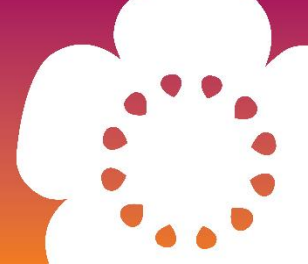


Increasing Uptake of Sexual and Reproductive Health Services in Afar, Ethiopia

Lessons Learned from EngenderHealth's A'ago Project



Background

Ethiopia has achieved immense progress with respect to maternal, newborn, and child survival and healthcare service delivery in the last two decades. However, within the country, considerable disparities in health outcomes and health system performance among the different regions persist (Bobo, Yesuf, and Woldie 2017; Yesuf and Calderon-Margalit 2013; Sheehy et al. 2021). The Afar region, in particular, demonstrates low maternal and obstetric indicators and sexual and reproductive health and rights (SRHR) outcomes. For instance:

- ❁ **Maternal and obstetric care.** Afar has performed worse than the rest of the country regarding improvements in antenatal care visits, births attended by skilled providers, and facility-based deliveries (CSA and ICF 2016; EPHI and ICF 2021). By 2019, in Afar, levels of these indicators were 11 percentage points, 19 percentage points, and 20 percentage points lower than the national level, respectively (UNICEF n.d.). An analysis of hospital-based maternal deaths also reported dramatic inequalities in maternal mortality ratios among regions, ranging from 74 deaths per 100,000 live births in Tigray to 548 deaths per 100,000 live births in Afar (Geleto et al. 2020).
- ❁ **Contraceptive care.** The Ministry of Health's Health Sector Transformation Plan II: 2020/21–2024/25 sought to increase the national contraceptive prevalence rate from approximately 41% in 2021 to 50% by the end of 2025. This goal is incredibly ambitious for Afar, where only 12.7% of women of reproductive age reported using a modern contraceptive method in 2019. Similarly, while the total fertility rate in 2019 was 4.1 births per woman nationally, it was 5.8 in Afar (Gebre and Edossa 2020).
- ❁ **Adolescent and youth SRHR.** Adolescent and youth SRHR is also a critical concern in Afar, with approximately 40% of the population under the age of 18 estimated in 2019 (UNICEF n.d.). Within this population, the median age of marriage is at 16.8 years; further, the adolescent birth rate is approximately 23%, meaning nearly one-quarter of girls aged 15 to 19 have already begun childbearing (CSA and ICF 2016).
- ❁ **Female genital cutting (FGC).** FGC is prevalent in the region. Approximately 91% of females aged 15 to 19 had undergone FGC in 2016 (UNICEF n.d.). Similarly, operational research conducted by EngenderHealth in 2017 found that 89% of respondents have undergone FGC and 29% of respondents' youngest daughters were circumcised.

In Afar, sociocultural norms, gender inequalities, a vast adolescent population, and a large, highly mobile pastoral community combine to prevent the local health system from responding to critical health needs and thwart progress in maternal and obstetric health and SRHR outcomes. The government of Ethiopia is working to address these challenges by strengthening healthcare infrastructure at the primary level and by improving and expanding SRHR interventions. This includes expanding access to a wide range of modern contraceptive methods and comprehensive abortion care and ensuring a compassionate healthcare workforce is capable of providing high-quality contraceptive care (MOH 2021).

Project Summary

In 2017, EngenderHealth, with a consortium of partners and funding from the Embassy of the Kingdom of the Netherlands, launched the A'ago project. The word "A'ago" is an adaptation of the Afari word



“ahago,” which means “hope.” We chose this name as a reflection of the project’s goal of improving the SRHR outcomes of adolescents and youth in Afar and ultimately leading to healthy, empowered, and productive young people in the region. To achieve this goal, the project established three objectives: (1) to increase demand for SRHR information and services among young people and their communities, (2) to increase access to and quality of SRHR services, and (3) to improve the enabling environment for adolescents and youth, particularly girls and young women, to exercise their SRHR. In an effort to generate demand, the project supported 38 out-of-school structures (e.g., youth advisory parliaments, youth clubs, and community youth groups), 34 schools (21 primary, 10 high school, and 3 tertiary education institutions), 516 women development teams. To support SRHR service provision, A’ago also supported 260 health facilities, 224 public health facilities (10 hospitals, 121 health centers, and 93 health posts), and 36 private health facilities. Over the period of implementation, the project trained 1,963 health professionals and 3,585 health extension workers on various SRHR services and renovated 40 health facilities. Furthermore, project-supported providers and facilities reached approximately 257,571 young people with comprehensive SRHR information and delivered preferred modern contraceptive methods to 216,169 women and girls.

Project Approach and Strategies

A’ago built on best practices from previous projects implemented by the consortium partners. EngenderHealth lead the project, bringing SRHR expertise and experience in health systems strengthening, including supporting regional health bureaus and strengthening facility-level service provision in Ethiopia. Amref Health Africa provided complementary experience in community-led health programming. A’ago also leveraged Triggerise’s digital mHealth solutions to provide critical SRHR information and reward healthy behaviors, and Phillips provided innovative portable medical kits to help bring healthcare to remote areas. The A’ago project coupled three primary strategies with three crosscutting strategies:

- 🌸 **Strengthening community systems** to improve knowledge of and attitudes about SRHR and facilitate referrals for services, particularly among young people (*primary strategy*)
- 🌸 **Strengthening health systems** focused on enabling facilities and providers to deliver high-quality SRHR services, including comprehensive contraception and comprehensive abortion care, thereby making SRHR increasingly accessible to young people (*primary strategy*)
- 🌸 **Supporting an enabling environment** in which SRHR laws are enforced and youth are meaningfully engaged at all levels to ensure programming meets their unique needs (*primary strategy*)
- 🌸 **Introducing technological innovations** that offer cost-effective solutions for increasing demand and uptake of SRHR services and enhancing SRHR outcomes, including by providing young people with comprehensive SRHR information and services and by extending services to remote and transient populations (*crosscutting strategy*)
- 🌸 **Systematically integrating gender** into the project, including by ensuring balanced representation and participation in project design and implementation and by including key interventions to directly target women and girls (*crosscutting strategy*)
- 🌸 **Encouraging meaningful youth participation (MYP)**, ensuring adolescents and youth are not passive beneficiaries but rather active participants in planning, implementing, and evaluating the project, including through partnering with existing community structures, such as local youth associations and clubs, youth parliaments, and student groups (*crosscutting strategy*)

Key Interventions

The A'ago consortium implemented a series of interventions to support the project objectives.

Table 1: Priority Project Interventions

Intervention	Description
Objective 1: Increased Demand for SRHR Information and Services	
1.1 SRHR education for out-of-school adolescents and youth	Fostering community engagement via community-level youth groups, health extension workers, and media; initiating/scaling up mHealth solutions to reward healthy behaviors
1.2 SRHR education for in-school adolescents and youth	Introducing/scaling up comprehensive sexuality education; introducing/scaling up Aflateen Youth In Charge comprehensive sexuality education initiative; supporting menstrual hygiene management
1.3 Engagement of influential community leaders	Training health extension workers to engage influential community leaders (e.g., kebele, clan, and religious leaders) and conducting SRHR sensitization for these leaders; facilitating experience sharing for community leaders and youth
1.4 Initiation and scale up of mHealth solutions to reward healthy behaviors	Configuring the Tiko mHealth application, conducting Tiko system trainings, and establishing reward mechanisms; developing/disseminating marketing materials and digital content
Objective 2: Increased Access to SRHR Services	
2.1 Health worker capacity building	Training facility- and community-based health workers on essential SRHR services
2.2 Quality improvement for SRHR	Standardizing trainings including: clinical training for service providers and government officers, structured on-the-job trainings, catchment-based clinical mentorship, and values clarification training for healthcare workers
2.3 Strengthening of SRHR structures	Strengthening outreach teams and private sector partners to expand SRHR services; improving supply chain management of essential commodities and supplies; renovating health facilities; distributing portable medical equipment
Objective 3: Improved Enabling Environment for Adolescent and Youth to Exercise their SRHRs	
3.1 Strengthening of community structures	Establishing/strengthening women development armies (WDAs), establishing/supporting youth-led structures; strengthening the Health Extension Program
3.2 Empowerment of young people to demand and exercise their SRHR	Developing MYP strategy and manuals and conducting MYP trainings; facilitating entrepreneurship training; linking microfinance and supporting out-of-school youth with seed funds for selected small businesses
3.3 Enforcement of SRHR supportive laws	Conducting workshops to position SRHR as a key priority and encourage budget allocation at the local level arranging experience-sharing opportunities for local leaders; sensitizing judiciaries and law enforcement bodies on SRHR

Measuring Success

Evaluation Methodology

In the final year of implementation, A'ago conducted an evaluation of the project. The purpose of this evaluation was to assess the reach and effectiveness of A'ago interventions and to identify successes and promising strategies for replicability and sustainability as well as limitations and challenges in support of program learning. To complete this evaluation, we applied a mixed-method approach that included a review of donor reports and local independent evaluations supplemented with a small number of additional interviews with consortium partners conducted electronically amid the COVID-19 pandemic. The desk review included quantitative data from baseline and endline household and school surveys, health facility reviews, and the District Health Information System as well as qualitative data from mid- and endline evaluations comprising in-depth interviews with implementing partners, civil society stakeholders, local government officials, and healthcare management teams.

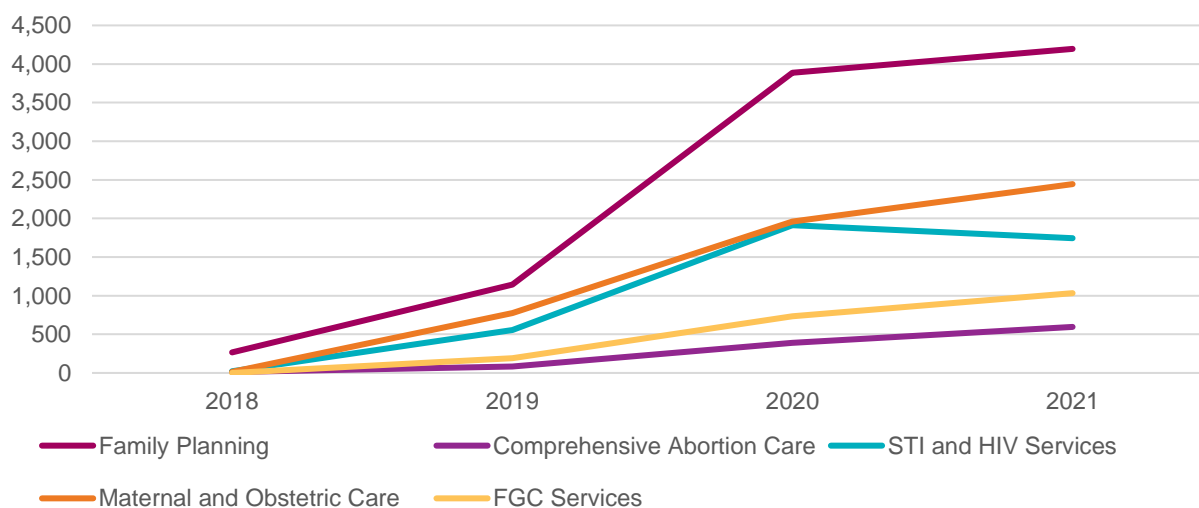
Project Achievements

An assessment of impact and intermediate outcomes demonstrated notable achievements. The A'ago project conclusively contributed to improved knowledge and attitudes related to increased access to and uptake of SRHR services and specifically among adolescents and youth aged 10 to 19 years.

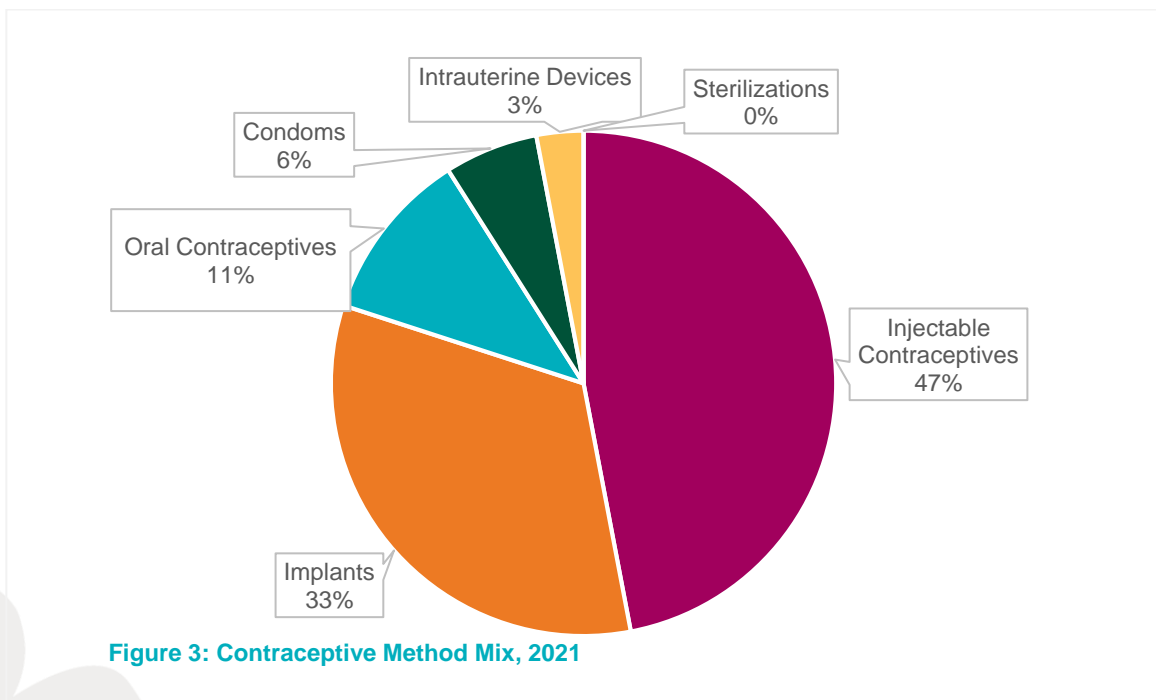
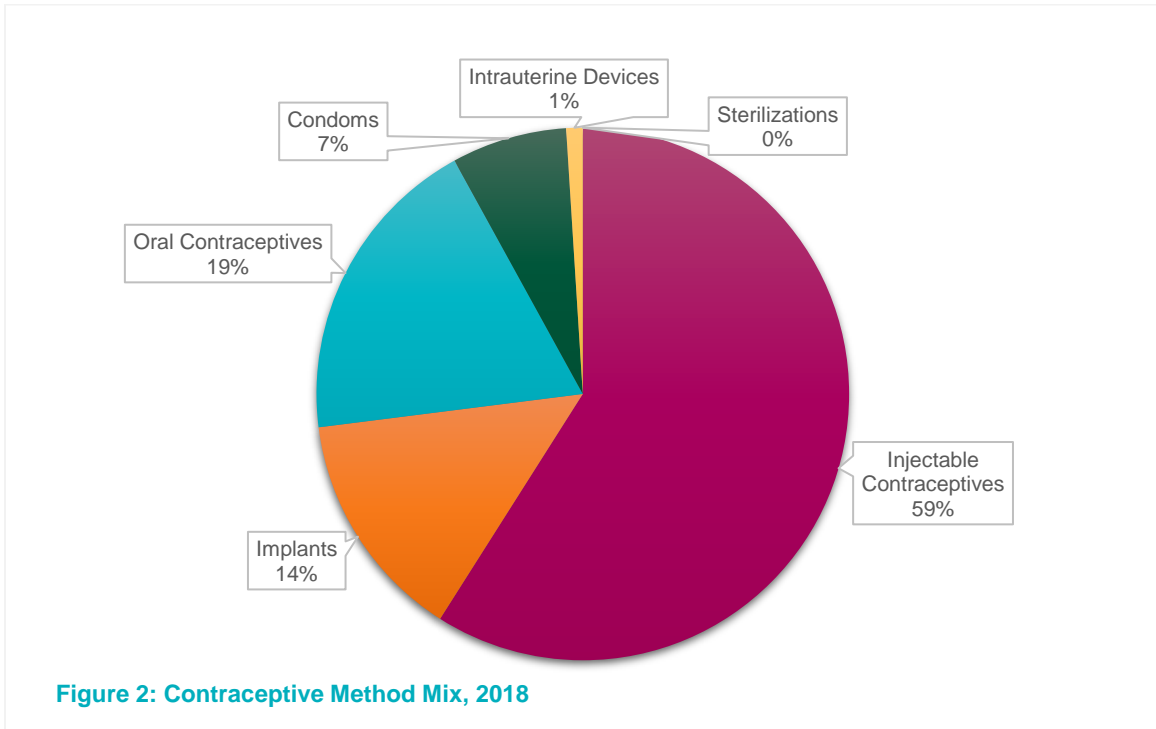
Service Uptake

In terms of couple years of protection, the data are particularly impressive, with an increase from approximately 2,341 in 2018 to 98,251 in 2020 among project-supported facilities. In addition to supporting contraceptive uptake, the project also contributed, in varying degrees, to increases in maternal and obstetric care, sexually transmitted infection (STI) (including HIV services), FGC services, and comprehensive abortion care uptake among adolescents and youth (see Figure 1).

Figure 1: Average Adolescent and Youth Monthly Service Uptake



Additionally, the contraceptive method mix changed as part of both routine and postabortion contraceptive care, with an increase from approximately 15% of long-acting reversible contraceptive method uptake in 2018 to 36% in 2021 (see Figures 2 and 3).



A’ago also contributed to appreciable increases in adolescent and youth uptake of maternal and obstetric care during the intervention period. Project-led household surveys demonstrated that adolescent and youth antenatal care visits increased by approximately 11 percentage points from 20.6% in 2016 to 31.1% in 2019 and that skilled birth attendance among this population more than tripled, increasing from 21% to 64% (EPHI and ICF 2021). As a result, childbearing among adolescents (aged 15 to 19 years) decreased by more than four percentage points from 60.9% to 56.5%, according to the household surveys conducted by the project.

Knowledge, Attitude, and Practices

A pre–post household survey identified clear evidence that project interventions were associated with statistically significant and appreciable improvements in knowledge, attitudes, and practices among the target populations (see Table 2). For instance, adolescent and youth knowledge of contraceptive methods (all 15 available methods) increased from 36% at baseline to 52% at endline and ever-use of contraceptive methods among this population increased from 61.8% at baseline to 92.0% at endline, while current use of modern contraceptive methods increased from 20.4% at baseline to 23.0% at endline. Similarly, comprehensive knowledge of STIs (including HIV) increased from 71% to 81% and attitudinal support for gender equality increased from 61% to 80%. However, our findings also suggest further needs for improvement with regard to general SRHR knowledge and attitudes, neither of which changed over time. Similarly, despite project interventions, respondents reported an increase in circumcision of their youngest daughters, from 28.75% at baseline to 34.6% at endline. Further, the average age of circumcision fell from two years to approximately seven days. A qualitative study found that this increase in FGC during the immediate postpartum period is the result of shifts in local norms resulting, at least in part, from the project’s effort to create awareness around the harmful effects of FGC and to enhance the role and response of key community stakeholders (including government authorities, police, women’s and youth groups, religious leaders, and others) in combatting this harmful practice. As parents now fear punishment if they are caught and reported for engaging in FGC at home, they have begun inviting cultural circumcisers to complete the procedure at health facilities where there may be less of an opportunity for these various stakeholders to notice. These concerning findings require further investigation and intervention.

Table 1: Pre–Post Intervention Adolescent and Youth Household Survey, Select Findings

Category	Baseline (N = 1,553*)	Endline (N = 1,502*)
Knowledge of contraceptive methods	36%	52%
Ever-use of contraception	61.8%	92.0%
Current use of contraception	20.4%	23.0%
Comprehensive knowledge of STIs, including HIV	71%	81%
Attitudinal support (favorable attitudes) for gender equality	61%	80%
Among respondents who delivered in the past 12 months, proportion of skilled deliveries	20.7%	64.8%
Among respondents with a daughter, the percentage who circumcised their last (youngest) daughters	28.75%	34.6%
Among respondents who circumcised their youngest daughter, the median age of circumcision	2 years	7 days

* Denominators for some indicators fluctuate due to missing data and questionnaire skip patterns

Results from a pre–post school survey also indicated appreciable improvements in selected intervention areas as a result of activities targeting in-school youth. Specifically, project interventions were positively associated with self-efficacy, personal understanding, knowledge of modern contraceptive methods, and gender equality in SRHR issues. For instance, with regard to perceptions of adolescents and young students related to SRHR issues, scores increased from 46.43% at baseline to 79.74% at endline among intervention students and awareness of contraceptive methods increased from 86.85% to 95.64%. Similarly, scores related to perceptions of gender equality increased from 57.17% to 65.72% among intervention students.

Project Innovations: Tiko Mobile Platform

Triggerise’s mobile-based digital Tiko system sought to promote demand for SRHR services by improving awareness and strengthening community-facility linkages through rewarding referral agents, clients, and healthcare providers for positive behaviors. Our study identified clear benefits associated with the platform, particularly with regard to improvements in referrals and provider efficiencies. As one provider noted, “it saves time” by reducing typical bureaucratic processes at the facility and “encourages clients to go to the health center.” By the end of the project, approximately 21,495 adolescents and youth received direct benefits through the Tiko intervention.

However, an analysis of user data at the end of the third year of the project found that most users were older (51% were between the ages of 20 and 24 and 32% were between 25 and 29), and most used the platform to access antenatal care (42%) or STI/HIV testing (29%)—demonstrating a gap in serving younger adolescents and improving contraceptive uptake. Additionally, it is important to note the intervention’s reach is limited to literate populations with access (and specifically private access) to mobile technology. Understanding linkages between literacy and socioeconomic status (as indicated by mobile phone ownership) and health-seeking behaviors, it is likely that many of the Tiko users would have accessed services regardless of the app.

Further, our evaluation also identified a couple of important unanticipated negative outcomes associated with this intervention. For instance, one client who received services from a project-supported facility reported experiencing negative repercussions from using the Tiko platform after her spouse received messages from the application, indicating issues with privacy. We also acknowledge that by incentivizing providers, the project may have inadvertently negatively impacted non-Tiko clients. One respondent cited “discriminatory” practices, noting that providers offer preferential treatment to Tiko clients as compared to non-Tiko clients. Finally, it is possible that some clients may have accessed services solely to receive “Tiko miles,” which could be converted to in-kind commodity support at nearby shops.

Project Innovations: Philips Backpacks and Equipment Kits

The Philips-led backpack intervention demonstrated success in expanding services to remote areas and pastoralist communities. A’ago supported provision of these backpacks to approximately 123 health centers and health posts, which, with this new portable equipment, were able to expand services, mainly maternal and obstetric outreach care to previously underserved areas. By the third year of the project, approximately 10 outreach health teams and 122 health extension workers were able to use these backpacks to provide community-based and household-level services. The project also facilitated training of an additional 222 healthcare workers specifically for midwifery outreach.

Anecdotal evidence indicates that this is a promising practice for expanding healthcare reach. By coupling equipment provision with training and mentoring, the project increased the capacity of healthcare workers, thereby improving service quality and accessibility. The positive response from clients further motivated

these providers. As one health extension worker participating in the backpack intervention noted, “Mothers are very happy when we give them SRHR services using the [portable ultrasound] tools inside it [the backpack]...The community has liked it.”

Concluding Remarks: Lessons Learned and Recommendations

Overall, our findings indicate that the A’ago project’s supply-side interventions, which aimed to expand access to high-quality SRHR and maternal and obstetric care, aligned well with awareness-generation interventions, which improved knowledge and attitudes related to SRHR and led to increased demand. The project effectively improved the lives of adolescents and youth and strengthened the health system to sustain critical SRHR services. Our successes indicate several promising practices that merit consideration for replication and expansion, for instance:

- Employing a variety of social and behavioral change communication strategies and community mobilization interventions—including individual outreach, community dialogues, and mass media campaigns—is vital to promoting MYP, transforming gender norms, and increasing demand for and uptake of SRHR services.
- Collaboration with the private sector can improve comprehensive abortion care access and uptake.
- Strengthening primary healthcare systems, strengthening the capacity of health extension workers, and establishing functional health posts are all critical for increasing access to community-level SRHR and maternal health services.
- Catchment-based mentorship and structured on-the-job training interventions are crucial for ensuring health workers are able to deliver high-quality of SRHR services.
- Introducing innovative interventions, including digital outreach platforms and portable medical kits, can improve perceptions of service quality and increase community demand and uptake.

However, there are also areas for improvement and learning. A few key lessons learned and recommendations for future programming include the following:

- Strengthening existing systems is critical for sustainability. Interventions that focused on enhancing provider skills and community and facility structures were key to ensuring the system was able to respond to increased demand and will support continued service delivery beyond the life of project.
- An agile approach to innovation is important for maximizing impact. The backpack intervention was well-regarded by providers and clients alike and demonstrated success in serving hard-to-reach areas and pastoralist communities. However, ineffective planning and coordination limited the scope and sustainability of this intervention. With additional funding, a revised intervention that emphasizes provider training that includes maintenance and linkages with the supply chain system from the start could multiply our project’s impact. Similarly, recognizing the limitations observed with the Tiko platform, future projects must consider literacy and wealth indicators when prioritizing similar technological interventions. For instance, while this may be a winning strategy for engaging youth in urban areas where literacy rates are relatively high and personal mobile phone ownership is prevalent, alternative innovations are necessary in areas where education and income rates are lower.
- Continuous research and evaluation are paramount to long-term success. While the project demonstrated numerous achievements, we also recognize learning gaps persist. For instance, despite

concerted efforts to improve contraceptive uptake among adolescents and youth, uptake among this population increased, but at a similar rate as the rest of the population. Additional inquiry as to why this was the case could be key to identifying high-impact approaches for dramatically improving adolescent and youth SRHR outcomes.

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