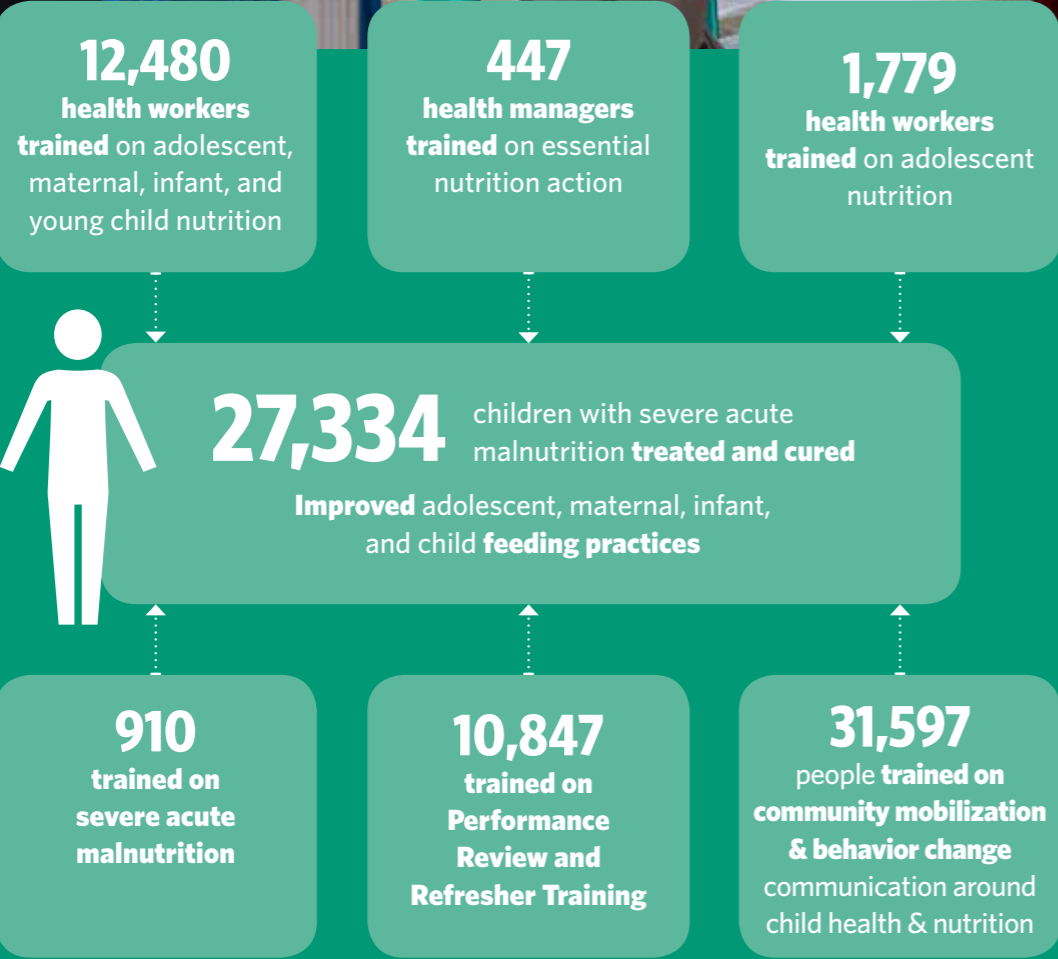
To reverse the situation, IFHP provided nutrition training to HEWs and other staff. After the training, these health workers began educating mothers on proper feeding practices. Using locally available foods, the health workers demonstrated healthy food preparation and discussed the value of breastfeeding. Families took part in roleplaying scenarios and took a tour of the health center's vegetable garden.

"The activities help people understand that they can prepare complementary foods with what they already have, and that it's very important for their children's health," says

Andualem. "Community health workers have played a big role in helping mothers learn how to prepare foods that have the nutrients their children need. We hold these demonstrations as often as we can, and we have them on vaccination days, when many people visit the health posts. In this way, we make sure the practice reaches more and more people."



A year after this intervention started, malnutrition in the area dropped markedly. "In 2013, the number of children admitted to the health center for severe malnutrition decreased significantly," Andualem says. "Only 4 were admitted. And while in 2012, more than 80 children had to be enrolled in the outpatient therapeutic program, in 2013, the number has been reduced to 15. We are highly encouraged by these results and are committed to continuing the interventions."



# Community Mobilization & Behavior Change

IFHP's community mobilization and behavior change intervention built the capacity of the public sector and implementing partner organizations to effectively and efficiently work on improving household and community health-seeking behavior.

The interventions targeted the Health Extension Program to improve health practices at household and community levels. The community mobilization and behavior change activities aimed for:

1. establishing family planning as a culture and community norm;
2. increasing knowledge and awareness on the benefits of preventive and promotive health practices;
3. increasing recognition of illness, malnutrition and other maternal and child health complications; and
4. increasing timely and appropriate health care seeking behavior.

In order to reach these expected results, IFHP applied the following strategies: supporting the Health Extension Program to implement the model family program, supporting HEWs to mobilize communities, implementing comprehensive behavior change strategy, reinforcing and disseminating key messages through multiple channels, strengthening public sector's capacity for community mobilization and behavior change leadership, and fostering interpersonal communication and community dialogue.

These strategies were used to systematically address household and community norms and behaviors that hinder service utilization or appropriate health care seeking.



## Serving My Peers, Serving My Community: Using Radio to Reach Larger Audiences

"Hey! This is FM 105.2 and I am your host Mikias from your mobile studio," says a boisterous voice over the radio. Mikias, a peer educator in Wondo Secondary and Preparatory School of Aleta Wondo town, introduces the next song, and a stream of sweet local music comes over the airwaves.

Mikias is one of 15 peer educators trained by IFHP at his school of more than 3,000 students. As a group, they use morning and afternoon breaks to share health messages through an in-school FM radio station invented by Tsegazeab, a fellow peer educator. The students and the local community tune in to the program using mobile phones and radios. The producers also use the school's megaphone to reach students who don't have mobile phones.

"Most students in the school have limited knowledge on sexual and reproductive health issues," says Tsegazeab. "There are also misconceptions concerning pregnancy and HIV and AIDS. As a peer educator, this is worrisome."

So one day, I asked myself, 'Why don't we create a radio program to help reach students with health information?' I started to refer to different sources to learn about FM transmission and finally came up with this small device. I made it from scraps and secondhand radio parts," he says proudly.

His efforts won him recognition award during Young Students' Scientific Innovation Contest by the regional education bureau.

Peer educators at the school educate and counsel fellow young people on a variety of sexual reproductive health issues: family planning, unwanted pregnancy, sexually transmitted infections, HIV, and substance abuse, among others. The peer educators also refer their colleagues to receive youth-friendly services at a nearby health center.

IFHP provides five days of basic training to the peer educators, and then the program follows their performance and provides them with refresher training once a year. IFHP has trained more than 22,994 peer educators in Amhara, Tigray, Oromia, SNNP, Benshangul Gumuz, and Somali regions.

"The training helped me improve my confidence and develop self-esteem," says Tsegazeab. "Serving my peers gives me great satisfaction."

And he hopes the program continues. "We are about to complete high school," he explains. "We need to have successors. The peer education activities should not be discontinued."



# Strengthening the Health System for Better Outcomes

The foundation of sustainable improvements in MNCH is an efficient and effective health system. Low health system capacity is an underlying problem threatening Ethiopia's short-term health gains. Consequently, health system strengthening is a major pillar of IFHP's work.

The IFHP approach to strengthening health systems includes addressing key constraints related to health workers' staffing, infrastructure, health commodities, or logistics (such as equipment and medicines); tracking progress through routine HMIS and community health information systems; and effective financing and proper governance.

Training of health managers was a focal point of IFHP's efforts: technical and financial support was provided to the Ministry of Health and its regional structures (Regional Health Bureaus, Zonal Health Office, Woreda Health Offices, and PHCUs). Capacity building heavily emphasized ensuring quality of care, utilization of existing basic services, and sustainability planning. As PHCUs increasingly became the focus of primary health care services, IFHP provided management strengthening support. The program also partnered with the public sector to ensure consistent and quality follow-up visits, integrated supportive supervision (ISS), and impactful performance review meetings. Using data for decision making (UDDM) was incorporated at all levels and into all training and supervision efforts. In promoting data for decision making, use of HMIS, and evidence, IFHP coordinated its efforts with other partners to maximize resource utilization.

## Using Performance Data to Inform Decision-Making in Soro



Two years ago, Ebenezer Bekele's hometown of Soro was the least performing woreda in the Hadiya Zone.

When IFHP offered trainings on using data for decision making, it began to turn around. "The training we received on how to use our performance data was an eye opener," remembers Ebenezer, head of the Woreda Health Office. "We knew very little about using our own data to identify gaps and propose solutions. Our decisions were usually arbitrary and based on anecdotes."

Use of data for decision making refers to the collection and analysis of various types of data to help improve the success of the health sector. Health systems require quality data from health information systems to ensure that the workforce is fully funded and equipped with the necessary commodities, infrastructure, resources, and policies.

"Now, we are completely data-driven," Ebenezer says proudly. Every side of the wall in his office is filled with graphs and tables, reflecting plans and achievements of the office. "We get information at arm's length for our day-to-day decisions. One of the major challenges to use the data was its lack of timeliness, accuracy, consistency, and completeness. But the woreda health office has managed to improve all these challenges.

"The improvement in this woreda was due to frequent integrated supportive supervision and follow-up at all levels," Ebenezer confirms. Data handling has improved thanks to standardized supervision practices. Supervision is conducted on a regular schedule with written and oral feedback given to supervisees. Performance data is collected, monitored, and reviewed regularly. Reports are sent in a timely manner, and there is continuous follow-up and performance auditing.

Ebenezer is thankful for the training on data for decision making. "It is a great help for us. This year we won a recognition award from the Regional Health Bureau for our outstanding performance. Now we are on the top of the list."





# Learning to Inform Policy & Program Investment

To improve program coverage and quality on a continuous basis, IFHP became a learning organization. Gaining information and experience from program implementation, synthesizing model practices, conducting operations research, and sharing and applying the lessons learned was the IFHP pathway to improving program coverage and quality.

In so doing, IFHP has contributed to the evolution of Ethiopia's health programs and evolving national health strategies. IFHP underscores the need for decision-makers, health professionals, communities, and program staff to participate fully in acquiring and sharing knowledge based on experience of what works and what does not. Systematic program learning also provided a platform for creating visibility and awareness about the different activities of IFHP and contributing to policy dialogue.

To implement and prioritize program learning as a central IFHP objective, the program carefully documented its successes and challenges. Various operations research studies were conducted and findings were shared widely. The results of some of the studies were published in peer-reviewed journals (local and international) and made available to policy and decision-makers. Different program- and research-based oral and poster presentations were made during

national and international conferences. In so doing, the program's experiences were shared with national and international audiences. Several promising practices were identified and some of them were recognized nationally. Program learning evidences were used to inform program decisions and actions.



IFHP collaborated with religious leaders to bring change on the perception of modern family planning among leaders. In this regard, a milestone achievement has been made in bringing the Ethiopian Islamic Affairs Supreme Council from a censorious

position to an advocate of modern family planning, which ultimately led to fatwa declaration (religious ruling). The declaration approves the use of modern contraceptives with the exception of permanent methods. Similar work has been done with the Ethiopian Orthodox Church and other religious leaders to promote the reproductive health of mothers and children.

***IFHP has contributed to the evolution of Ethiopia's health programs and evolving national health strategies.***



## Challenges

Despite the remarkable achievements of IFHP, there were challenges along the way. These challenges can be viewed at different levels: system, service, and community.

**SYSTEM LEVEL:** Despite efforts to institutionalize management standards (ISS, performance review meeting, UDDM & HMIS, and woreda-based planning) within the public health system, there is no consistent commitment and ownership of the management standards across the woredas supported by the program. Some woredas failed to prepare budgeted plans and retain trained staff for the implementation of the standards using locally available resources.

Frequent stock-outs of drugs, equipment, and supplies affected the continuity and quality of the family planning and reproductive health and MNCH services. In this regard, there were shortages of HIV test kits, infection prevention materials, some family planning methods, laboratory reagents, and essential maternal and newborn health supplies and equipment.

Lack of continuous follow-up erodes achievements attained. For example, ensuring cancelled marriages stay cancelled was a challenge as it needed continuous follow-up. Even if there are improvements over time, the recording, reporting, and use of data for decision making has a long way to go. The HMIS also does not capture some program activities, such as gender and youth-friendly services.

Identifying program lessons, documenting, and sharing them is nothing without the application of this knowledge. Application of knowledge requires breaking away from traditions and trying something new. This has not been an easy task to implement, monitor, and evaluate.

**SERVICE LEVEL:** Service-level challenges emanate from the point of service delivery or health facilities. Meeting the service quality expectations of communities has always been a challenge. Attrition of trained staff, high workload, varying level of staff motivation and wrong recruitment, training, and deployment of staff have been affecting the availability, accessibility, and quality of family planning and reproductive health and MNCH services.

**COMMUNITY LEVEL:** Even if different barriers that affect service uptake have been reduced through targeted and context sensitive IEC/BC interventions, challenges remain that prevent communities from fully utilizing the services available. Lack of partner

involvement, difficult topographies, transportation problems, myths, misconceptions, and economic and social barriers have all affected the uptake of family planning and reproductive health and MNCH services. Even today, despite huge progress, there is still some practice of child marriage and female genital cutting in very rural kebeles.

Difficult terrain, lack of roads and transportation, and scattered settlements affect communities' treatment-seeking behavior and access to quality services. For example, identifying and referring women with obstetric fistula for treatment is challenging because of the topography—it limits access to treatment services in remote and distant areas.

## Lessons Learned

Throughout implementation, IFHP has been a learning program, continuously documenting lessons learned and sharing and applying them to improve the program.

The most important lesson is that a comprehensive, integrated approach addressing both the supply and demand side of the health system—targeted demand creation, training health care providers, improving facility readiness, supporting the referral network, and strengthening the health system—is essential to improved access to quality family planning and reproductive health and MNCH services.

We have seen that disseminating context-sensitive health messages via appropriate selection of channels is important in creating demand. In this regard, empowering community structures and key gatekeepers, such as community and religious leaders, is critical in achieving meaningful changes in social norms and values.

However, demand creation alone is not enough without making quality services available and accessible. Continuously improving providers' skills—through training, task sharing, regular clinical mentoring, and follow-up—plays a key role. Besides trainings and follow-up, providing demand-based and gap-filling supplies helps ensure continuity of services. Conducting program-specific follow-up and review meetings also helps identify bottlenecks, provide updates, transfer skills, and solve problems encountered during implementation. Use of HMIS registers at all IFHP-supported sites increases compliance, ownership, and data quality. The innovative approaches such as the backup service increase service coverage, access, and opportunity to reach communities that do not usually come to health facilities.

Implementing an effective program requires collaboration and partnership at different levels. The success of our program mainly hinges upon our close partnership and collaboration with the Ministry of Health and its regional structures. The partnership stretched from joint planning during woreda-based planning, through implementation, to monitoring and evaluation. Similarly, the potential of bringing multi-level stakeholders together in areas like gender, adolescent and youth reproductive health, and nutrition has returns. A strong partnership with the Ministry of Health and its regional structures and other ministries not only helped synergize IFHP's efforts but also solicited the necessary buy-in needed to implement and sustain the interventions.



## Acronyms

<b>ART:</b>	Antiretroviral Therapy
<b>BCC:</b>	Behavior Change Communication
<b>BEMONC:</b>	Basic Emergency Obstetric Newborn Care
<b>CBNC:</b>	Community-based Newborn Care
<b>ENC:</b>	Essential Newborn Care
<b>EPI:</b>	Expanded Program of Immunization
<b>FMOH:</b>	Federal Ministry of Health
<b>HC:</b>	Health Center
<b>HEW:</b>	Health Extension Worker
<b>HMIS:</b>	Health Management Information System
<b>ICCM:</b>	Integrated Community Case Management
<b>IEC/BC:</b>	Information, Education and Communication/ Behavior Change
<b>IFHP:</b>	Integrated Family Health Program
<b>IMNCI:</b>	Integrated Management of Newborn and Childhood Illnesses
<b>ISS:</b>	Integrated Supportive Supervision
<b>IUCD:</b>	Intrauterine Contraceptive Device
<b>JSI:</b>	John Snow Incorporated
<b>KOICA:</b>	Korea International Cooperation Agency
<b>MIYCF:</b>	Maternal, Infant, and Young Child Feeding
<b>MNH:</b>	Maternal and Newborn Health
<b>MNCH:</b>	Maternal, Newborn, and Child Health
<b>MNH:</b>	Maternal and Newborn Health
<b>ORT:</b>	Oral Rehydration Therapy
<b>PHCU:</b>	Primary Health Care Unit
<b>PMTCT:</b>	Prevention of Mother-to-Child Transmission of HIV
<b>PNC:</b>	Postnatal Care
<b>PP-IUCD:</b>	Postpartum Intrauterine Contraceptive Device
<b>REACH:</b>	Reflection and Action for Change
<b>SNNP:</b>	Southern Nations, Nationalities, and Peoples' Region
<b>SRH:</b>	Sexual & Reproductive Health
<b>UDDM:</b>	Using Data for Decision-making
<b>VCT:</b>	Voluntary Counseling and Testing
<b>YFS:</b>	Youth-friendly Services



**USAID**  
FROM THE AMERICAN PEOPLE

**E2A** EVIDENCE TO ACTION  
for Strengthened Reproductive Health



## For further information:

### **Integrated Family Health Program**

Tel: +251 11320 3501 Fax: +251 11 320 3572

Nefas Silk Lafto Sub City Woreda 03

Del Gebeya Area, Addis Ababa, Ethiopia