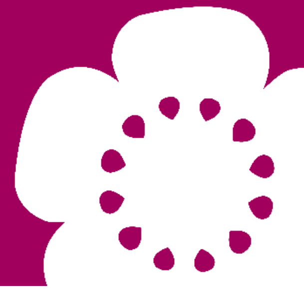
Sustaining Comprehensive Contraception and Abortion Care Services among Transitioned Facilities in Ethiopia

Lessons Learned from EngenderHealth's Access to Better Reproductive Health Initiative (ABRI) Project



Background

Since its launch in April 2008, the Access to Better Reproductive Health Initiative (ABRI) project has followed a rights-based programming approach that puts the sexual and reproductive health and rights (SRHR) needs, interests, and priorities of women and girls at the center of project implementation. EngenderHealth implements the project in six regions (Afar, Amhara, Benishangul-Gumuz, Harari, Oromia, and the Southern Nations, Nationalities, and Peoples' Region [SNNPR]) and two city administrations (Addis Ababa and Dire Dawa). Over the last 12 years, the ABRI project has provided strategic capacity building and technical assistance to the Ministry of Health (MOH) and its subsidiaries focused on improving service delivery, developing and adopting relevant policies and standards, and strengthening systems-related capabilities. We supported a total of 632 public health facilities and catchment communities; trained 17,419 healthcare providers, (including 11,943 community-level providers), in comprehensive contraception (CC) and comprehensive abortion care (CAC) information and service delivery; and distributed nearly five million dollars' worth of CC and CAC supplies and commodities. To date, the project has served more than eight million girls, women, and families with CC and CAC services (7,786,362 with CC and 342,175 with CAC), contributing to a goal of reducing maternal morbidity and mortality in Ethiopia.

Despite the impressive progress achieved by EngenderHealth through the ABRI project, the work to ensure sustainable access to and utilization of SRHR information and services is far from complete. We recognize that there are still millions of women and girls left behind—including married and unmarried adolescents and youth, as well women and girls who have experienced sexual and gender-based violence—who are unable to exercise their rights to full, free, and informed choice. While the MOH has undertaken important steps to initiate domestic finance allocation for health in general, including developing a costed implementation plan for family planning, broader progress has been slow and uncertain and the MOH remains heavily reliant on external aid to finance public health services, including SRHR programs.

Moreover, there is a high level of turnover of trained providers and technical and managerial staff at all levels of the health system, which severely affects the continuity of essential life-saving services, such as CC and CAC. Supply chain challenges, especially a lack of available medical instruments and infection prevention supplies, are frequent and persistent.

Beginning in March 2019, the MOH and our donor directed the project to move beyond the current focus of supporting direct service delivery toward enabling the MOH to take full ownership and accountability for sustaining CC and CAC service delivery. While EngenderHealth has been providing system strengthening support to the MOH throughout the life of the ABRI project, this new guidance called for a paradigm shift in our approach, requiring us to transition the core functions that we used to carry out directly to the MOH. This transition will contribute to building a more resilient public health system capable of delivering uninterrupted essential services.

EngenderHealth's ABRI Transition Plan

Definition: A systematic process of handing over critical CC- and CAC-related technical assistance for service delivery, quality assurance, and health system strengthening functions to the MOH and its subsidiaries. After the transition, the MOH and regional health bureaus will sustain uninterrupted provision of CC and CAC services.

Goal: To contribute to building a more resilient public health system that will deliver uninterrupted essential services at scale and serve more people in more places. The transition will focus on building the capacity of woreda health offices and primary healthcare units to deliver integrated CC and CAC services within reproductive, maternal, neonatal, child, and adolescent health programs.

Timeline: Between January 2020 and December 2021, EngenderHealth will transition 632 public health facilities to the MOH (100% of project-supported facilities). We transitioned 50% of sites by the end of 2020 and will transition the remaining 50% by the end of 2021.

Process: EngenderHealth will follow a streamlined and systematic process to ensure a smooth and seamless transition. Key steps will include co-designing, signing memoranda of understanding, providing tailored support, tapering, and capturing and sharing learning.

To this end, in 2020, ABRI developed a plan for the sustainability and transition of healthcare facilities. The plan aimed to transition support for mature healthcare facilities from the ABRI project to woreda health offices. We developed the transition plan in coordination with regional health bureaus, zonal health departments, woreda health offices, and healthcare facilities that were simultaneously developing a sustainability action plan, which divided responsibilities across all government structures to ensure high-quality CC and CAC services. During the planning meeting, participants identified conditions and mechanisms to ensure successful transitioning and sustainability, including: (1) building the capacity of government partners to conduct supportive supervision and performance reviews, (2) strengthening supply chain management, (3) providing structured on-the-job training (SOJT), and (4) implementing catchment-based mentoring.

In 2020, ABRI transitioned 355 healthcare facilities to woreda health offices. In 2021, we will transition the remaining 277 healthcare facilities. In November and December 2020, ABRI conducted a qualitative study to assess the readiness and performance of transitioned and transitioning healthcare facilities for sustaining CC and CAC services. The aim of this report is to share health facility managers' and other stakeholders' perspectives related to the extent to which high-quality CC and CAC services have been sustained among

transitioned facilities and to review the extent to which these activities have ensured sustainability of project interventions.

Methodology

We conducted a qualitative study in three regional states (Amhara, Oromia, and SNNP) and one city administration (Addis Ababa). We enrolled 39 key informants (KIs) (75% male) from healthcare facilities, woreda health offices, zonal health departments, and regional health bureaus. The study team purposely selected these KIs because of their current positions and their experience with CC and CAC services, with most KIs having served for more than five years in their current positions (59%). The study team asked the KIs a series of questions related to successes, challenges, and sustainability strategies of the ABRI project using a semi-structured questionnaire. The study team coded the data and implemented a thematic-based analysis. Investigators identified themes based on the interview guide and related to barriers and facilitators associated with sustaining uninterrupted availability of high-quality CC and CAC services, as well as the project sustainability and exit strategies.

Key Findings

Success Factors in Sustaining Uninterrupted Availability of CC and CAC Services

Respondents commonly noted that ABRI was successful in creating demand for and expanding access to CC and CAC services. Respondents stated that the number of CAC clients was much higher in ABRI-supported facilities than other facilities. KIs also noted that CAC services were barely available in facilities that were not supported by the project. Furthermore, KIs shared that contraceptive uptake continued to increase even after the ABRI-supported facilities transitioned to woreda health offices.

> *"In our zone, safe abortion care is almost exclusively performed among health facilities that receive support from ABRI. We expected that midwives had the competence to provide safe abortion care at least for those in the first trimester. But in fact, they have never performed the procedure (despite the need). We know that the work of ABRI on value clarifications and the trainings to improve the skills of providers bears fruit. We believe that such lessons from ABRI-supported facilities can be scaled up to other facilities (in our zone)." – KI, Wolyita Zonal Health Department.*

Sustainability and Exit Strategies

The following sections present the extent to which the ABRI project was able to ensure successful transitioning and sustainability, as outlined in the action plan.

Building the Capacity of Government Partners to Conduct Supportive Supervision and Performance Reviews

KIs from the regional health bureaus and zonal health departments stated that ABRI-supported health providers received adequate training through the project. Participants agreed that staff have sufficient experience and expertise to conduct supportive supervision and performance reviews and implement these independently. KIs from this group also reported that they were confident that the services would continue without interruption after the transition is complete.

That said, KIs from the lower-level healthcare facilities and woreda health offices had a different view. These KIs reiterated that the government system did not yet have the capacity to effectively deliver quality CC and CAC services after the transition. While they noted that the ABRI project had excellent experience and expertise in providing training and coaching support as well as facilitating performance review meetings, they believed that supervisors at the regional health bureaus and zonal health departments still did not have sufficient expertise to conduct supportive supervision nor would they able to maintain service quality after transitioning.

> *"I don't think those people working at woredas and regions have a similar level of experience with that as the ABRI staff. ABRI staff are well-trained and committed to building the capacity of our staff. They motivated us to provide good quality family planning and abortion services. By the way, I give more credit to them on their work to motivate us. They did not give us money, but they showed us professionalism and commitment. That was the motivating factor for us." – KI, Wondogenet Health Center*

Strengthening Supply Chain Management

KIs noted that after ABRI reduced its support, healthcare facilities encountered frequent stock-outs of supplies and medications for medical abortions, suggesting issues with supply chain management. While ABRI had established mechanisms to ensure delivery of supplies and medications through the Ethiopian Pharmaceuticals Supply Agency (EPSA), several challenges occurred resulting in these stock-outs.

> *"Before ABRI minimized its support, they [ABRI] were providing supplies and medicines. For example, they provided us with drugs for medical abortion. Now we are receiving those supplies and drugs from EPSA. They [EPSA] never deliver the drugs on time. Last summer, we were unable to provide medical abortion for more than a month because of stock-out of the drugs." – KI, Debrebirhan Health Center*

Providing SOJT

We asked KIs to comment on the status of SOJT activities in their facilities. According to many of the respondents, the SOJT approach was another strategy to ensure sustainability of CC and CAC services. However, the responses from KIs revealed variations in

implementing SOJTs at the regional level. The KIs in the Amhara region believed that healthcare providers were less interested in attending SOJTs, citing lack of incentives as a key reason. Indeed, in Amhara, ABRI provided small stipends for providers who attended SOJTs during the weekends. KIs raised concerns that the region may not be able to pay for such incentives in the future, which could threaten the sustainability of these sites since providers might be less willing to attend or be engaged in such trainings.

Unlike the Amhara region, KIs in the Sidama and SNNP regions noted that many of the healthcare providers at the ABRI-supported facilities eagerly attended SOJTs. As a result, these providers effectively performed procedures, including insertion of long-acting reversible contraceptive methods and CAC services. Our results from these two regions show that the SOJT model may be a promising, sustainable strategy for the transitioning process.

In contrast, the KIs in the Oromia region noted that many healthcare providers had attended SOJT and agreed that such trainings would contribute to long-term sustainability. However, they also acknowledged that SOJTs were unable to train a sufficient number of providers on CAC or insertion and removal of intrauterine devices. The consensus from these KIs was that the SOJTs needed to reach more providers and failed to sufficiently develop skills related to intrauterine device insertion and removal and for CAC.

Implementing Catchment-Based Mentoring

KIs had mixed feelings about the outcomes of catchment-based mentoring activities. KIs from healthcare facilities reiterated that mentors from hospitals were not well-experienced and reflected that this intervention was less helpful. In contrast, KIs from regional health bureaus and zonal health departments viewed the catchment-based mentoring positively; however, they noted that the program should be expanded to include reproductive, maternal, neonatal, and child health (RMNCH) services. These KIs suggested that unless mentors consider all elements of RMNCH programs, mentoring would not be cost-effective nor sustainable. Moreover, KIs raised concerns that there are no financing mechanisms to support the catchment-based mentoring for the foreseeable future.

> *"The issue now is its sustainability. ABRI focuses on CC and CAC. The plan from the MOH is to conduct mentoring in an integrated way. When I say integrated, I mean mentors should cover all RMNCH interventions. If it is conducted in an integrated approach, the program can be sustained as funds can be secured from different sources. If it is intervention-specific, the funding sources will be narrow. We may not be able to cover the expenses while mentors travel to various health centers and the program will finally stumble. At the moment, the government does not allocate budget for catchment-based mentoring." – KI, SNNP Regional Health Bureau*

Program Recommendations

Based on the qualitative data, the ABRI project has identified the following recommendations:

- Establish coordination mechanisms at the district level, such as technical working groups. Strategies should strengthen the coordination mechanisms between zonal health departments and woreda health offices. Technical working groups should meet regularly, and steering committees and taskforces should be revitalized. This would allow for examinations of project sustainability and evaluations of supervision and performance reviews.
- Intensify support to strengthen the supervisory, monitoring, and leadership capacity of the zonal health departments and woreda health offices.
- Establish coordination mechanisms between the EPSA program and the decentralized health delivery system, including the EPSA hubs and the regional health bureaus and zonal health departments. This approach may help minimize barriers in supply chain management and help overcome stock-outs.
- Coordinate activities related to catchment-based mentoring with other partners that have similar interests and target all priority RMNCH interventions instead of solely focusing on CC and CAC services. Catchment-based mentoring could also be enhanced by boosting the capacity of mentors in line with national guidelines and protocols.
- Ensure funding for catchment-based mentoring using various financing mechanisms. ABRI and other organizations can refocus their efforts on conducting policy advocacy to secure financing from the government treasury.

Acknowledgemets

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