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Promising Practices in Maternal and Newborn Health and Family Planning and Reproductive Health in Ethiopia in 2012

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Abbreviations and Acronyms

ANC	Antenatal Care
ART	Antiretroviral Therapy
BEmONC	Basic Emergency Obstetric and Newborn Care
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
EDHS	Ethiopian Demographic and Health Survey
EmONC	Emergency Obstetric and Newborn Care
ESOG	Ethiopian Society of Obstetricians and Gynecologists
FMOH	Federal Ministry of Health
HEW	Health Extension Workers
HSDP	Health Sector Development Plan
IBP	Implementing Best Practices
IFHP	Integrated Family Health Program
IMC	International Medical Corps
MCHIP	Maternal and Child Health Integrated Program
MDG	Millennium Development Goal
MNH	Maternal and Newborn Health
MWA	Maternity Waiting Area
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission of HIV
RHB	Regional Health Bureau
SAA	Social Analysis for Action
SBM-R	Standard-Based Management and Recognition
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

Executive Summary

In Ethiopia, the Federal Ministry of Health (FMOH)promotes the identification, documentation, and dissemination of information on effective interventions that can be scaled up to improve the provision of quality maternal and newborn health and family planning and reproductive health services for the reduction of maternal and newborn morbidity and mortality in Ethiopia.

The Ethiopian health sector is guided by an equity-focused, positive policy environment that prioritizes the reduction of the country's high rate of maternal and newborn morbidity and mortality. Huge investments have been made in expanding and equipping health facilities and many effective interventions are being implemented through partnerships with stakeholders. As a result, much has been achieved in reducing the rate of child mortality, but reductions in maternal mortality are lagging behind. Certain gaps have been identified by the government and development partners and targeted for special attention in order for the country to attain the Millennium Development Goal 5—improve maternal health. These gaps include: low levels of skilled attendance at birth, low coverage rates for the prevention of mother-to-child transmission of HIV, and high unmet need for family planning. (Health Sector Development Plan IV)

The FMOH and its stakeholders acknowledge that there are many effective practices being implemented in Ethiopia to improve maternal and newborn health. The documentation of promising practices in this report is based on the understanding these successful practices could be scaled up through identification, documentation, and dissemination. Therefore, the Safe Motherhood Technical Working Group agreed to produce a report on promising practices. The group used lessons learned from previous experiences in documentation of practices and reached consensus to use *the internationally accepted* criteria of promising practices: practices that bear evidence of effectiveness and efficiency and that are replicable for the reduction of maternal and newborn mortality. After the selection of the promising practices, which was based on reports submitted by implementers, a validation field visit was undertaken by independent reviewers. Twenty-five facilities in four regions were visited to qualify, clarify, and validate the information contained in the reports. The review also included key informant interviews, site visits, and observations. Accordingly, out of a total of 21 practices submitted, nine were documented. These were later reduced to seven as two practices had already been documented in previous publications.

The practices documented here are grouped under two thematic areas: (1) maternal and newborn health and (2) family planning and reproductive health.

The maternal and newborn health thematic area includes the following practices:

- Standard-Based Management and Recognition (SBM-R®) to improve maternal and newborn health services at health centers and hospitals.
- Competency-based basic emergency obstetric and newborn care training—an in-service training for mid-level health care providers on basic and essential emergency obstetric and newborn care.
- Comprehensive emergency obstetric and newborn care training—a six-month training for general practitioners and health officers at regional hospitals.

The family planning and reproductive health thematic area includes the following practices:

- Family planning and HIV integration—to integrate family planning services with antiretroviral therapy services for people living with HIV.

- Social Change for Family Planning Results Initiative—uses a social mobilization tool to change behavior to improve the uptake of family planning.
- Sexual and reproductive health in emergencies—a practice for integrating key safe motherhood and sexual and reproductive health interventions in emergency programs.
- Cervical cancer screening—using visual inspection as a quick and cost effective practice for the identification and treatment of premalignant lesions of the cervix.

Validation field visits allowed reviewers to collect additional data to determine whether the selected practices fulfilled the selection criteria by establishing their effectiveness, efficiency, and cost effectiveness for sustainability and replicability. Reviews documented the relevant issues such as gaps targeted, steps taken, results achieved, reasons for success, sustainability, as well as lessons learned and recommendations.

The Discussion section of this report analyzes the key points of each practice with respect to relevance, effectiveness, efficiency, sustainability, and replicability. It also looks into the success factors such as the enabling policy environment, availability of resources and tools, as well as the challenges that were encountered.

In conclusion, this report is in line with the government's initiatives to identify, verify, and document promising practices in maternal and newborn health and reproductive health services. It is hoped that the dissemination of this report will promote scale-up of these promising practices and will have a synergistic effect on stakeholders who can use the experiences shared and the lessons learned.

It is also worthwhile to reiterate that in the course of preparation of this report, the reviewers came across other successful practices and recommend the continuation of documentation and dissemination of promising practices.

Background

The Government of Ethiopia is committed to achieving Millennium Development Goals (MDG) 4 and 5 to reduce child and maternal mortality, with a target of reducing the maternal mortality ratio to 267 per 100,000 live births and newborn mortality rate to 15 per 1,000 live births by 2015. This commitment has been articulated in the Health Sector Development Program (HSDP) IV, and more specifically in the *National Reproductive Health Strategy 2006–2015*[10] and the *Road Map for Accelerating the Reduction Maternal and Newborn Morbidity and Mortality in Ethiopia (2012–2015).*[11]

Ethiopia has one of the highest burdens of maternal and newborn mortality in the world, with a maternal mortality ratio of 676/100,000 and a newborn mortality rate of 37/1,000.

Table 1. Trends in maternal and newborn health and family planning and reproductive health

DATA SOURCE: DEMOGRAPHIC HEALTH SURVEYS	2000	2005	2011
<5 Mortality Rate	166	123	88
<1 Mortality Rate	97	77	59
Newborn Mortality Rate	49	39	37
Maternal Mortality Ratio	873	673	676
Total Fertility Rate	5.5	5.4	4.8
Unmet Family Planning Need	N/A	35%	25%

According to the *National Baseline Assessment for Emergency Obstetric and Newborn Care in Ethiopia, 2008*[3] (hereinafter referred to as the National EmONC Assessment), a majority of the 971 maternal deaths in hospitals and health centers during 2008 were the result of seven causes.

Table 2. Major causes of maternal deaths in Ethiopia

MAJOR CAUSES OF MATERNAL DEATHS* IN ETHIOPIA	%
Obstructed/prolonged labor	19%
Ruptured uterus	18%
Severe pre-eclampsia/eclampsia	16%
Postpartum hemorrhage/retained placenta	11%
Complications from abortion	9%
Antepartum hemorrhage	7%
Postpartum sepsis	7%
* *National Baseline Assessment for Emergency Obstetric and Newborn Care in Ethiopia, 2008*	

Quality emergency obstetric care can avert most of these deaths; however, many of these deaths are the result of three main delays:[i]

1. **Delay in seeking care**—often due to socioeconomic factors of the woman and her family, such as distance, cost, perception of quality of care at the facility, and illness factors, including recognition of the severity of the problem and the woman's status

[i] Thaddeus S & Maine D. 1994. Too far to walk: maternal mortality in context. *Soc Sci Med.* 38(8):1091–1110.

2. **Delay in the pregnant woman reaching the facility**—often due to distance to facility and availability of transportation
3. **Delay in the provision of the appropriate service at the facility—**often due to lack of adequate and appropriate treatment, which is affected by the number and competency of staff, availability of essential drugs and equipment, and proper diagnosis and management of complications

Women in Ethiopia have a high-risk of reproductive health complications due to early onset of childbearing and too many pregnancies that are too close together. In Ethiopia, demographic and sociocultural factors contribute to the high maternal and newborn mortality rates; these factors are related to poverty and to strong traditional and cultural values that often discriminate against women, depriving them of access to social services such as health and education.[9] Existing maternal health services have been underutilized; until recently, almost 90% of births took place at home. The reasons for this are complex and are attributed in part to a lack of knowledge among women and their families about potential complications that may arise in childbirth and their consequences and the perception that pregnancy and childbirth are viewed as normal life events and therefore do not require health care assistance or even preventative care. Other factors include the accessibility and affordability of services. The National EmONC Assessment showed the inadequacy of facilities, especially a shortage of health care providers with the necessary skills for the provision of basic and comprehensive emergency obstetric care.[3] Gaps in service provision can discourage women from accessing care at facilities.[ii]

The data in Table 1 indicate the gains made in the reduction of child and infant mortality rates and the corresponding lack of improvement in maternal and newborn mortality rates. The decrease in total fertility rate is partly due to the improvement in the coverage of family planning (FP) but the unmet need (25%) is still high.

The Government of Ethiopia's current development program for the health sector[1] prioritizes maternal and newborn health, therefore it is working to increase the number of functioning and adequately equipped health facilities and is implementing interventions targeting each of the three delays.

1. To address the **delay in seeking care**, the Health Extension Program has been expanded by support and social mobilization assistance from the community-based Health Development Army. The financial aspects hindering access are being addressed through health financing schemes to make maternal and child health care free of charge.
2. To address the **delay in the pregnant woman reaching the facility**, the government has procured and distributed 800 ambulances to be used by the *woredas* (districts) for maternal emergencies.
3. And, to address the **delay in the provision of the appropriate service at the facility,** the government and its stakeholders are working to :
    - Improve the quality of health services
    - Support the provision of essential equipment and supplies
    - Scale up the numbers of midwives being trained to increase coverage of skilled attendance at birth
    - Standardize in-service training in basic emergency obstetric and newborn care

[ii] Thaddeus & Maine.

- Deploy a new cadre of Integrated Emergency Surgical Health Officers, who have been trained in comprehensive emergency obstetric care, to remote hospitals that do not have doctors

In addition, the role of health extension workers (HEWs) has been strengthened, allowing them to play a more central role as a link in the continuum of care and to provide a long-acting family planning method, Implanon, at the community level.

It is hoped that the practices documented in this report will contribute to the advancement of the gains achieved through the various initiatives for addressing the government's maternal and newborn (MNH) and family planning/reproductive health (FP/RH) priorities.

Documenting Promising Practices in Maternal and Newborn Health and Family Planning and Reproductive Health

RATIONALE

The Federal Ministry of Health (FMOH) and its stakeholders acknowledge that there are many effective practices being implemented in Ethiopia to improve maternal and newborn health and that these practices could potentially be scaled up. In line with its mandate to guide and promote strategies and interventions to improve the quality of maternal and newborn health care, the FMOH, along with its stakeholders, supported the exercise of documenting promising practices in maternal and newborn health and in family planning and reproductive health.

Goal: To improve access to high-quality maternal and newborn health services by documenting promising practices with the aim of replicating and scaling up of practices that are considered effective in the context of Ethiopia.

Objectives: To identify effective promising MNH and FP/RH practices in Ethiopia, validate and document the promising practices, and promote the scale-up of the promising practices.

EXPERIENCES GAINED FROM PAST DOCUMENTATION EXERCISES

The Implementing Best Practices (IBP) Initiative was introduced in Ethiopia in 2004; its first document, *Documenting Reproductive Health Practices in Ethiopia*, was developed by the FMOH and the IBP country team and published in May 2006.[4] During the documentation process, the team's main challenges were to reach consensus on the application of the term "best" and the fact that only a few implementing organizations submitted documents on their best practices for review.

Since then, nationwide measures have been taken to build skills for documenting effective practices. These measures have included regional-level orientation sessions, dissemination of new tools and approaches on ways to use data to improve programs, and initiating a process to share information across partners and related government agencies. Subsequent documents outlining promising practices include *Promising Practices in PMTCT in Ethiopia,*[5] produced by the FMOH and Jhpiego in 2009, and the FMOH's quarterly health bulletin, *Policy and Practice.*

THE PROCESS OF DOCUMENTING PROMISING PRACTICES

Groundwork (July 2011)

A meeting of the FMOH's Safe Motherhood Technical Working Group was convened in July 2011; participants reached consensus on the goal of identifying, validating, and documenting promising practices in MNH and FP/RH. Criteria used to identify promising practices were adapted from the World Health Organization (WHO) and the United Nations (UN) Educational, Scientific and Cultural Organization (UNESCO)[2, 6] and included practices that are evidence-based, effective, efficient, replicable, and sustainable. A smaller group of representatives of the Safe Motherhood Technical Working Group, a core technical committee comprised of experts from the FMOH, UN agencies, and the United States Agency for International Development (USAID), was established to guide the process. This core technical committee agreed on the thematic areas and that technical

professionals (noted in Appendix 5) would be nominated to select the promising practices that would be further validated by independent reviewers.

Questionnaires were sent to all stakeholders involved in MNH and FP/RH with the request that they submit nominations of potential promising practices. Accordingly, 21 practices were submitted, out of which nine were selected to be documented in the *Promising Practices in MNH and FP/RH, Ethiopia*.

Preparatory Steps (July 2011)

A review of the promising practices selection criteria was conducted in July 2011 to respond to recommendations to provide clarification on the differences between "best" and "promising" practices because the practices were to be selected mainly based on the WHO guideline that outlines criteria for selecting "best practices." According to this guideline, the word "best" should not be considered in the superlative or "gold standard" sense because the results of the practice could be partial.[2]

According to the definition in the *Advance Africa Best Practices Compendium,*[8] which was used for the *Documentation of Promising Practices in PMTCT in Ethiopia,*[5] a "Promising Practice is a method or technique that has been shown to work effectively to produce successful outcomes. Promising practices are supported, to some degree, by subjective data (for example, interviews and anecdotal reports from the individuals implementing the practice) and objective data (such as feedback from subject matter experts and the results of external audits)." In this definition, effective practices may be "promising" or "best" depending on the strength or the "pyramid" of the evidence, where best is at the top. Best practices are supported by substantial evidence and are defined as specific sets of actions exhibiting quantitative and qualitative evidence of success as well as having demonstrated abilities to be adapted, transferred, and replicated. [7, 8]

Validation and Documentation (May-July 2012)

The objectives of the validation were to collect relevant, detailed information on the short-listed promising practices in order to qualify and validate the information and to collect any new and relevant data available since the submission in 2011.

Validation and Documentation Methodology

A number of planning meetings were arranged by the FMOH/Urban Health Directorate, whereby the participation of stakeholders from the Safe Motherhood Technical Working Group reached consensus on the composition of the review team to work with a consultant, the review period, and a tentative list of sites to be visited. The group reviewed and endorsed field visit guides that were prepared by the consultant to ensure consistency and comparability of data that were to be collected.

In order to facilitate the validation process, the FMOH sent official letters requesting assistance from officials in the regions of the implementing sites and the stakeholders.

The validation team carried out the field visits between June and July 2012.

Twenty-five health facilities ranging from health posts to hospitals were visited in three regions in Ethiopia: Amhara, Oromiya, and the Southern Nations and Nationalities People's Region (SNNPR). Government health officials, program managers, facility heads, and service providers were interviewed as key informants (sites visited and key informants are listed in Appendix 5).

Key informant interviews were also conducted with technical officers of the Ethiopian headquarters of the agencies whose promising practices were selected, namely the United Nations

Population Fund (UNFPA), International Medical Corps (IMC), Ethiopian Society of Obstetricians and Gynecologists (ESOG), Integrated Family Health Program (IFHP), CARE, Jhpiego, and WHO.

The write-up of the report was undertaken by the consultant and the draft was reviewed by FMOH authorities and key partners.

Report on the Promising Practices in Maternal and Newborn Health and Family Planning and Reproductive Health in 2012[iii]

The practices documented here are grouped under two thematic areas: maternal and newborn health and family planning/reproductive health.

Each promising practice report in this document consists of the objectives, description of the intervention, implementation strategies or steps, activities that were undertaken, results/achievements, lessons learned and challenges, sustainability, replicability, and recommendations for scale-up.

In the course of the preparation of this report, two practices went beyond what could be termed "promising practices"—community-based Implanon provision and the Attat Hospital maternity waiting area. The first has been endorsed and scaled up, while the latter has been documented widely, consequently, these two have been excluded from the list, but they are detailed in the Appendix 1.

Table 3 is a summary of the key findings of the seven promising practices, while the detailed reports of all the nine practices are included in Appendix 1.

Theme 1: Interventions for maternal and newborn health (implementation sites)

- Essential MNH standards (Tigray, Amhara, Oromiya, and SNNPR)
- Competency-based basic emergency obstetric and newborn care (BEmONC) training (Tigray, Amhara, Oromiya, SNNP, Benshangul Gumuz, Gambella, Somali, and Afar)
- Comprehensive emergency obstetric and newborn care (CEmONC) training (Oromiya, SNNPR, Tigray, Amhara, Afar, Benshangul Gumuz, Gambella, and Somali)

Theme 2: Interventions for family planning and reproductive health (implementation sites)

- Family planning and HIV integration (Amhara, Oromiya, SNNPR, and Tigray)
- Social Change for Family Planning Results Initiative (Oromiya, East Harerge)
- Sexual and reproductive health in emergencies (Oromiya, West Harerge)
- Cervical cancer screening (Oromiya, Amhara, SNNPR)

The contact information and the resources from the documents submitted are in Appendix 3.

[iii] Data were collected in 2012 with the final drafts of the report compiled in 2013.

Table 3. Summary of Promising Practices in Maternal and Newborn Health and Family Planning and Reproductive Health in 2012 in Ethiopia

THEMATIC AREA 1: PROMISING PRACTICES IN MATERNAL AND NEWBORN HEALTH							
Practice	**Gap targeted**	**Practice success**	**Success factor**	**Cost effectiveness**	**Sustainability**	**Possible challenges to scale-up practice**	**Recommendations**
Essential MNH Standards	Lack of standards for performance and quality of services for MNH	The standards are designed for staff to assess the performance of their facility to improve quality of services Joint identification, participatory planning to solve gaps, managerial decision-making, and monitoring of changes	Inclusion during training of all managers, including district level managers and staff Staff involved in problem identification, planning, and follow-up	Staff learned to identify gaps and find local solutions to improve facility performance	The use of standards has brought about changes in the attitudes of staff and managers, which could go on beyond the life of the project. The emphasis of a quality improvement approach addresses many service-delivery areas	Inadequate resources, including staffing resources, to fill the gaps identified	Include standards for MNH as a tool for implementation of government initiatives in facilities along with initiatives such as the Balanced Score Card, the Ethiopian Hospital Reform and a health care financing scheme
Competency-based BEmONC Training	Inadequately skilled health care providers in BEmONC	Filled the critical gap of skilled attendants to provide quality BEmONC services with a standard competency- based training approach	Uses an adult learning method; well-designed and tested tools and standardized approach	Training is costly, but within the context of the need for BEmONC services, the cost of the training is justifiable	Any refresher/in-service training program requires long-term commitment. Competency- based training is more likely to result in long-term changes	Lack of essential supplies and equipment in facilities when providers return after training; low facility utilization in health centers could mean learned skills are not practiced	Strengthen pre-service training to ensure competency-based BEmONC skills are imbedded in curricula for midwives. Establish less resource intensive approach to ensure post-training follow-up
CEmONC Training	Lack of comprehensive emergency obstetric care, including cesarean sections, in regional hospitals	Regional hospitals have been able to provide CEmONC services since the program started	Federal and regional government commitment and ownership, and partnership among stakeholders	Training is costly but cost outweighed by the need to have CEmONC services provided by skilled, competent providers	A standardized in-service training program requires long-term commitment and is more likely to result in long-term changes	Delay in facility readiness, lack of anesthetists, and other essential services such as blood transfusion; low patient caseload	Strengthen pre-service training of MDs (and GPs and anesthetists) to ensure CEmONC skills are integrated into their curricula. Ensure budget allocation for all elements of CEmONC service delivery.

THEMATIC AREA 2: PROMISING PRACTICES IN FAMILY PLANNING AND REPRODUCTIVE HEALTH							
Practice	**Gap targeted**	**Practice success**	**Success factor**	**Cost effectiveness**	**Sustainability**	**Possible challenges to scale-up**	**Recommendations**
FP & HIV Integration	Lack of FP services for people living with HIV accessing antiretroviral therapy (ART) services	During year one, more than 50,000 HIV-positive women received FP All prongs of prevention of mother-to-child transmission of HIV (PMTCT) addressed	Practice utilizes same space/staff as HIV care, ART, and other HIV services, and is therefore integrated	Does not require additional resources to continue service after staff trained	The project was integrated into an existing program; sustainability beyond life of project will happen if policy demands integration of FP with HIV services	FP services not included in HIV care and ART	Increase government ownership to ensure integration of FP into HIV services, training for staff, and provision of FP commodities at ART sites
Social Change for Family Planning Results Initiative	Low FP service utilization due to social norms and attitudes toward FP	Enabled open communication between couples and communities on sexual health matters. Resulted in higher demand for FP usage	The existence of community-based women's groups and health promoters; the user-friendly guide and tool for SAA[iv]	Requires minimal resources for training materials; meetings use existing staff and facilitators	Leads to change in attitudes and behavior, which can be long-lasting. Adopted by others such as the education sector	Health interventions generally have few programs directed at the social and behavioral issues that hinder the utilization of FP so practice would need to be integrated into those	The SAA tool could be adapted and used for social mobilization by the Health Extension Program and to support the Health Development Army

[iv] Social Analysis and Action (SAA) is a participatory community-dialogue tool used by CARE to help communities identify their issues around FP access.

THEMATIC AREA 2: PROMISING PRACTICES IN FAMILY PLANNING AND REPRODUCTIVE HEALTH							
Practice	**Gap targeted**	**Practice success**	**Success factor**	**Cost effectiveness**	**Sustainability**	**Possible challenges to scale-up**	**Recommendations**
Sexual and Reproductive Health in Emergency Situations	Inadequate safe motherhood and RH services in emergency settings	Safe motherhood/RH education for more than 50,000 women in two drought-affected localities (at time of writing). Equipping of health posts	Collaboration and coordination between government and partners; community participation The project was integrated into an already successful nutrition program	Integrated service provision using existing program platforms; procurement of locally assembled delivery kits and medical equipment for health posts	As this is an emergency program the emphasis is not sustainability but rather preparedness	Addresses emergencies so not for scale-up however, challenges in preparing for emergencies are: ▪ Short project duration dependent on short-term (often emergency) funding ▪ Need to recruit specially trained staff ▪ At times, inaccessibility of most of the sites requires additional logistics support, and any existing facilities are poorly equipped to provide the emergency services	The inclusion of safe motherhood/RH interventions should be incorporated into the government's emergency preparedness plan.

THEMATIC AREA 2: PROMISING PRACTICES IN FAMILY PLANNING AND REPRODUCTIVE HEALTH							
Practice	**Gap targeted**	**Practice success**	**Success factor**	**Cost effectiveness**	**Sustainability**	**Possible challenges to scale-up**	**Recommendations**
Cervical Cancer Screening - Single Visit Approach (SVA)	Lack of cervical cancer screening services for resource-limited settings	14 hospitals equipped and staffed to provide SVA (five of them are centers of excellence) More than 8,500 HIV-positive women received screening by visual inspection of the cervix after application of acetic acid (VIA) and about 800 were treated with cryotherapy for precancerous lesions (at time of writing)	Commitment and ownership by policy makers and managers. Testing and treating premalignant lesions in less than half an hour at little cost	Screening uses locally available supplies, does not require complex laboratory infrastructure, and may be performed by mid–level health professionals	National RH strategy includes the screening and early treatment of cervical cancer Services initiated and integrated into services in public facilities; centers of excellence have potential to act as role models for scale up	Funding restricted to HIV-positive women but services needed for all women of reproductive age. Cervical cancer screening is not yet routine in RH services	The inclusion/integration of SVA with cryotherapy should be part of a minimum RH package at regional and district level hospitals

Discussion

CONTEXT

The selected promising practices were implemented in an enabling policy environment and situation that prioritized the reduction of maternal and newborn morbidity and mortality. The HSDP IV[1] and the *Roadmap for the Accelerated Reduction of Maternal and Neonatal Morbidity and Mortality*[11] list key interventions, including those that address supply and demand issues.

The key interventions endorsed by the government cover the continuum-of-care, including pre-pregnancy, pregnancy, labor and delivery, through the postpartum periods and reaching across all levels of health service delivery—from the household in the community up to the highest referral level.

The success of this safe motherhood initiative depends on an effective and equitable health system—maternal and newborn survival services need a functional health system with basic and comprehensive emergency care 24 hours a day, seven days a week. In addition, success depends on overcoming the three delays that impact maternal survival. To address the first delay—seeking care—the government is strengthening the Health Extension Program, which is designed to reach individual households with health messages delivered by Health Extension Workers (HEWs), including how to recognize potential problems. The Health Extension Program is being reinforced by the Health Development Army, which mobilizes women and their families to adopt the healthy behaviors they were taught by the HEWs.

To address the second delay, the government has supported increased access to care by providing free maternal and child health services at the primary health care level (health posts and health centers) and more recently at district and regional hospitals. The government has also procured 800 ambulances to be used by the *woredas* for maternal emergencies.

To deal with the third delay, the government is seeking to improve services through improving and expanding infrastructure, strengthening and upgrading the logistics system, distributing essential equipment and supplies—including pharmaceuticals—and improving the availability of blood banks and referral linkages.

Much emphasis has been placed on improving the skills of health care practitioners through in-service trainings with efforts being led by the government to coordinate and standardize training courses. BEmONC training is available for mid-level health care workers (midwives, nurses, and health officers) and is being provided by partners and by some regional health offices. The national training package has now adopted a competency-based approach. CEmONC training for health officers and general practitioners is available at selected regional hospitals. The relatively new master's level Integrated Emergency Surgery Officers training is a three-year program primarily intended for health officers (nurses and midwives are to be admitted in later cohorts) being held in five universities. Another short-term alternative is on-site coaching and mentoring of general practitioners at rural and remote hospitals by obstetricians over a six-month period. It is understood that many of these interventions have been adapted from other countries but their application is based on evidence and appropriateness in the Ethiopian context. Given the size, diversity, and complexity of Ethiopia, more than one approach may be required to address the human resource needs across the country. To date, none of these training programs have been formally evaluated.

RELEVANCE OF PRACTICE

In general, all of the selected practices documented in this report qualify as "promising practices" according to international criteria. The documentation in this report has allowed scrutiny of the practices' success, how they fit within the priorities of the national efforts, and their contribution to strengthening the health response for the reduction of maternal and newborn morbidity and mortality.

The following discussion will further elaborate on the selected practices in the context of the criteria of selection for the MNH and the FP/RH thematic areas.

The promising practices under the MNH thematic area address the most critical gaps in the provision of lifesaving, quality maternal and newborn services that were highlighted in the National EmONC Assessment, which showed that facilities do not perform the required signal EmONC functions[5] and that the level of skilled attendance is sub-optimal.[3] Hence, the practice of using essential MNH standards promotes the institutionalization of performance standards that can be used by individual providers and facility and district managers to measure and reward achievements and recognize performance. The competency-based BEmONC training practice was developed to ensure that the training mid-level providers received actually equipped them with the knowledge and skills to provide basic and essential EmONC; it also supports the strategy to increase the numbers of skilled providers.

Comprehensive emergency obstetric and newborn care (CEmONC) has not been sufficiently available in Ethiopia to meet recommended standards. According to the National EmONC Assessment, the cesarean section rate was below 1% (WHO recommends 5–15%). The main reason for the limited availability of this lifesaving procedure is the lack of qualified professionals. To meet this need, one practice is implementing a six-month, on-site practical training at regional hospitals for general practitioners with coaching and mentoring provided by resident or seconded obstetricians. This practice has the added value of also improving the clinical facilities during the training. Another strategy to fill the gap in the availability of emergency surgical care is the enrollment of health officers in the master's degree Integrated Emergency Surgery Officers program, which is currently being run in five universities. The first two groups of surgical officers graduated in 2013 and most have been deployed to rural hospitals or recently upgraded "primary hospitals."

The promising practices under the thematic area of FP/RH focus on improving the provision of quality FP services by addressing social determinants that hinder the uptake of FP and by addressing the needs of underserved populations. To address behavioral and social norms hindering the utilization of FP services, one practice uses a participatory, community-dialogue tool to help communities identify their issues around FP access.

To address the needs of underserved populations, one of the promising practices gives attention to the low FP-service coverage among HIV-positive women, which is in part due to inadequacies in providers' skills and knowledge and the lack of integration of FP services into ART programs. Another practice addressed the availability of sexual and RH services for women displaced by emergencies, for whom services are not available. While the practice was designed for women displaced by drought, the practice could be applied to other emergency situations as well.

[5] Signal functions for **emergency obstetric and newborn care—basic** emergency obstetric and newborn care (BEmONC): parenteral treatment of infection (antibiotics), parenteral treatment of pre-eclampsia/eclampsia (anticonvulsants), parenteral treatment of postpartum hemorrhage (uterotonics), manual vacuum aspiration of retained products of conception, vacuum-assisted delivery, manual removal of the placenta, and newborn resuscitation. **Comprehensive** emergency obstetric and newborn care (CEmONC): all components of BEmONC plus surgical capability and blood transfusion.

A fourth FP/RH practice focuses on the provision of services for the early detection and treatment of cervical cancer for HIV-positive women. This is in line with a priority of the national RH strategy[10] to prevent and provide early treatment of reproductive organ cancers, especially cervical cancer. According to the National EmONC Assessment, in 2008 only 5% of the hospitals that had maternal health services reported providing services for the detection of cervical cancer using the Pap smear. The single visit approach (SVA) to cervical cancer screening, provided by one of the promising practices, is quicker and more affordable than Pap smears and can be done by mid-level providers.

EFFECTIVENESS/PRACTICE SUCCESS AND SUCCESS FACTORS

All the selected promising practices achieved the program objectives that were set at the beginning of implementation. Each practice reported on its successes, which were supported with qualitative and quantitative data collected as part of the programs' monitoring and evaluation strategy.

The enabling policy environment and the support of partners were cited as grounds for the success of the interventions. In addition, the design of the promising practices took into account proper identification of gaps (gap analysis), adequate resources for implementation, the evidence-base for the intervention(s), and availability of implementing partners' knowledge, technical skills, and expertise, including the development and use of standardized tools.

EFFICIENCY/COST EFFECTIVENESS

Some of the practices (CEmONC and competency-based BEmONC trainings) require relatively more financial and human resources than some of the other practices. However, these costs must be viewed within the context of unacceptably high rates of maternal and newborn deaths and disabilities, and in the context of the provision of equitable services, which is one of the guiding principles of the HSDP IV. Other considerations include the fact that the training courses developed the capacity of local trainers and they adapted existing, globally-available training materials to the Ethiopian setting, which helps to minimize their costs.

Some of the practices (for instance, FP/HIV integration and screening for cervical cancer) can be considered cost effective because they utilize the existing facility set-up and staff that are already in place. The implementation design of the practices also used local trainers and adapted existing training materials.

SUSTAINABILITY AND OPPORTUNITIES

In as much as the promising practices address Ethiopia's priority strategies and have shown effectiveness, the next step would be to maintain gains and scale up the interventions. Sustainability of the practices will be supported by a positive policy environment and the commitment of the government to reduce maternal and newborn morbidity and mortality. Furthermore, some of the practices have put in place resources—such as trained staff, facility equipment, standards, and tools—that could facilitate the expansion to other relevant programs. For instance, the cervical cancer screening practice, which was established to target HIV-positive women through PEPFAR funds, put in place equipment and trained staff in 14 hospitals that can be utilized and scaled up to provide routine cervical cancer screening as part of routine RH services for all women of reproductive age.

REPLICABILITY AND POSSIBLE CHALLENGES TO SCALE-UP

Improvements in MNH service provision require addressing multiple gaps to ensure all signal functions are met; training alone will not result in a reduction in maternal and newborn mortality. However, ensuring the availability of skilled providers who have received evidence-based training that equips them with the skills to manage BEmONC and CEmONC—depending on the setting—needs to be considered part of the package for a functioning health system. One of the challenges of the BEmONC and the CEmONC training is low utilization of health facilities, which results in low caseloads and therefore hinders acquisition of skills because there are limited opportunities for health care providers to use the skills they learned in the classroom in order to become competent providers.

With regard to the use of MNH standards, some facilities do not use even the most basic standards for maternal service delivery—for instance, partographs—which raises questions about the ability and motivation of providers to implement a number of standards. Some of the key informants reported that the use of the standards "overloaded" them, and they would like the standards to be simplified and to be used as job aids, to guide referrals, as well as to guide performance.

Although the majority of the key informants interviewed for all practices described the "job satisfaction" they gained from the skills they acquired, several mentioned that an improved working environment and incentives are also needed for maintaining and scaling up the MNH standards; this was also said for all the practices that were reviewed.

The selected FP/RH practices apply simple and user-friendly tools that can be adapted for scale up. Sharing of experiences, adaptation of already-developed guides and training materials, and use of national- and regional-level trainers could facilitate the replication of the promising practices. Replication mostly requires enabling and functioning health scenarios. The following are some of the challenges frequently mentioned by key informants that should be considered during planning for scale-up of any of the practices:

- High staff turnover and attrition are threats to the continuation of all of the practices
- Current weaknesses in reporting, data collection, and data quality to monitor effectiveness
- Need for integration—while this is advocated by Government policies, a new service (such as. ensuring access to FP services in ART clinics) this is often seen as additional work for providers
- Scaling up a new practice (such as the significant increase in the demand for long-acting FP methods) must include providing back-up services—for example, removal of the long-acting method—as well as ensuring that choice is still available for clients who choose other methods

Recommendations

Based on the study and validation of the selected promising practices the independent review team made the following recommendations:

- The government's strategy should ensure the appropriate allocation of resources and prioritize effective implementation and monitoring and evaluation of MNH and FP/RH programs practices.
- The identification and documentation of effective and efficient practices, and dissemination through orientation, discussions, and experience-sharing visits must be included in the plans of regional health bureaus, zonal, and *woreda* health offices.
- Sufficient allocation of the necessary resources by regional governments is required for the continuation and scale-up of the practices by the national government as most of the practices reviewed are reliant on donor support.
- The success of the promising practices and their replicability is dependent on the availability of a consistent supply of materials, a robust logistics system, and availability of staff needed to implement activities.
- Programs should be planned with due consideration for the high rates of staff turnover and attrition. Considerations must be given to the selection of appropriate staff for training, including their ability to absorb the training, their commitment and interest to serve after training, and the training's relevance to their current assignment and professional career development. Improving management and issues affecting motivation also need to be addressed.
- Pre-service education programs and education institutions should be strengthened to provide education programs that graduate skilled providers that are "fit for purpose." While they are successful in filling gaps, in-service trainings, such as competency-based BEmONC and the six-month training for CEmONC, cannot replace pre-service education. Therefore, special efforts are needed to strengthen the pre-service education programs.
- Plan to conduct assessments of training and evaluations of the impact of training on provider performance as well as facility performance.
- For improved CEmONC utilization, effective referral linkages must be in place and efforts to look at the referral mechanism and ways strengthen it should be expanded.
- Monitoring and evaluating programs are needed to ensure quality of the practices. A follow-up mechanism is also needed to evaluate the long-term outcome and impact of the practices to inform decisions and stakeholders.
- The design of the practices from the onset must include strategies for their sustainability.

General recommendations:

- Adapt the practices to the specific needs of the local situation.
- Encourage regional-/*woredas*-based plans to include promising practices.
- Provide FMOH with guidance and monitoring so that quality is not compromised during scale-up and expansion of effective practices.
- Implement community mobilizations programs to raise awareness and improve demand for services.

- Encourage documentation of all practices by training health providers and managerial staff in documenting and use of data for decision making. Also encourage "data use" through regular feedback and review meetings with a focus on how to use data to inform service improvement.

Appendix 1: Reports of Promising Practices in Maternal and Newborn Health and Family Planning and Reproductive Health in 2012

THEMATIC AREA 1: MATERNAL AND NEWBORN CARE INTERVENTIONS

The Use of Standards-Based Management and Recognition for Performance and Quality Improvement in Maternal and Newborn Services

Implemented by Jhpiego

Background

The essential maternal and newborn health Standards-Based Management and Recognition (SBM-R®) tool developed by Jhpiego is used to improve health programs by using evidence-based standards to identify gaps and appropriate interventions to address those gaps in order to improve the performance of health facilities. The SBM-R tool transfers evidence-based technical materials, such as guidelines and protocols, into operational tools containing performance standards that can be used as job aids or guidelines for regular self, internal, and external appraisals of a facility's performance. The approach provides facilities with the process, mechanisms, and tools that empower them to continually pursue and achieve the desired standards—most health facilities do not have standards for quality MNH services.

This practice has proved successful in the sites visited. Although this practice has been implemented in many selected facilities in the country, the Bugi and Boditti Health Centers in Wolayta Zone of SNNPR were visited as a representative sample.

The Intervention

- Implementation began with a three-day training for a team of health facility managers and health care providers who have the knowledge and experience to select and implement standards for essential MNH. Personnel in related areas such as pharmacy and laboratory services were also included.
- The team conducted a baseline assessment to measure the actual performance of the facility using the SBM-R tool, which is designed to identify gaps in the essential and key elements of MNH services. After identifying the gaps, the team analyzed the causes and selected interventions that could address the gaps. Interventions, which are within the capacity and resources of the health facility, were prioritized and resources were allocated or mobilized. The team prepared a plan of action for the next four to five months.
- After an initial period (four to five months) of implementing the plan of action, an internal exercise was undertaken to monitor progress.
- The team received a refresher training enabling them to conduct another round of needs assessments. Once again, a gap analysis was done and interventions were planned for the second four-to-five-month period.

Results

While Jhpiego has been using SBM-R for HIV services in Ethiopia since 2007, the use of standards for MNH was initiated in 2010.

- The average score from the baseline assessments for both health centers visited (Boditti and Bugi) was 25%, a less than acceptable level of performance. Four months after the baseline, the first internal assessment showed that average scores for both health centers increased

to 65%, and eight to nine months after the baseline, average scores had increased to 85%, indicating significant improvement in the facilities' performance.

- The facilities' records show that since the start of implementation of the standards, utilization of skilled attendant deliveries increased by three- to four-fold
- Other improvements since the practice started included implementing measures for infection prevention, reorganizing the labor room, making the facilities more women-friendly, and providing culturally-appropriate services for birth, such as the coffee ceremony for birthing women and their families.

Feedback from the Validation Visit

According to the key informants, the implementation of the MNH standards and the SBM-R tools have enabled the staff, management, district government administration, and stakeholders to jointly identify weaknesses and gaps affecting the facilities' performance and their capacity to manage maternal and newborn emergencies.

The *woreda* health office reported that the feedback from the community is now so positive that they would like to replicate the approach in other health centers in the district.
The facility records of the two health centers visited show that the following are undertaken according to the standard:

- Birth-preparedness and complication-readiness plans are prepared in consultation with the client
- Partograph use
- Active management of the third stage of labor
- Newborn resuscitation

Midwives interviewed by the review team (June 2012) revealed that the SBM-R tool made them more confident and skillful in providing maternal and newborn care and, as a result, "they are able to manage complicated cases and they do not refer as many cases as they used to."

What Made the Practice Successful?

SBM-R differs from other improvement tools because its main goal is empowering health care providers and facilities to be part of continuous performance improvement and to take action to fill identified gaps. SBM-R empowers facilities to take responsibility and action.

- The focus is on the desired performance rather than on the problems.
- It uses detailed standards that tell the health provider what to do and how to do it.
- The emphasis is on making rapid results by first addressing the easiest gaps.
- Measurements are for managerial decision-making rather than for evaluation.
- Quality assurance is built into the daily activity of the facility.
- The standards can also serve as job aids for health care providers to improve their knowledge and skills to provide quality care.

Lessons Learned

The performance of facilities may be limited due to a lack of resource and gaps in staff knowledge and skill. With the introduction of standards for quality of care and resultant improved care, an increase in demand for maternal and newborn services should be anticipated and planned for.

Training in Basic Emergency Obstetric and Newborn Care Using a Competency-Based Approach

Implemented by Jhpiego

Background

The competency-based approach for BEmONC training developed by Jhpiego uses adult-learning principles that stress learning by doing and builds knowledge, skills, and attitudes. The BEmONC training course is job-oriented and uses a symptoms-based approach, with emphasis on critical decision-making skills through rapid assessment of the conditions of the patient with limited dependency on laboratory tests. The approach also takes into account health care providers' attitudes towards women's rights and concepts of providing women-friendly care. For interviews pertaining to the practice, the validation team visit focused on Asela Hospital, Asela (Oromiya); and Felege Hiwot Hospital, Bahir Dar (Amhara). Additional information was gathered from midwives trained in the practice in Wolayta (SNNPR) and Adaba (Oromiya).

The Intervention

Site selection for training sites was undertaken using a standardized checklist to determine, among other things, facility readiness. Training materials, including teaching and job aids, reference materials, and evaluation tools, had been prepared by Jhpiego. Training was conducted using a variety of teaching methodologies and a humanistic approach by simulation on models and through role play. Once trainees are competent on the models, they move to the clinic to provide care to patients under supervision of the trainers.

The trainer-to-trainee ratio was 1:4; the maximum number of trainees is 16 per course. The duration of the training is 18 days, with eight days of theory and 10 days of supervised clinical skills practice. The approach uses a checklist of procedures; a minimum of 16 procedures have to be performed during the practical component before trainees complete the course.

The skill areas the training focuses include: supporting and assisting normal births, use of the partograph, active management of the third stage of labor, newborn resuscitation, and management of major obstetric complications such as hemorrhage, sepsis, pre-eclampsia and eclampsia, and retained placenta. Post-training follow-up is also part of the training and includes interviews (in person or by telephone), supportive supervision, mentoring, and coaching.

Results

Number of providers trained in a program funded by UNICEF by August 2012:

- More than 1,100 health care professionals (520 midwives, 325 nurses, and 120 health officers) from more than 110 hospitals and more than 900 health centers in eight regions have been trained under one particular project. Note: Jhpiego has been conducting this form of training for a number of years; however, these results are from one project that was visited.

Feedback from the Validation Visit

Key informants interviewed in Wolayta (Oromiya) reported, and the facility records showed, that the number of deliveries had more than doubled and the number of referrals had dropped since at least one provider from the facility had been trained. The trained midwives and nurses that the review team spoke to said they gave scores of very good to excellent to all aspects of the training, including teaching and the clinical practice. One midwife said "it was during the training that I learned what it meant to be a midwife," and another expressed how "confident" she had become when managing normal births and complicated deliveries. A male midwife explained that the training had made him more effective in making decisions during emergencies and that this

motivated him. All interviewed trainees recommended the competency approach for BEmONC training for all health care providers who provide maternal and newborn care.

What Made the Practice Successful?

The competency-based approach for BEmONC training was a success because:

- A need or gap had been identified, which made the intervention responsive and timely
- The training was well designed and had effective tools to meet the needs of the trainees
- The approach was evidence-based and user-friendly and addressed relevant topics

Lessons Learned

The competency-based BEmONC training focuses on the acquisition of desired competencies and requires a limited trainer-to-trainee ratio to ensure effective supervision and mentoring. It is a resource intensive training course and would be expensive to provide to all health care providers in a short period of time. Therefore, the focus should be to strengthen pre-service education to ensure all graduates are equipped with the necessary knowledge and skills to manage emergency obstetric and newborn care. This in-service training would be useful for midwifery trainers/tutors so that they can cascade the BEmONC training to their students. It would also be helpful for health care workers who have not received any clinical updates or professional training in BEmONC for a number of years.

Comprehensive Emergency Obstetric and Newborn Care Training: Improving the Availability of Emergency Obstetric Surgery in the Regional Hospitals of Ethiopia

Implemented by the FMOH/Regional Health Bureaus and the Ethiopian Society of Obstetricians and Gynecologists

Background

The objectives of this practice was the training of general practitioners in regional hospitals on cesarean section surgery as a short-term solution to fill gaps in the acute shortage of health workers with the skills to perform emergency, lifesaving surgery. It also aimed to build the capacity of regional hospitals by providing the necessary equipment to ensure functionality. During the 18 month project, 22 regional hospitals in eight regions were able to provide emergency services for maternal health. Debre Tabor Hospital (Amhara) was visited by the validation team; supplementary information was provided by Yirgalem Hospital (SNNPR).

The Intervention

The intervention has been implemented for six months with on-site coaching and mentoring provided to general practitioners by an obstetrician who is temporarily assigned to a regional hospital. The obstetrician also ensures provision of emergency obstetric surgery and services while serving at the facility. The Ethiopian Society of Gynecologists and Obstetricians (ESOG) recruited obstetricians to act as trainers and mentors for a period of six months. Once oriented to the training tool developed by ESOG, the trainers then assisted the regional health bureau with the selection of general practitioner trainees. They also assisted with the assessment of proposed training sites in order to facilitate strengthening of the site by the FMOH and the regional health bureaus.

The general practitioner training is mainly practical and is supported by clinical procedure manuals on obstetric care. During the first three months, the obstetricians provided hands-on practical training and guided trainees in procedures and in surgery. During the second three-month period, the trainees were allowed to work more independently with mentoring provided by the trainers. Upon the completion of the six-month mentoring period, trainees were certified by the FMOH based on the recommendation of their trainers and ESOG.

Results

The main reported success of the practice was that the CEmONC training initiated lifesaving obstetric surgery at regional hospitals, mostly in remote areas that did not previously provide it. According to a 2012 report by ESOG, over an 18 month period, it was possible to train and certify 42 general practitioners and health officers for the provision of obstetric emergency care in 22 regional hospitals in eight regions, and equip and staff the hospitals with the required staff and resources. Over 20,000 women received services during the 18 months. In comparison to baseline figures from these 22 facilities, an increase in the number of deliveries was reported, specifically an increase above 100% for instrumental deliveries, emergency and elective cesarean sections, repair of ruptured uteruses, and other maternal procedures such as dilatation and curettage. The numbers of antenatal care and FP clients also increased in the facilities.

Feedback from the Validation Visit

The validation team visited Debre Tabor Hospital in Amhara and met with the trainer and two general practitioners who had just completed the training. Prior to its selection for the project, the hospital had not been able to provide cesarean sections and other emergency surgical services for 18 months as it did not have an obstetrician. The staff interviewed said reasons for the success of the training included the availability of equipment, availability of staff to provide a 24-hour service as they were residing on the hospital compound, and a series of orientations for all maternity unit staff on the use of standards and clinical practices in relation to the BEmONC signal functions.

What Made the Practice Successful?

The steps taken to strengthen the training sites and to select committed staff to undertake the training were found to be important for the practice's success. The existence of the necessary infrastructure (such as anesthesia and blood bank) at the site visited (Debre Tabor Hospital) allowed the practice to begin implementation immediately. The effective coordination efforts by the hospitals, regional health bureaus, FMOH, and the partners (ESOG) were also cited as contributing to the success. Another contributing factor was the on-site training, which is considered an innovative approach that supports service provision during the training at the facility where the trainees work. According to the key informants, the training also benefitted the trainers who acquired additional teaching and managerial skills.

Lessons Learned

CEmONC service provision requires not only the presence of trained staff but also an adequately equipped facility—facility readiness. A delay in facility readiness was described as a challenge for other regional hospitals that lacked equipment, blood bank, or anesthesia. Some sites also reported low patient caseloads, which limited practical experience. Increasing public awareness about timely referral and strengthening the referral system play an important role in increasing the number of women who use facilities.

THEMATIC AREA 2: FAMILY PLANNING AND REPRODUCTIVE HEALTH INTERVENTIONS

Family Planning/HIV Service Integration: A Means to Reduce Unintended HIV-Positive Pregnancies and Pediatric HIV Infections

Implemented by Pathfinder

Background

This program, implemented by Pathfinder, adopts the strategy of integrating FP counseling and FP services through regular HIV prevention and care programs, particularly with ART and PMTCT services, using the sites and providers that are already in place. The program has

proved to be effective and efficient and has covered 300 health centers. The sites visited by the validation team were Boditti Health Center, (SNNPR), Addis Zemen Health Center (Amhara), and Adaba Health Center (Oromiya).

The Intervention

- Development of a training package on FP/HIV integration with the necessary job aids.
- Facility assessments to identify HIV service availability, client flow, human resource availability, and the status of contraceptive supply.
- In four major regions—Oromiya, Amhara, SNNPR, and Tigray—104 facilities were selected in semi-urban locations with relatively high client flow and accessibility for regular follow-up and support. The program provided job aids, contraceptive supplies, and trainings for service providers and implemented regular follow-up visits and mentorship programs.

Results

At the end of the first year of implementation, nearly 52,563 HIV-positive women received counseling on FP at ART, voluntary counseling and testing, and PMTCT service delivery points (personal communication from the Pathfinder data manager, December 2012). It is thought that the actual number of HIV-positive women receiving FP counseling and services is likely to be higher than reported because some facilities with FP/HIV service integration did not capture whether the FP service was provided at HIV service outlets due to omissions in health management information reporting forms.

The project surpassed its target to reach 223 health centers and hospitals, reaching more than 300 health centers, with more than 1,000 service providers trained on FP counseling and service provision in four regions (Amhara, Oromiya, SNNPR, and Tigray). The project also focused on providing FP commodities; information, education, and communication materials for HIV service providers; and regular supervision and mentoring at the implementing facilities. Integration has addressed previously missed opportunities for the provision of FP services at HIV service outlets and the quality of care has reportedly improved following the training of health care providers.

Feedback from the Validation Visit

In interviews during the field visit, a key informant who manages the ART section at a health center explained that she is more confident in her ability to counsel clients after she received additional training on FP service provision at the start of FP/HIV integration program. The training provided her with skills to communicate better with people living with HIV so she can now explain to them their FP options.

Another nurse at a health center in Amhara region remarked that at the beginning of the program, some staff members had a negative attitude towards doing both FP and ART because they thought FP counseling would be additional work. However, the training changed their attitude and they are more motivated with greater job satisfaction as they appreciate the practical aspect and the appropriateness of integrating FP with HIV programming.

What Made the Practice Successful?

The program addresses an important gap in both FP/RH and HIV programming. The program is based mainly on the integration of activities, with minimal investment in training and follow-up supervision, which is considered cost-effective. In addition, the program provides services that are client-friendly and saves costs for the client as integrated services means fewer trips to the health facility. The program is supported through the government's contraceptive security and logistics system.

Lessons Learned

Factors that facilitated the intervention included building consensus and motivating service providers by showing them that the service is needed. In addition, the increased availability of resources, such as training materials and FP supplies, at different service delivery points facilitated integration of FP into HIV service delivery points.

Implementation of the Social Change for Family Planning Results Initiative Implemented by CARE

Background

A 2008 baseline assessment[6] by CARE of FP programs in Ethiopia indicated that in addition to the gaps in service provision, the low coverage of FP is partly due to social determinants that hinder women's uptake of FP. A community-based FP/RH program was designed to address the social norms and behaviors that hinder service utilization by bringing about changes in attitude through community dialogue. The sites visited were in East Harerge Zone and in West Harerge Zone in Oromiya.

The Intervention

The Social Analysis and Action (SAA) approach to exploring and facilitating change starts by analyzing the situation and challenging a certain belief—for example, children are God's gift and fertility is not to be interfered with—or for exploring a social norm, such as whether a certain religion forbids the use of FP. At a community meeting, topics such as the resources needed to bring up many children and the risks and burdens of repeated childbearing for mothers may be used to spark a discussion. SAA allows the community to analyze the under-utilization of existing FP services by women in light of the lack of resources in the community. A common driving force to questioning a community's norms and attitude is challenging gender inequality.

The main implementation steps of SAA included:

- Orientation and sensitization workshops were held to sensitize the project staff on the SAA methodology; facilitators were recruited from the community.
- Groups representing marginalized community segments, such as single women (widowed/divorced, youth), and a core group were established.
- Training tools and guides, including a facilitator's guide to SAA, were developed.
- Group dialogues were arranged and facilitated for community leaders as well as for small, homogenous groups who were not using FP services because of community perceptions of their sexuality (widow/divorced, newly married couples, young unmarried couples).
- Trainings were held for school clubs on the SAA tool using drama and case stories that address different social issues in order to improve perceptions on FP usage.

Results

The qualitative assessment conducted for a mid-term review showed the following key results of the SAA initiatives:[7]

- Couples improved their communications on sexual RH issues, including FP.
- Couples used a consultative decision-making process on use of household assets and FP.

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[6] CARE. 2009. Social Change and Family Planning Results Initiative Baseline Report, January 2009. http://familyplanning.care2share.wikispaces.net/file/view/Ethiopia%20RI%20Baseline%20Summary.pdf/189520903/Ethiopia%20RI%20Baseline%20Summary.pdf

[7] Care. 2011. Social Change and Family Planning Results Initiative Mid-Term Review Report, January 2011. http://familyplanning.care2share.wikispaces.net/Results+Initiative

- Marginalized women, such as widows and divorced women, and newly married couples had a safe space to discuss their sexual RH needs with their peer/solidarity groups; some have started using FP.
- The community recognized the risks and problems of unwanted pregnancy among youth and started to accept the provision of FP information and services to unmarried youth.
- HEWs and community facilitators reported confidence/self-efficacy in challenging social norms and, as a result, increased the number of FP clients.

Feedback from the Validation Visit

Key informants' views: a HEW said the SAA tool has allowed her to better understand the reality about the reproductive rights and needs of unmarried young people in order to reduce unplanned pregnancies and resulting problems. A male staff member of the *woreda* health office explained that through the SAA, he and his colleagues have discussed the dangers of closely-spaced children and the high burden of housework on women. This has led to several couples jointly deciding on limiting their family size through the use of long-acting FP methods. Others mentioned that the SAA has helped them to do their job better by strengthening their capacity to facilitate community dialogues. Representatives from the zonal and *woreda* health offices explained that the tool has been disseminated down to the community level through the Health Extension Program and school clubs.

According to the *woreda* health office, the FP utilization rate among *kebeles* (wards) where the Social Change for Family Planning Results Initiative was implemented has increased so much that a shortage of contraceptives in health facilities are being reported.

What Made the Practice Successful?[8]

- The SAA approach is a participatory method that uses recurrent dialogue for reflection, challenge, and action, and is an improvement over the traditional methods of message transfer.
- The reflective process and group discussions on the root causes of participants' problems empowers them to find their own solutions.
- The involvement of stakeholders and partners from the beginning of the project has brought everyone on board.

Lessons Learned

The SAA tool effectively provided opportunities for communities to analyze and challenge their own beliefs and practices that affect health. Community reflection, analysis, and negotiations facilitate positive behavior and are more effective than providing information through traditional channels to bring about social change to increase and sustain FP services. This practice breaks through social norms and values that hinder FP usage.

Sexual and Reproductive Health in Emergency Situations

Implemented by the International Medical Corps

Background

The project implemented an integrated RH program to reduce maternal and newborn mortality and morbidity in eight food insecure *woredas* in Wolayta Zone in SNNPR and in East Harerge Zone in Oromiya Region. The project aimed to address the RH and safe motherhood needs of people affected by drought, a group that often lack the most basic and lifesaving health interventions because they prioritize food, water, shelter, and treatment of communicable diseases. In drought-

[8] CARE. 2011. Mid-Term Report.

affected areas, women in particular have specific vulnerabilities such as malnutrition, vitamin deficiencies, and anemia. In addition, gender inequality results in gender-based violence, unsafe sexual practices, and unintended pregnancies. Most rural facilities in such drought-affected areas also face gaps, including inadequate water and electricity, a lack of basic equipment and supplies, and a scarcity of health care providers other than HEWs. This practice could be applicable to other emergency situations. The team visited Gursum in East Harerge, Oromiya.

The Intervention

- Conducted needs assessment of the selected primary health care units to identify gaps in equipment and staff training, used staff recruited specifically for this project (nurses and an RH coordinator)
- Integrated health education into the existing nutrition program targeting "leader mothers" (community-level health promoters)
- Implemented social mobilization for community actions and to raise awareness among the community about safe motherhood and the RH needs of youth
- Identified and referred malnourished pregnant and lactating women for treatment, as well as iron foliate supplementation, through the link with a community-based nutrition program
- Established task forces, under the leadership of the *woreda* health office, for joint planning of the implementation of the program and joint supervision with representatives of the zonal and *woreda* offices of the health sector and the offices of disaster prevention and preparedness, women's affair, police, education, and the Bureau of Finance and Economic Development.

Results

- More than 15,000 pregnant and lactating women received iron foliate
- More than 11,283 clean delivery kits were distributed to health posts
- 40 targeted health posts and eight health centers were equipped with key RH medical supplies based on the finding of the gap assessment
- Health providers at the health centers received training on delivery skills, infection prevention, post-abortion care, prevention of gender-based violence, and management of survivors of sexual assault
- HEWs, community volunteers, and "leader mothers" were sensitized on sexual RH, gender-based violence, and HIV/AIDS
- Over 50,000 women and girls received sexual RH focused health education

Feedback from the Validation Visit

Key informants explained that the material input from the project has contributed to the success of the health financing scheme. For instance, Gursum Health Center recently received an award for its success in providing free maternal health services because the health center was able to utilize the equipment supplied by UNFPA/IMC, thereby saving money the center would have spent buy the equipment. In addition, the validation team learned that through refresher courses, the health care providers were better prepared and informed on RH needs and were able to manage or refer mothers in the target population.

What Made the Practice Successful?

Collaboration and coordination between the partners and government line offices at all levels contributed to the successful implementation of the project. Community involvement and participation was a key factor for its success. In addition, the intervention was integrated into an already successful nutrition program, which was equipped with its own resources, staff, and vehicles. Lastly, the needs identified at the beginning of the project and the tools and opportunities offered by the partners' experienced staff ensured the successful implementation of the project.

Lessons Learned

No matter how difficult their circumstances may be, people are eager for and receptive to health promotion information and are able to acquire and accept knowledge—changes can be achieved. The project has built the capacity of the existing facilities, improving their capacity and enabling current and future functionality.

Single Visit Approach to Cervical Cancer Prevention using VIA and Cryotherapy

Implemented by Pathfinder

Background

Cervical cancer is preventable and, in most cases, curable if identified in its early stages. Cytology-based screening (Pap smear) is the standard test, but it is inaccessible for the majority of Ethiopian women. According to the National EmONC assessment,[3] only 5% of the surveyed facilities had the capacity for screening for cancer of the cervix using a Pap smear, which requires a sophisticated laboratory and highly skilled professionals. These facilities are located in urban areas and are mostly privately owned; few government hospitals have such resources. The review team visited the implementation of the practice at Asella Hospital (Oromiya), Yirgalem Hospital (SNNPR), and the Felege Hiwot Hospital (Amhara).

The Intervention

Pathfinder International, in collaboration with the FMOH, designed a project to integrate the single visit approach to cervical cancer screening and prevention into existing HIV/AIDS care and treatment services. The project uses a screening test using visual inspection of the cervix after application of acetic acid (VIA) and cryotherapy for women with premalignant lesions—all in a single visit. It aims to increase access to and utilization of cervical cancer prevention services for HIV-positive women in Ethiopia. The objectives include building the national capacity for integrating cervical cancer prevention strategies into the national HIV care and treatment plan and into the comprehensive care package for people living with HIV, and increasing cervical cancer awareness and service uptake by women living with HIV. It is hoped that the project will contribute towards the integration of cervical cancer screening into the regular RH program, which has been articulated in the revised RH Strategy, 2006.

Implementation steps:

- Health facility assessments were conducted jointly with the respective Regional Health Bureau to guide site selection and assess needs for essential medical equipment and supplies for screening and treatment.
- Cryotherapy machines, pelvic models, CO_2 cylinders, and other necessary medical equipment and supplies were procured and distributed to selected sites.
- Patient counseling guides, training materials, and quality management tools, such as clinical standards of practice and monitoring and evaluation tools, were developed/adapted from existing tools and distributed.

- Initial training on the single visit approach to cervical cancer prevention was given to multidisciplinary teams of providers, including obstetricians/gynecologists and nurses from the five selected hospitals.
- Orientation workshops and one-on-one briefings, as well as community awareness-raising were conducted for key stakeholders, including policy makers, managers, and health care providers.

Results

- Fourteen hospitals in five regions of Ethiopia are fully equipped with the necessary medical equipment and health care providers trained to provide the single visit approach; five of these hospitals are selected as "Centers of Excellence." Three of these hospitals are equipped with the latest pre-cancer treatment technology for legions too large to be treated with cryotherapy (loop electro surgical excision procedure).
- More than 40 medical doctors and nurses were trained on the single-visit approach to cervical cancer prevention. More than 8,500 women with HIV received VIA and about 800 were treated with cryotherapy for pre-cancerous lesions.
- Analysis of the routine project data indicated that 99% of women accepted VIA after pre-test counseling; 95% of women with pre-cancerous lesions that were eligible for cryotherapy received immediate treatment.

Feedback from the Validation Visit

Visits to two implementing sites (Asella Hospital and Yirgalem Hospital in June 2012) showed that the clinical rooms used for the single visit approach have all the necessary equipment needed to provide the service. Health care providers appreciated that they had learned about the magnitude of the pre-cancer problem; they were impressed with how it can be prevented through simple methods like the single visit approach. They found the skills easy to learn and were happy and motivated by being able to actually perform the screening and treatment and see good results. One head nurse explained "this service is needed for all women (whether they are HIV positive or not), my worry is the possibility of its interruption when the project ends."

What Makes this Practice Successful?

The project demonstrated a simple procedure for the early detection and the treatment of pre-malignant lesions of cancer of the cervix. It is a simple procedure that can be performed by mid-level health care providers. It is cost–effective, uses locally available supplies, does not require complex laboratory infrastructure, and can be performed at district hospitals and health centers.

In addition, the multidisciplinary, competency-based training model has enhanced provider skills, knowledge, and team spirit.

Lessons Learned

The single visit approach for cervical cancer prevention can easily be integrated into existing RH services. Its cost effectiveness and simplicity make it easy to expand to primary health care settings, which would allow access to most women in need in Ethiopia.

Community-Based Provision of the Long-Acting Family Planning Method, Implanon, by Health Extension Workers

Implemented by Integrated Family Health Program

Background

Although FP has been a priority in Ethiopia, FP services have been out of reach for the majority of rural women and the unmet need for FP has remained high. The FMOH revised the Health

Extension Program mandate to enable recently trained and deployed HEWs to provide the long-acting family method, Implanon, at the community level. In collaboration with the FMOH, IFHP and other partners supported the design of the initiative that was initially piloted in eight *woredas* in four regions (2009). Following a three-month follow-up assessment that determined that the project was a success, it was scaled up, reaching 286 *woredas* by May 2012. The review team visited health posts and health centers in Wolayta and Sodo Zuria (SNNPR), Adabba (Oromiya), and Woreta (Amhara).

The Intervention

Preparatory stage: 2009

- Consultations were held between the FMOH, IFHP, and other partners, as well as health offices (regional, zonal and woreda) to identify implementation sites.
- The necessary logistics and training materials were organized.
- Community mobilization was conducted to create demand and to promote the service.
- A roll-out training for HEWs in the eight pilot *woredas* took six days.
- After the training, each HEW was provided with Implanon and the supplies necessary for insertion for 20 clients for use at the health post of her assignment.
- Post-training follow-up and supportive supervision were carried out by a team from the FMOH, regional health bureaus, and IFHP and its partners.

A review confirmed the success of the practice, which received the endorsement of the FMOH, which led to the national launch of the "Implanon Scale-up Initiative," 2009-2012.

Implanon Scale-up

During the scale-up, the steps taken in the pilot phase were repeated: preparation, training of trainers, rollout of basic Implanon insertion training, post-training supportive supervision, and program review meetings.

A program assessment recommended the distribution of more post-training supply packages for trained HEWs and a gap-filling supply package for health posts as demand increased because of social mobilization.

Staff at 200 health centers were trained in removal of Implanon and were provided with removal kits; staff make regular, monthly visits to health posts to provide implant-removal services.

Results

More than 5,350 HEWs have been trained on the provision of Implanon, reaching 286 *woredas*. A program assessment survey showed that 25% of the clients were new acceptors and more than 20% had shifted from a short-acting to a long-acting FP method.

Feedback from the Validation Visit

The team interviewed HEWs in Adabba (Oromiya) and Sodo (SNNPR) who are among those deployed at the beginning of the Health Extension Program, more than five years ago. These HEWs explained that until the project started, women in their areas had limited information on FP services, and those that were counseled on FP could not access services regularly due to a lack of transportation and time. The HEWs are thus pleased to have simple but effective long-acting FP methods they can offer to their clients. They also expressed feeling encouraged by the

support from health centers as it enables them to refer women who wanted removal of the Implanon or women who choose other FP methods.

An HEW at a health post in West Harerge said, "Now I have something that I can give to the women with too many children who live very far from facilities and whom I always wanted to help." Another said, "I tell the women that I have provided Implanon to my own sisters and cousin and I will use it after I have two children."

What Made the Practice Successful?

- The pilot project developed a process that was used during the scale-up; training materials were developed for the training of trainers, which also created a pool of trainers.
- Implanon, which consists of a single rod, is simple to use and effective as a long-acting FP method.
- Provision of the necessary materials for the trained HEWs allowed them to initiate the service at health posts. The initiative included close monitoring and filling of gaps to ensure continuous service provision.
- The activities were organized through a partnership of IFHP and the FMOH leadership involving regional- to community-level stakeholders.
- The intensive community mobilization allowed dissemination of information that increased demand for the service.
- The intervention builds the capacity of health posts to provide a long-acting FP method (Implanon) at the community level through linkage and the back-up support from health centers and health providers for services beyond the capacity of the health posts (for the removal of implants, for the provision of other forms of long-acting FP methods, such as intrauterine contraceptive devices); hence, the availability of a comprehensive range of FP methods was increased in the primary health unit (health posts and health centers).

Lessons Learned

- Innovative approaches succeed with government and social mobilization.
- Task shifting of long-acting FP services, such as insertion of Implanon, is possible through skilled training and counseling of community-level care providers.
- Post training and a continued supply of materials are important for success.
- When planning social mobilization for awareness creation, it is important to have adequate resources to respond to the resulting increase in demand for services.

Maternity Waiting Area at Attat Hospital

Implemented by Attat Our Lady of Lourdes Catholic Hospital Integrated Health Service

Background

The maternity waiting area (MWA) of Attat Our Lady of Lourdes Catholic Hospital Integrated Health Service—in Guraage Zone of the SNNPR—was opened in 1973 with the objective of providing timely, lifesaving, emergency care to women who live in remote areas with no access to emergency obstetric care. The catchment population for the MWA is more than 800,000; pregnant women are referred to the MWA from the Attat antenatal clinic and from nearby clinics and health centers. However, the hospital accepts all women who come for the service, including women from Addis Ababa.

The Intervention

The MWA at Attat Hospital is built like a rural home with bathrooms, a common kitchen, and a laundry. Clients are charged a nominal fee of 40 Birr and must provide their own food. Admission is usually at 36 weeks, but if she has emergency complications, a client may be admitted earlier. Upon admission, a pregnant woman receives an ANC appointment, including a sonogram to ascertain her gestational age. The residents are visited daily by nurses and have weekly ANC follow-up; those with early signs of pre-eclampsia have their blood pressure checked twice a day; all services are available 24 hours a day. At the onset of labor, the woman is transferred to the maternity ward and the delivery room for the necessary service, including for PMTCT. After delivery, the mother and her baby are discharged following a post-natal checkup, on average, six hours after birth. However, women who had complications or surgery usually stay longer in the postnatal ward or in the MWA.

Results

According to the 2011 Attat Hospital annual report, 501 women were admitted to the MWA: the majority had previous cesarean sections or poor obstetric history—for example, stillbirths or repeat abortions—and the rest had serious or life-threatening illness, such as pre-eclampsia, or other medical reasons, including malaria during pregnancy, HIV, and severe illness.

An article[9] published online in the *British Journal of Obstetrics and Gynecology* in July 2010 describes maternal mortality and stillbirth rates among women admitted for delivery to Attat Hospital between 1987 and 2008, comparing women who were first admitted to the MWA and those admitted directly to the maternity unit. The study concluded that maternal mortality was substantially lower in women admitted via the MWA (90 per 100,000 live births for MWA users, and 1,333 per 100,000 live births for non-MWA users) as were stillbirths (18 per 1,000 live births for MWA users and 191 per 1,000 live births for non-MWA users), with the difference accounted for partly by the provision of timely and appropriate services for women who used the MWA. The rate of cesarean section was 38% for women at the MWA compared to 20% for non-MWA users. There were no uterine rupture cases among the MWA while the rate for non-MWA users was 6%.

An added value of the MWA is that it has raised awareness on the benefits of medical care for survival of mothers and newborns as the community witnesses the success of the program. Health care providers see it as an important link between the community and emergency obstetric care. MWAs are considered to be a solution for each of the three delays.

What Made the Practice Successful?

- Highly motivated, committed, trained, and experienced staff
- Well organized management and service
- An integrated BEmONC service regularly available and backed by adequate CEmONC
- Emergency surgical care provided by surgeons and recently by general practitioners who are trained at the hospital to perform cesarean sections, repair ruptured uterus, and provide post- abortion care. There is always a qualified surgeon resident at the hospital in case of complications.

Lessons Learned

MWAs can improve access to MNH services and have a significant role in averting the loss of maternal and newborn life. They are particularly justified for women who live in remote localities with poor infrastructures and transportation. Every pregnant woman is at risk of complications if care is delayed but mothers with known current complications and past obstetrics complications

[9] Kelly J et al. 2010. The role of a maternity waiting area (MWA) in reducing maternal mortality and stillbirths in high-risk women in rural Ethiopia. *BJOG* 2010; DOI: 10.1111/j.1471-0528.2010.02669.x.

have benefitted from the MWA in Attat. Questions concerning the affordability and feasibility of MWAs are frequently asked; the MWAs can be simple structures similar to local houses; what is crucial is its proximity to an adequately functioning health facility that ensures the provision of effective basic and comprehensive emergency obstetrics care.

Appendix 2: Contact Information and Resources on the Selected Promising Practices

THE USE OF STANDARDS-BASED MANAGEMENT AND RECOGNITION FOR PERFORMANCE AND QUALITY IMPROVEMENT IN MATERNAL AND NEWBORN SERVICES

Implemented by Jhpiego

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Resources

Jhpiego. 2007. Standards-Based Management and Recognition—A Field Guide: A Practical Approach for Improving the Performance and Quality of Health Services, http://www.jhpiego.org/files/SBMR%20FieldGuide.pdf

TRAINING IN BASIC EMERGENCY OBSTETRIC AND NEWBORN CARE USING A COMPETENCY-BASED APPROACH

Implemented by Jhpiego

Resources

- BEmONC training reports and follow-up reports
- Ethiopian Federal Ministry of Health. Health and Health Related Indicators, 2009. Addis Ababa
- Jhpiego. 2000. *Clinical Training Skills for Reproductive Health Professionals*. Baltimore
- Jhpiego. 1998. *Advanced Training Skills for Reproductive Health Professionals*, 2nd ed. Baltimore
- Quality of Care for Maternal and Newborn Health Services National Survey Report, 2010
- Sullivan RL. 1995. *The Competency-Based Approach to Training*. Baltimore.

COMPREHENSIVE EMERGENCY OBSTETRIC CARE TRAINING: IMPROVING THE AVAILABILITY OF EMERGENCY OBSTETRIC SURGERY IN REGIONAL HOSPITALS IN ETHIOPIA

Implemented by the Ethiopian Society of Obstetricians and Gynaecologists

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Resources

Ethiopian Society of Obstetricians and Gynecologists. 2012. CEmONC Project, Facts and Figures, July 2012. (sent upon request)

FAMILY PLANNING/HIV SERVICE INTEGRATION—A MEANS TO REDUCE UNINTENDED HIV-POSITIVE PREGNANCIES AND PEDIATRIC HIV INFECTIONS

Implemented by Pathfinder

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Resources

Pathfinder. 2011. *Integrating Family Planning and HIV in Ethiopia, an Analysis of Pathfinder's Approach and Scale-up*. Technical brief, also available on www.pathfinder.org/Ethiopia.

IMPLEMENTATION OF THE SOCIAL CHANGE FOR FAMILY PLANNING RESULTS INITIATIVE

Implemented by CARE

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Resources

- CARE. 2011. Social Change and Family Planning Results Initiative Mid-Term Review Report.
- CARE. 2009. Social Change and Family Planning Results Initiative Baseline Report.
- CARE. 2007. Social Analysis and Action Manual.

SEXUAL AND REPRODUCTIVE HEALTH IN EMERGENCY SITUATIONS

Implemented by the International Medical Corps

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SINGLE VISIT APPROACH TO CERVICAL CANCER PREVENTION USING VIA AND CRYOTHERAPY

Implemented by Pathfinder

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Resources

- Alliance for Cervical Cancer Prevention. 2004. Cervical Cancer Prevention Fact Sheet: Risk factors for Cervical Cancer: Evidence to Date. http://www.path.org/publications/files/RH_fs_risk_factors.pdf
- Ferlay J, Shin HR, Bray F, Forman D, Mathers C and Parkin DM. 2010. GLOBOCAN 2008, Cancer Incidence and Mortality Worldwide: IARC CancerBase No. 10 [Internet]. Lyon, France: International Agency for Research on Cancer. Available from: http://globocan.iarc.fr.

COMMUNITY-BASED PROVISION OF A LONG-ACTING FAMILY PLANNING METHOD, IMPLANON, BY HEALTH EXTENSION WORKERS

Implemented by Integrated Family Health Program

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Resources

- IFHP. 2011. Scale-up of Task–Shifting for Community–Based Provision of Implanon, Technical Summary 2009-2011. Available on www.pathfinder.org/Ethiopia.
- IFHP. 2010. Provision of Long-acting Methods of Family Planning at the Community Level. An unpublished training assessment report from analysis of data collected during the training period.
- IFHP-Implanon Scale-up Initiative Program Summary—Integrated Family Health Program from July 2009- March 2012. Addis Ababa.

MATERNITY WAITING AREA AT ATTAT HOSPITAL

Implemented by Attat Our Lady of Lourdes Catholic Hospital Integrated Health Service

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Resources

- Kelly J et al. 2010. The role of a maternity waiting area (MWA) in reducing maternal mortality and stillbirths in high-risk women in rural Ethiopia. *BJOG*; DOI: 10.1111/j.1471-0528.2010.02669.x.
- 2011 Annual Report, Attat Hospital Integrated Health Service.

Appendix 3: Questionnaire Used for the Review of the Selected Promising Practices

GENERIC INTERVIEW QUESTIONNAIRE (ADAPTED BY THE REVIEW TEAM ACCORDING TO THE TYPE OF PROMISING PRACTICE UNDER REVIEW)

Background:

- The title/name of the practice
- What population group is the primary focus for the selected practice?
- Information about the location of the practice
    - Is the practice region-wide or in one area of the region/district (specify)?
    - What is the approximate population size?

Baseline data: specify the beneficiary or the target:

- State the evidence that the practice supports the government's strategy/objectives for maternal, newborn, and child health
- Describe the need or justification for the practice: what were the origins? (The sources could be the findings of a needs assessment, national or local data, etc.)
- Indicate the goal and the key objectives of the practice

Design of the practice: the model or the approach used:

- Is the practice based on a theoretical foundation or is it replicated and/or adapted from practices that have proved successful elsewhere? If the latter, specify
- Specify the guidelines used, including samples on how the tools were adapted
- What resources did you need: technical, human resources, additional training and skills and financial?
- Mention the tools such as clinical materials, facility space, additional staff and other inputs allocated and made available to implement the practice
- Who supplied these resources?
- Explain the level of collaboration within the program management/service provision
- Are there partners involved?
    - Who are they?
    - What role did each partner to manager
- Please list the strategies/steps you took to implement this promising practice
- Mention if and what preparatory steps such as training, facility-level changes have been considered? Describe the actions that were taken.

List the key activities in the practice:

- Is there a quality-improvement component in your work plan? (Specify)
- Is there an evaluation plan for the practice?
- Mention the indicators selected and the short-term and long-terms outcomes
- Funding: Please specify your funding source, indicating partners' support

Implementation:

- Indicate the time frame for the practice, start/final date, or indicate if it is ongoing
- Did you use a phased or continuous process?
- The cost of the practice: estimated cost per client: by type/amount of personnel, funds, supplies/materials, etc.
- Was this practice implemented as intended?
- What did not work as planned or expected?
- Why do you think it did not work?
- Discuss the challenges you faced in implementing this practice and how you overcame the challenges you encountered in implementing your practice
- Discuss the lessons learned.
- What unexpected results or positive side-effects have been achieved?

Results/Outcomes:

- What is the status of this promising practice now?
  - Has it been finalized or is it on-going?
- Results of the practice: What data did you collect to measure the outcomes of the practice? Give specific data, including both short-term and long term outcomes
- Please include, or attach, any data from assessments, evaluations, or service delivery statistical reports (compare with data before the implementation of this promising practice) on the number of people that have benefitted from the practice
- Have you received any feedback from your promising practice's target population, service providers, partners?
- Was there an expert/peer review process that determined your practice to have significant evidence of effectiveness (for example, peer-reviewed journal, conference presentations)?
- What is/are the main reasons for the success of the practice? Please list as many reasons as you can
- Can you mention what factors facilitated the success of the practice?
- What would you keep and what would you change if you were creating this practice now?
- Has your practice been replicated (specify in what settings and populations)?

Sustainability:

- Do you know the next steps for your practice? Describe a follow-up plan
- Is there a sustainability plan in place? If yes, please describe
- What has been done to ensure sustainability (capacity building, training provided, resource mobilization, etc.)?
- Is the change your promising practice has brought about sustainable?
- What products/resources resulted from your practice (for example, website, published article, agency report, brochures, online toolkit)
- How would you tell other people about this practice (what is your "take away" message)?

Replicability of the practice:

- Describe the audience or practitioner who would benefit from learning about the practice
- Do you think that it would be possible to repeat your success elsewhere in Ethiopia?
  - In what environment would it be suitable to replicate the promising practice?
- What recommendations would you have to others who will be implementing similar practices?
- What would it take for its replication in terms of resources, actions, and human resources?
- Interviewee contact information (Name, Phone, Email)

Site Visit Guide (facilities include outreach service sites and other sites where the practice is delivered)
Method: Interview program staff, service providers, outreach staff, if any, and other relevant actors. Qualitative data will be collected through observation of clinical practices activities, training materials and the attitude of staff. The review team will agree on a rating of the activities at the practice site.

Facility visit guide:

- Names and location of the facility
- Why were the site(s) selected for the implementation of the promising practice?
- How accessible is the facility?
  - Are there means of transportation?
- Has the inclusion of the practice changed the affordability of the service: is the service more expensive or less?
- Have changes been made to the facility because of the practice?
- Specify changes in infrastructure (expansion, water, electricity, etc.) and refurbishing, and specify if new equipment has been installed

Staff members' interview guide (mention responsibility): Where possible, two staff members will be interviewed, a staff member responsible for program management and a service provider.

- Do you participate in the management and monitoring of the promising practice?
- Mention the training you received, skill acquired, including short training in preparation for the practice
- Do you get adequate supportive supervision?
- Has the practice improved your job satisfaction?
- What are some of the quality improvement opportunities available to you in relation to the promising practice?
- Do you think this promising practice is sustainable?
- If yes, mention what reassuring conditions exist and if not what are the risks?
- Mention feedback received from service users
- Do you see this as successful practice?
    - In your opinion, what are the key issues that make it successful?
- Please give your advice to colleagues who may want to replicate the practice
- What would you advise your colleagues to do, or not to do?

Appendix 4: References

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Appendix 5: List of Contributors

LIST OF ORGANIZATIONS THAT SUBMITTED REPORTS

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- IntraHealth Ethiopia
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- Jhpiego–Ethiopia
- Hamlin College, Addis Ababa
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- Save the Children UK, Ethiopia
- UNFPA, Ethiopia Country Office

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