PATHFINDER INTERNATIONAL TECHNICAL BRIEF

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STRENGTHENING HEALTH SERVICE DELIVERY IN ETHIOPIA: THE INTEGRATED FAMILY HEALTH PROGRAM

The USAID-funded Integrated Family Health Program (IFHP) is jointly implemented by Pathfinder International and John Snow, Inc. (JSI), in collaboration with local implementing partner organizations. IFHP supports the government of Ethiopia (GOE) to implement an integrated service delivery model to improve family planning and maternal, newborn, and child health in rural and hard-to-reach communities. IFHP's geographic coverage encompasses 40 percent of the population living in the four major regions of Amhara, Oromia, Tigray, and Southern Nations, Nationalities, and People's Region (SNNPR), and to a lesser extent in Benishangul Gumuz and Somali.

Reflecting on the last five years of implementation, this technical publication shares how IFHP—guided by the government's vision for improved service delivery—has mobilized drivers for systems strengthening by prioritizing community needs and facilitating informed decision making. As a result of the support, IFHP has improved access, coverage, and quality of health services at the community and household levels.

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JSI John Snow, Inc.

Integrated Family Health Program

E2A EVIDENCE TO ACTION for Strengthened Reproductive Health

Ethiopian Context

Ethiopia has a population of approximately 88 million, more than 80 percent of which lives in rural areas.[1] In 2003, the government introduced the Health Extension Program (HEP), a community-based health service delivery program, to improve primary health care at the community level and meet the needs of the country's largely rural population. To date, the HEP has deployed over 34,000 rural health extension workers (HEWs) across the country to deliver an integrated health care package and increase service utilization. As a result of this government investment, Ethiopia decreased its child mortality by two-thirds between 2000 and 2011 (from 77 to 31 deaths per 100 births) and increased the use of modern contraceptive methods among currently married women (from 6.3 percent to 40.4 percent) between 2000 and 2013.[2]

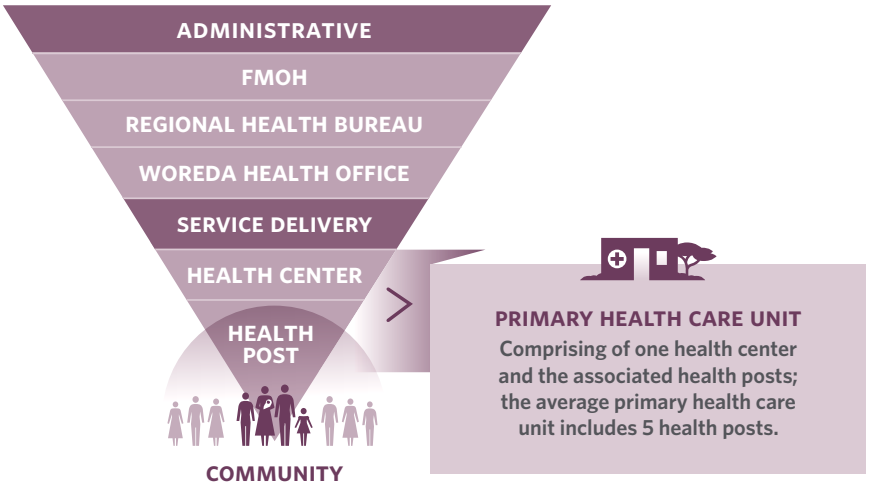

FIGURE 1: THE ETHIOPIAN HEALTH SYSTEM. *Health posts staffed by HEWs are the lowest levels of primary health care in the health system. At the national level, the FMOH oversees health services across the country. Regional health bureaus oversee health administration at the zonal (sub-regional) level, followed by woredas at the district level.*

The Integrated Family Health Program has supported the implementation of the HEP since 2008, and provides support to 300* woreda/district health offices (WorHOs) covering more than 1,200 health centers and over 11,000 HEWs. During implementation, IFHP has prioritized community needs and capacitated HEWs to act as the connecting bridge between the community and the health system. (See Figure 1 for an illustration of levels of the Ethiopian health system, including the primary health care unit level at which IFHP operates, and community.) This approach has contributed to an increase in the availability and quality of family planning and maternal, newborn, and child health services, products, and information in Ethiopia.

IFHP's Systems Strengthening Approach

Given the scale of coverage, the range of technical areas, and the varied levels of health system and community actors involved, implementation of the HEP is a complex task. To create an enabling environment for implementation and manage this complexity, in partnership with the GOE, IFHP uses an integrated systems strengthening approach that considers the linkages, relationships, interactions, and behaviors that contribute to improving health outcomes during program design and implementation.[3,†]

This approach uses "systems thinking"[‡] to support implementers' investment in improving the interactions between the community and health system. The integrated approach expands the capacity of informed, competent, and accountable stakeholders in both systems in order to manage the complexity of implementation.

This document focuses on three drivers (illustrated in Figure 2) that have built and sustained the needed momentum for improved community and health system interactions under IFHP: 1) a shared vision among implementers and governments; 2) informed decision making and feedback loops for learning; and 3) the prioritization of community needs to ensure relevant programming. The following sections illustrate how IFHP has incorporated these drivers and facilitators into its implementation.

Drivers for Systems Strengthening

Sharing the government's vision

The GOE is committed to improving health outcomes, and the progress Ethiopia has made in advancing toward its health targets and the Millennium Development Goals[§] can be attributed to strong political will and leadership. IFHP shares the government's vision, and works at all levels of government — federal, regional, zonal, and woreda — to support smooth implementation.

All of IFHP's work follows the Federal Ministry of Health's (FMOH) vision, from the federal level down to the community. At the federal level, IFHP engages with stakeholders through: providing technical assistance to the FMOH on policies and guidelines; furnishing inputs on strategic initiatives; participating in technical working groups; and contributing to national strategies. (IFHP has provided input to working groups for gender and health, family planning, safe motherhood, adolescent and youth reproductive health, child health, prevention of mother-to-child transmission of HIV [PMTCT], and malaria, and to national strategies for family planning, gender, reproductive health, and child health.) IFHP then aligns its implementation at the community level with woreda annual workplans and national policies, under the guidance of the Regional Health Bureaus.

* The number of woredas supported by IFHP has changed over the course of implementation due to GOE restructuring.

† IFHP's approach builds upon the World Health Organization's (WHO) health systems strengthening framework (widely recognized as a guide for working with national health systems) and engages the community as an active contributor to health outcomes rather than a passive participant in health service delivery.

‡ Systems thinking is an approach to problem solving that views problems as part of a wider dynamic system.

This close relationship and technical partnership allows IFHP to facilitate the alignment of objectives at the national and sub-national levels. Through supportive supervision and mentorship, IFHP builds HEW supervisors' and the WorHOs' capacity to operationalize the government's vision, as well as to manage their own teams, which enhances health workforce performance and follow through. Each of these investments contributes to the reinforcement of the GOE and IFHP's shared vision for health services throughout the primary health care unit level and into the community.

Informed decision making and feedback loops

When implementing a complex project with a scope as large as IFHP, having access to the right information to facilitate decision making is an essential driver for success. Therefore, IFHP has worked with government health program managers to improve their capacity to conduct operations research and analyze data to inform planning and mark progress over time.

In 2011, IFHP partnered with Addis Ababa University's School of Public Health to train 24 Regional Health Bureau and IFHP staff on conducting exploratory and diagnostic research. The training was practice based, requiring participants to apply what they learned by conducting five studies. The results informed program implementation and are under final review with the peer-reviewed *Ethiopian Journal of Health Development*.[4] The capacity to conduct and analyze research has been invaluable to understanding trends in service use and ensuring relevant programming approaches.

IFHP has also implemented a program monitoring system that uses random follow-up visits to strengthen delivery of its own programs. The random follow-up visits were inspired by the GOE's quality improvement routine follow-up visits, which IFHP supports by helping to build the supportive supervisory skills of WorHO managers and by enhancing their performance in review meetings.[5] The random follow-up visits are a unique program management mechanism that uses a project-developed checklist to collect generalizable, unbiased data annually to facilitate monitoring of program outcomes at the household, community, health post, health center, and WorHO levels. The initiative uses a random sampling methodology, which is a rigorous means of tracking changes in quality and outcome indicators, allowing for unbiased results that have been compared and used for program decision making from year to year within each region and across the entire program area.

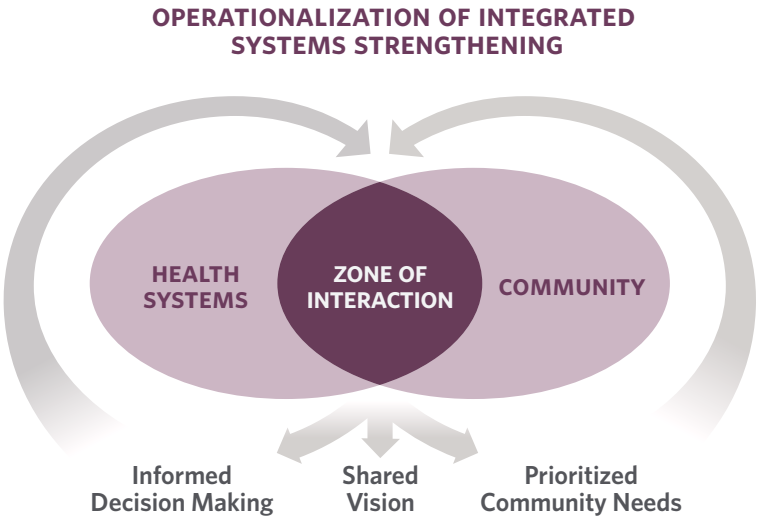

FIGURE 2: *Through Pathfinder's integrated systems strengthening (ISS) approach, a zone of interaction is established that enables communities and health systems to work together to achieve a shared vision, ensure informed decision making, and prioritize community needs. In turn, these drivers play a key role in sustaining the ISS.*

The tools capture a wealth of information about the intermediate outcomes of IFHP support, including client perspectives on HEW performance, experiences with coordination between HEWs and community-based volunteers, and challenges in the kebele/community and health facility. IFHP's frontline program staff use this information to assess program quality at the WorHO level and address challenges in a systematic way.

Prioritizing community needs

An essential consideration in large-scale project management is the relationship between clients and the health system, as it is not possible to affect health outcomes without the uptake of healthy behaviors and health services by the community. IFHP has made a concerted effort to prioritize community needs in programming and views the community as partners, which has created the necessary environment for increased service uptake.

An example of IFHP's prioritization of the community is evident in the maternal and newborn health (MNH) initiative, which sought to address the slow uptake of skilled birth attendance. (Only 14.5 percent of births are attended by skilled health personnel.)[6] To address this challenge, IFHP brought community members and leaders, local health administrators, and providers together to identify barriers that were preventing women and their families from accessing skilled birth attendance. As a group, the team identified barriers such as facilities' lack of space for overnight stay and their reluctance to permit clients' inclusion of traditional practices during or after birth. See Figure 3 for a breakdown of IFHP's core strategic steps for the MNH initiative (figure source: JSI).[7]

Once these community concerns were identified, stakeholders brainstormed ways to eliminate them. As a result of this partnership, IFHP-supported health facilities combined funding from woredas with funds generated by out-patient fees to build rooms in the facilities to accommodate mothers and families who travel long distances. They also allocated resources to accommodate the making of traditional porridge *(genfo)* and cultural customs such as coffee ceremonies during delivery at health center level.

[§] The United Nations (UN) Millennium Development Goals are eight goals that UN Member States have agreed to try to achieve by 2015.

MATERNAL AND NEWBORN HEALTH CORE STRATEGIC STEPS

STEP 1	Build buy-in at woredas level: Present the strategy and package of interventions at Woreda Health Offices to ensure ownership of the program
STEP 2	Strengthening human resources for MNH at health centers: Train health center health professionals in BEmONC, PMTCT, and postpartum family planning—including quality assurance
STEP 3	Ensure essential MNH commodities: Ensure medical equipment, drugs, as well as clinical protocols and guidelines are available at health centers.
STEP 4	Community sensitization at woreda and kebele levels: Bring together community leaders, local health administrators, and health providers to identify barriers that may prevent women and families from accessing skilled birth attendance and suggest solutions to bridge those gaps.
STEP 5	Strengthen HEW capacity to delivery MNH services: Train and mentor HEWs in antenatal care, birth preparedness, danger signs, essential newborn care and newborn resuscitations postnatal care, infection prevention, and healthy timing and spacing of pregnancy.
STEP 6	Formalize and strengthen linkages between health posts and health centers to ensure the continuum of care at Primary Health Care Units and to improve the referral system.
STEP 7	Synchronize behavior change activities and demand creation with availability of MNH services: Implement behavior change activities only when there are trained providers and facilities have necessary supplies on hand.
STEP 8	Monitor progress and provide continuous support for MNH by strengthening the availability and adequate use of information at all levels of the health system.

FIGURE 3: *IFHP's framework for a comprehensive approach to MNH interventions*

The consideration of client needs and prioritization of community perspectives was complemented by training health professionals and midwives in basic emergency obstetrics and newborn care (BEmONC), PMTCT, and postpartum family planning, as well as by building awareness in the community about changes in the facility. As a result of this prioritization of community needs, IFHP's endline assessment has shown an increase in deliveries attended by skilled health personnel from 6.5 percent to 36 percent between 2008 and 2013.[8]

Conclusion

All three of the above drivers are critical enablers of the health system and have contributed significantly to sustaining and strengthening health service delivery. By creating an environment where the end user takes priority and informed stakeholders are working toward a shared goal and give feedback for midcourse corrections, IFHP created the necessary synergies that have helped bring the country closer to its goal of improving health outcomes and increasing access to primary health services among its largely rural population.

[1] Central Statistical Agency [Ethiopia], *Population Projection of Ethiopia for all Regions at Woreda Level from 2014-2017* (Addis Ababa: 2013).

[2] Central Statistical Agency [Ethiopia] and ICF International, *Ethiopia Demographic and Health Survey 2011* (Addis Ababa and Calverton, MD: Central Statistical Agency and ICF International, 2012); Central Statistical Agency [Ethiopia], *Ethiopia Mini Demographic and Health Survey 2014* (Addis Ababa: 2014).

[3] Don De Savigny and Taghreed Adam (eds.), *Systems Thinking for Health Systems Strengthening* (Geneva: WHO, 2009).

[4] Pathfinder International, *Introducing Operations Research to Large-scale Program Implementation in Ethiopia* (Watertown, MA: Pathfinder International, 2013).

[5] IFHP, *Outcome Monitoring in IFHP Target Areas using Data from Random Follow-up Visits* (Addis Ababa, 2011).

[6] Central Statistical Agency [Ethiopia], *Ethiopia Mini Demographic and Health Survey 2014.*

[7] IFHP, *Saving Maternal and Newborn Lives in Ethiopia* (Boston: JSI, 2012).

[8] IFHP, *Endline Assessment* (Addis Ababa: 2014)

ABOUT THE PROGRAM: The Integrated Family Health Program (2008–present) is a USAID-funded program that supports the GOE's integrated model to strengthen voluntary family planning, reproductive health, and maternal, newborn, and child health services. IFHP assists in the provision of services covering 40 percent of the country, in the four major regions of Amhara, Oromia, Tigray, and Southern Nations, Nationalities, and People's Region (SNNPR) and, to a lesser extent, in Benishangul Gumuz and Somali regions. The program is jointly implemented by Pathfinder International and John Snow, Inc., in collaboration with local implementing partner organizations.

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COVER: Follow-up visit at household level Bambiko Kebele, South Gondar, Amhara Regional State PHOTO: Abiy Mesfin