ASSESSMENT OF SCALE-UP | ETHIOPIA
Expanding Voluntary Contraceptive Methods to include LARCs in Youth-Friendly Service Units

February 2019
About E2A

The Evidence to Action Project (E2A) is the US Agency for International Development's (USAID) global flagship for strengthening family planning and reproductive health service delivery. The project aims to address the reproductive health care needs of girls, women, and underserved communities around the world by increasing support, building evidence, and leading the scale-up of evidence-based practices that improve family planning services. A Cooperative Agreement awarded in September 2011, E2A will continue until September 2019. E2A is led by Pathfinder International in partnership with ExpandNet, IntraHealth International, Management Sciences for Health, and PATH.

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<tr>
<td>AYRH</td>
<td>Adolescent Youth Reproductive Health</td>
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<td>CAS</td>
<td>Complex Adaptive Systems</td>
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<td>E2A</td>
<td>Evidence to Action</td>
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<tr>
<td>EDHS</td>
<td>Ethiopia Demographic and Health Survey</td>
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<td>FMOH</td>
<td>Federal Ministry of Health</td>
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<td>FP</td>
<td>Family Planning</td>
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<td>GFF</td>
<td>Global Financing Facility</td>
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<td>HMIS</td>
<td>Health Management Information System</td>
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<td>IEC</td>
<td>Information, Education and Communication</td>
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<td>IFHP+</td>
<td>Integrated Family Health Program Plus</td>
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<td>IUD</td>
<td>Intra-Uterine Device</td>
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<tr>
<td>KII</td>
<td>Key Informant Interviews</td>
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<td>LARC</td>
<td>Long-Acting Reversible Contraceptive</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<tr>
<td>MNCH</td>
<td>Maternal, Newborn, and Child Health</td>
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<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
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<td>RH</td>
<td>Reproductive Health</td>
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<td>RHB</td>
<td>Regional Health Bureau</td>
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<td>YFS</td>
<td>Youth-Friendly Services</td>
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<td>mCPR</td>
<td>Modern Contraceptive Prevalence Rate</td>
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<td>USAID</td>
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<td>REST</td>
<td>Relief Society of Tigray</td>
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<td>SNNP</td>
<td>Southern Nations, Nationalities and Peoples</td>
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<tr>
<td>OSSA</td>
<td>Organization for Social Services for Aids in Ethiopia</td>
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<td>FGAE</td>
<td>Family Guidance Association of Ethiopia</td>
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Executive Summary

Background

Context for youth-friendly reproductive health services in Ethiopia

There are more than 21 million people in Ethiopia ages 15-24—comprising nearly 20.1 percent of Ethiopia’s total population.1 Reproductive-age adolescent and young women in this age bracket express high unmet need for family planning (FP) services. Although Ethiopia’s fertility rate has declined over the past two decades, teenage pregnancy rates remain consistently high.2

In Ethiopia, 14 percent of women 20–24 years old were married before they were 15 and 40 percent of women 20-24 years old were married before they were 18 years old.3 According to the 2016 Demographic and Health Survey, 13 percent of adolescent girls 15-19 years old had started childbearing—and, by 19 years old, that statistic jumped to 29 percent. Although adolescents and youth in Ethiopia are using modern contraceptives more than they were in the past—32 percent of 15-19-year-olds and 39 percent of 20-24-year-olds—most prefer short-acting methods. Only 6 percent of 15-19-year-olds and 10 percent of 20-24-year-olds use long-acting reversible contraceptives (LARCs) (i.e. implants and intrauterine devices).4 Because Ethiopian youth account for such a large proportion of Ethiopia’s total population, offering youth the full range of contraceptives, including LARCs, could have a significant impact on reducing unintended teenage pregnancies. This could translate into significant improvements in young Ethiopians’ health and well-being and contribute to the country’s economic growth and development.

A model for offering youth voluntary expanded contraceptive choice, including LARCs, at youth-friendly service (YFS) units was tested and scaled up in Ethiopia’s Amhara and Tigray regions from April 2014-December 2016. The scale-up process was subsequently documented. The three phases of testing (Phase 1), scale-up (Phase 2), and documenting scale-up (Phase 3) through a retrospective assessment are elaborated below in this report.

Testing a service-delivery model offering expanded contraceptive choice to youth (Phase 1)

The Integrated Family Health Program Plus (IFHP+), a USAID-funded program implemented by Pathfinder International and John Snow Inc., from 2008-2016, used an integrated model to strengthen reproductive health (RH) and maternal, newborn, and child health (MNCH) services for rural and underserved populations in Ethiopia. This included targeting youth with RH services8 at YFS units in 248 health centers across six regions - Amhara; Oromia; Southern Nations, Nationalities and Peoples (SNNP); Tigray; Somali; and parts of Beneshangul Gumuz.

At select YFS units in Amhara and Tigray9-10 the USAID-funded Evidence to Action (E2A) Project and IFHP+ conducted a study that pilot tested a model offering voluntary expanded contraceptive choice—including LARCs—to youth in the same place that they receive other youth-friendly RH services. A three-pronged approach comprised the service delivery model9-10.
1. **Supply**: competency-based skills training on LARCs insertion, removal and infection control.
2. **Demand**: refresher training for peer educators to counsel (dispel myths and misperceptions) youth on the safety and effectiveness of LARCs and refer them for services.
3. **Supportive Supervision**: supportive supervision on data collection by the project’s monitoring and evaluation (M&E) and adolescent and youth reproductive health (AYRH) officers, and supportive supervision by IFHP+ and Regional Health Office technical staff.

Results of the pilot test showed that training YFS providers to counsel on and provide all contraceptive methods, including LARCs, in one location with other RH services—referred to in this report as a ‘one-stop shop’—resulted in higher LARCs uptake among all sexually active young women including those delaying their first pregnancy.9-10

IFHP+ disseminated results nationally in August 2015 to representatives of the Amhara and Tigray Regional Health Bureaus (RHBs), the Federal Ministry of Health (FMOH), members of the Ethiopia Society of Obstetricians and Gynecologist, and other high-level stakeholders. Based on study results, IFHP+ urged the FMOH and RHBs to scale up the ‘tested’ model to other YFS units by training all YFS providers to offer LARCs at YFS units. This model9-10 was a change from the previous approach used by YFS providers who previously referred youth to the maternal and child health unit to voluntarily receive LARCs.

**Scaling up the YFS delivery model (Phase 2)**
IFHP+, in collaboration with the Amhara and Tigray RHBs, scaled up the tested model to 55 YFS units in Amhara and 52 YFS units in Tigray. IFHP+ also worked with the Oromia and SNNP RHBs to scale up the model to an additional 75 YFS units—49 in Oromia and 26 in SNNP. Scaling up entailed geographic expansion, i.e., the process of expanding to additional YFS units and bringing a new (although proven intervention) to more people on a sustained basis. Scaling up was restricted to health centers that had YFS units. At the 182 YFS units, YFS providers were trained to provide a range of contraceptive methods (including LARCs), peer educators were trained to dispel myths and misperceptions about LARCs, and IFHP+ and RHB technical staff carried out routine supportive supervision. It is important to note that scale-up sites did not receive supportive supervision for data collection. Systemic health systems challenges—including staff turnover and absences, poor quality of care, commodity security issues, and data quality problems—were not components of the scale-up.

**The retrospective assessment on scale-up (Phase 3)**
By retrospectively examining the scale-up of the YFS model in Amhara and Tigray regions, E2A sought to fill an evidence gap in rigorous documentation of the process and outcomes of scaling up a tested YFS delivery model. Specifically, the assessment sought to identify the factors that facilitated and/or inhibited scale-up of the model additional YFS units.

There are many effective and acceptable FP practices, including those focused-on meeting youth needs, but many of these have not been scaled up. Other best and promising practices have been scaled up without a well-defined systematic scale-up plan, and still others have been scaled up in segments and not as fully tested models. There is often a weak connection between advanced technical knowledge and its
translation into policies, programs, and action. This is largely due to the absence of systematic planning, failure to use systematic scaling-up approaches, lack of country ownership, and lack of rigorous documentation. The findings of the retrospective assessment conducted by E2A, in collaboration with Transform: Primary Health Care Project (the IFHP+ follow-on) are meant to contribute towards the filling of these evidence gaps. Findings are summarized below and detailed in this report.

Assessment Objective

The primary objective of the assessment was to assess the factors/elements that contributed to or inhibited the scale-up of the tested model to YFS units in Amhara and Tigray under IFHP+ and REST/Tigray.

Assessment Design

This retrospective assessment on scale-up used quantitative and qualitative data-collection methods, including qualitative key informant interviews (KIIs) and data extraction from Health Management Information System (HMIS) FP registers. The assessment was conducted in Amhara and Tigray, which are two regions of Ethiopia where the service-delivery model was tested. These regions were purposively selected from the four regions where IFHP+ (and subsequently Transform: Primary Health Care Project) maintain fully operational YFS programs. They were selected based on feasibility and practicality of day-to-day project oversight management. In Amhara, informants were drawn from the RHB, four zonal health offices and four woreda offices, and four health centers within those woredas—all of which had been supported by IFHP+/Transform: Primary Health Care Project. In Tigray, informants were drawn from the RHB, three woredas, and four health centers. Two health centers were supported by IFHP+ and two were not.

The KIIs were designed to elicit information on the factors that both facilitated and/or inhibited successful scale-up of the tested service delivery model to additional YFS units. In addition, information about solutions or resolutions to the challenges encountered were also explored. E2A interviewed senior management and technical staff from each health administrative and service delivery level (region, zone, woreda, and health center), as well as from the Transform: Primary Health Care Project central and regional offices (formerly IFHP+). Unlike Amhara KIIs, Tigray KIIs did not include informants from zones since Tigray does not have zonal health offices. Tigray KIIs also included the Relief Society of Tigray (REST) senior management and technical staff, as REST is the non-IFHP+ implementing partner in Tigray supporting YFS units. Interviews were conducted with staff directly involved in the development and/or implementation of scale-up plans, irrespective of whether they were working in the same position as when the model was scaled up or had transferred to a different position at the time of the assessment. The research team conducted 56 KIIs: 43 public-sector and 13 implementing partner interviews. Management personnel included a head or deputy head at each health administrative level and at the

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* IFHP+ project operational activities concluded in December 2016 with close-out completed by March 31, 2017; Transform: Primary Health Care Project commenced operations from January 2017.
* Amhara; Oromia; Southern Nations, Nationalities and Peoples (SNNP) and Tigray.
* Pathfinder International directly manages IFHP+ and subsequently Transform: Primary Health Care programs in Amhara and Tigray regions.
central and regional offices of the implementing partners. Technical staff included MNCH officers, youth advisors, family planning advisors, and M&E advisors.

**Study Limitations**

A major limitation of this study is the non-representativeness of the sample due to its qualitative design. Qualitative research involves the collection, analysis, and interpretation of data that yield rich and context-specific data that is not easily reduced to numbers. A second limitation is the variability across health centers in Tigray related to the peer educator programs. The two REST-supported health centers in the study sample, to the best of our knowledge, did not include a peer educators’ program, while the IFHP+ health centers in Tigray and Amhara did. The third limitation is that the study was not designed to draw inferences or generalize about the process and outcome of the scale-up approach in these two regions. Rather, it was an exploratory study to determine what worked, what did not work, and barriers and challenges addressed in the development and implementation of the scale-up approach.

**Scaling-up approaches**

The process of YFS service expansion described in this report did not align with one specific systematic scale-up framework. Instead, the author reviewed several systematic scale-up methodologies and observed that several factors are necessary to successfully scale up (geographically expanding) a ‘tested’ service-delivery model. The following six elements were drawn from the review and analysis of these frameworks for their potential contribution to the processes for effective scale-up; and are used to organize the findings of this YFS service delivery model scale-up assessment.

1. Stakeholder engagement
2. Roles and responsibilities
3. Supportive policy environment
4. Mobilizing financial resources
5. Quality of voluntary FP services (counseling and service provision)
6. Data availability and use

These six elements, which are further defined in the report, intrinsically play a role in both the planning and implementation of a scale-up strategy. The six elements do not contribute to scaling up independently. Rather the interplay between these elements, coupled with their relationship to inherent systemic health systems strengths and limitations, contributes to the findings of this study.

**Findings**

This report contains extensive qualitative results from KII's and quantitative results on LARCs uptake from FP registers. Cross-cutting results from Amhara and Tigray are elaborated below and organized by the six scaling-up elements.
Stakeholder Engagement:
The stakeholder engagement process clearly contributed to the sustainability and scale-up of the tested service-delivery model, mainly by nurturing government ownership. Key facilitating factors that supported stakeholder engagement included the government’s prioritization to address youth RH in national policies and guidelines, evidence from the pilot test, and mutual understanding between IFHP+ and the public health system - a trusted relationship built over a decade. Public-sector stakeholders expressed commitment to the tested service-delivery model and were inherently involved in decisions related to scale-up planning and implementation.

The structure and protocols established by Ethiopia’s national health system and healthcare financing reform guidelines determined how stakeholders were engaged in the scale-up process. The FMOH and the RHB focus on policy, strategy, and technical support. The lower administrative levels, zones and woredas, focus on overseeing the management and implementation of policy and strategy at health centers. Irrespective of region (Amhara and Tigray); administrative levels (RHB, zone and woreda); service delivery levels (health center); and implementing partners (IFHP+ and REST), the principal stakeholder (government/RHBs) were directly involved in approving the scale-up plan. IFHP+ sought formal approvals from the RHB by presenting the results of the pilot and scale-up plan. Thereafter, the RHB’s deputy head signed the approval letter that also designated the zones, woredas, and health centers selected for scale up. IFHP+, after receiving formal approval, visited the respective zones, woredas, and health centers to formally discuss implementation of the scale-up plan. The ultimate decision to accept or decline the scale-up plan rested with the woreda health office.

“It is part of the policy to address youth reproductive health needs” – Senior Manager/Regional Health Bureau: Amhara

“The implementing organization has to communicate with the regional health bureau about their plan. It is after the agreement that the lower health administrative levels are communicated to by the regional health bureau. That is the usual flow for any program implementation” – Senior Manager/Woreda: Amhara

“We have owned the LARC service and we are trying to make it sustainable through training more professionals” – Senior Technical/ Regional Health Bureau: Amhara

“A demand from the woreda and the regional health bureau is to sustain and scale-up the service in the remaining health facilities” - Senior Manager/Woreda: Tigray

Roles and Responsibilities:
There were no explicit roles and responsibilities defined for individuals overseeing the management of the scale-up plan. However, roles and responsibilities of the public health system and IFHP+ were well understood, as elaborated in guidelines and implementation protocols and after years of working together. Any friction during implementation was mutually resolved through dialogue.

“There is a national guideline that could help to avoid mix up of roles and responsibilities. We had a common understanding of the program not only with IFHP+, but also other implementing organization that we have been doing for many years” – Senior Manager/ Regional Health Bureau: Amhara
“They […] stakeholders…] have the same understanding…even the district knows each role and responsibility of each other” – Director/IFHP+ supported Health Center: Tigray

“[…] misunderstandings are addressed through […] communication and common understanding” - Senior Technical/Woreda: Tigray

Supportive Policy Environment:
Informants noted a policy environment that supports full access of young people to full contraceptive choice, irrespective of age, parity, and marital status. Translation of this policy environment into YFS, including the scale-up of LARCs training for YFS providers, however, continues to be impeded by several factors. Woredas and health centers are confronted with competing priorities, budgetary concerns, infrastructural weaknesses, staff shortages, provider bias, commodity insecurity, and irregular supportive supervision. The public sector and implementing partners attempted to address these challenges through mutual dialogue and understanding, especially during quarterly review meetings.

“The policy outlines that all reproductive age people have to have access to different contraceptive methods and it is their right to choose and use a method based on information” – Senior Technical/Woreda: Amhara

“There isn’t anyone that is against youth friendly service; even religious leaders are teaching family planning” - Senior Manager/Regional Health Bureau: Tigray

“Resource allocation to the YFS and reproductive health services of the young people is limited. This may be related to budget limitation and prioritizing other health problems over youth reproductive health service, or lack of commitment” – Senior Technical/Woreda: Amhara

Mobilizing Financial Resources
Health services in Ethiopia are primarily financed from four sources: the federal and regional governments; grants and loans from bilateral and multilateral donors; non-governmental organizations; and private contributions/out-of-pocket payments for services rendered. Despite significant improvement over the years, healthcare financing continues to be a major challenge in Ethiopia. Consequently, it is not surprising that budgetary constraints were a major stumbling block to scaling up the tested YFS service-delivery model. There is no specific budget line item for YFS, and budgetary allocations are split unevenly 70:30/curative: preventive, without delineation for specific preventive services. All maternal and child health and FP services fall under the preventive services and are provided free of cost.

Informants from the zones, woredas, and health centers cited income-generation activities led by health centers as a mechanism for raising additional funds for health centers. This type of financing is sanctioned by the current healthcare financing law. However, allocation of the funds generated through health center revenues are subject to decisions made by health center administrative boards and need to comply with defined RHB financial protocols.
“It is unthinkable...cognizant to the critical shortage of the financial resources it would not be possible to allocate budget for specific services like FP. The allocation would be for overall prevention activities in the woreda” - Senior Manager/Woreda – Tigray

“Using some money from the 30% of revenue to fulfill commodities and materials for YFS needs much effort to convince the board [...] and needs attention. In this regard, many HF use a very limited amount of it” - Senior Manager/Woreda: Tigray

“We constructed a YFS at the health center using our internal revenue” – Director/Health Center: Amhara

“It needs time to fully fund by the government capacity” – Senior Technical/IFHP+ Regional Office – Tigray

National policy in Ethiopia indicates a commitment to comprehensively addressing young people’s RH needs. However, programs designed to do just that are not adequately funded and often compete with funding for curative and emergency services. RHs’ renewed commitment to enabling young people to access full contraceptive choice is an emerging ray of hope. With its Global Financing Facility (GFF) funding\(^ {17}\) and FP2020\(^ {18}\) commitments, the FMOH and RHs should ensure that the budgetary allocations are incrementally revised to reach a suggested target of a 60:40/curative:preventive split to fulfill its FP2020 commitments\(^ {18}\) regarding strengthening YFS.

“There is a federal level proclamation that indicates that each health facility needs to mobilize resources on its own and allocate budget for the services they do want to strengthen. Accordingly, they can invest it on activities related to strengthening LARCs” – Senior Technical/Regional Health Bureau: Tigray

“I don’t know of any investment to strengthen LARCs at the YFS unit” – Director/Health Center: Amhara

“Health facilities retain their revenue; and improving the understanding of the need to strengthen YFS unit using their resource is another focus. Thus, influencing the allocation of resources for YFS is the task that needs to be the attention of the public sector” – Senior Manager/IFHP+ Regional Office: Tigray

“YFS is becoming a center of evaluation for health facilities and woredas in the region” - Senior Manager/Regional Health Bureau: Tigray

With regards to macro-level financial commitments, a measure of Ethiopia’s success in leveraging external funding is securing financing from the GFF\(^ {17}\) to contribute to a reduction in the financing gaps for Reproductive, Maternal and Child Nutrition, and Child and Youth Health. In addition, Ethiopia’s FP2020\(^ {18}\) Commitment 3 pledges the country to incrementally increasing and allocating earmarked budget for FP from the SDG pool fund; whereas Commitment 1 pledges Ethiopia to strengthen YFS and referral linkages including improving collection, analysis, and utilization of age- and sex-disaggregated data on adolescents and youth – illustrating Ethiopia’s coordinated efforts to improve the health status of its youthful population.

**Quality of Voluntary Family Planning Services (Counseling and Service Provision):**

Key informants mentioned four interlinked factors—providers (training, commitment, and staff turnover), availability of a separate space for YFS, sustainable commodity supplies, and supportive
supervision with timely feedback—as the major contributors to quality voluntary LARCs/FP services. The consistency of the responses across a diverse group of key informants indicates heightened awareness of quality of care issues that influence program scale-up and sustainability. One of the cornerstones for achieving sustainable programs at scale is an enabling environment within the context of service delivery and health systems strengthening. Therefore, addressing these broader health systems strengthening concerns is paramount to improving quality of voluntary FP services generally and YFS services in particular.

“They …young clients…] do not absolutely want to be served in rooms other than the YFS unit” – YFS Provider/REST-supported Health Center: Tigray

“We also have unavoidable staff turnover and interruption of the service” – Senior Manager/Woreda: Amhara

“Before the training for LARCs, our focus was short-acting family planning methods because we hadn’t been confident to counsel for a service that we would not be able to provide them” – YFS Provider/REST supported Health Center: Tigray

“We make everything available and near to them, so they are getting all information and the service accordingly. The integration of services in one place has also played a major role in improving the quality of the family planning service” – Director/IFHP+ supported Health Center Tigray

“At the regional level, there is increasing uptake of LARC by the young girls from almost nothing. This is one achievement” – Senior Technical/Regional Health Bureau: Amhara

Data Availability and Use:

Key informants from both regions mentioned that data were used for performance monitoring by the implementing partner and the public health sector. There were minor differences in the frequency (monthly or quarterly) of data submission from FP registers at the facility level to the next higher public health system administrative level. Performance monitoring issues included lack of data on contraceptive use by method type, forecasting commodity shortfalls, and low performance on a range of performance monitoring indicators. Challenges encountered included poor data quality (over- or under-reporting), and unavailability of age- and method-specific disaggregated data that hampered appropriate interpretation of YFS contraceptive utilization performance. While the national FP register has an age column, the compiled monthly and/or quarterly format does not.

“The first issue in quarterly meetings […] is whether we are achieving the rate […] LARCs utilization rate […] or not. Our plans will then be based on this. If the utilization rate is low, we have to improve and expand the services. The data is useful for planning and decision making” – Senior Technical/Woreda: Tigray

“We examine the data to find out which methods are increasing, and which ones are decreasing. We try to investigate the reasons” – Senior Technical/Woreda: Amhara
“The existing reporting format doesn’t have age disaggregated method use” – Senior Manager/Zone: Amhara

This shortcoming has been raised with the FMOH’s planning division on several occasions and is being addressed in the roll-out of the new HMIS, DHIS2 aligning with Ethiopia’s FP2020 Commitment 1.18

**LARCs Uptake:**

Key informant perceptions, by and large, indicated increase in LARCs uptake across the eight health centers, although these perceptions were largely uncorroborated by data from FP registers. At only two health centers (one each in Amhara and Tigray), a statistically significant increase in LARCs uptake was documented. This could be due to a confluence of aforementioned challenges to service quality and health systems strengthening.

“However, the health center, which have trained providers for LARC are making a difference in improving the method mix. Besides, I could say that there is a transformation from pill to Implanon in method of choice for FP” – Senior Manager/Woreda: Tigray

“The young people are now seeking service. The uptake of LARCs has increased. The increasing awareness and change of attitude towards LARCs are achievements” – Director/Health Center: Amhara

A major advantage of mixed methods evaluation studies is that the quantitative and qualitative findings corroborate and thereby provide a more holistic picture of the evaluation results. Our findings indicate some contradictions between the qualitative and quantitative results. For example, public sector and implementing partner stakeholders perceived an increase in LARCs uptake among new acceptors post-LARCs training even though the quantitative HMIS data did not show statistically significant LARCs increase among new acceptors, except in two of the eight YFS study units. These qualitative results may indicate a social desirability response bias – the tendency of respondents to answer questions that will be viewed favorably by others. In addition, the quantitative findings indicating the lack of a statistically significant increase in LARCs uptake could possibly reflect a ceiling effect – LARCs uptake among new acceptors had reached a pre-determined level. Irrespective of social desirability bias or ceiling effect, the low concurrence between our qualitative and quantitative findings might also reflect other contextual factors including seasonal variability, low peer educator influence, LARCs trained youth-friendly providers influence, staffing shortages, commodity insecurity among other quality of care issues. A combination of these confounding factors might have contributed to the conflicting qualitative and quantitative findings.

**Conclusions**

Although the Ethiopian government remains committed to improving AYRH, offering full contraceptive choice to young people continues to be hampered by limited financial resources. Without an obligated budget line item for AYRH generally—and more specifically for dedicated YFS units staffed with youth-friendly trained personnel established in health centers, hospitals and universities included in regional, woreda and health center budgets—there will continue to be challenges to sustaining and scaling up the
tested YFS delivery model in Amhara, Tigray, and beyond. To encourage LARCs uptake among adolescents and youth, reduce teenage pregnancies, delay first birth and space second and subsequent births, health systems need to be strengthened so that YFS units can offer adolescents and youth full contraceptive choice in a confidential and comfortable space where they can receive counseling and services that ensures voluntary informed choice by a trained youth-friendly provider. To accomplish this, health systems will need to be strengthened to address human resource shortages, quality of care, and data availability and use.

The ability to offer Ethiopian youth LARCs in a ‘one-stop-shop’ where they receive a full range of RH services is paramount to improving RH outcomes, reducing unintended pregnancy, improving maternal health, and achieving Sustainable Development Goal 3. Ethiopia has moved forward in updating its FP2020 commitments and leveraging funds to meet the aspirations of its young people. Specific suggestions targeting various policies and implementing structures include continuation and strengthening of policy dialogue at FMOH and RHBs to strengthen YFS, including incrementally increasing preventive care financial allocation; creating and strengthening YFS units; and addressing human resource challenges and quality of care. At the implementing zonal, woreda and health facility levels, establishing and strengthening YFS units, providing quality YF services including LARCs at YFS units and actively addressing human resource shortages, commodity security, data utilization of age- and sex-disaggregated HMIS DHIS2 and supportive supervision are critical.
Introduction

Background

Childbearing and Contraceptive Use Among Ethiopian Youth

Nearly 20.1 percent of Ethiopia’s 105 million people are youth ages 15-24.¹ The Ethiopia Demographic and Health Survey (EDHS) 2016² reports that the country’s total fertility rate has steadily declined over the course of the past 15 years, from 5.5 children per woman in 2000 to 4.6 children per woman in 2016. This is despite a persistently high child marriage rate—14 percent and 40 percent of women aged 20–24 years old were married before they were 15 and 18 years old respectively.¹ Teenage pregnancy rates remain consistently high. In 2011, the EDHS⁴ reported that 12 percent of adolescent girls, aged 15-19, had started childbearing, and that 34 percent were either mothers or pregnant with their first child by age 19. Of the young mothers, very few—only 1 percent—were 15 years of age. Not much had changed in 2016 in terms of these indicators. The 2016 EDHS² reported that 13 percent of adolescent girls, 15-19, had started childbearing. Just 2 percent of those adolescents were age 15, but by age 19, 29 percent of adolescents were either pregnant or new mothers.

The EDHS 2011⁴ reported relatively high unmet need for FP and total demand for spacing among the 15-19 age group —30.3 percent and 52.9 percent, respectively—and 20.3 percent and 49.8 percent among those ages 20-24, respectively. The EDHS 2016² shows a declining, though still relatively high, unmet need and total demand for spacing among youth: 20.5 percent of 15-19-year-olds and 18.5 percent of 20-24-year-olds expressed an unmet need for FP. Demand for pregnancy spacing of 15-19-year-olds and 20-24-year-olds also remained high: 48 percent and 50 percent, respectively.²

Modern contraceptive prevalence rate (mCPR) steadily increased among both age brackets of young Ethiopian women as reported in the EDHS of 2011⁴ and 2016². In 2011, 5.2 percent of adolescents, 15-19, and 22.2 percent of young women, were using a modern contraceptive; a negligible few were opting for either an intrauterine device (IUD) or implant.⁴ In 2016, 31.8 percent of those ages 15-19 and 38.5 percent of those ages 20-24 were using a modern contraceptive, with an increase among those using an IUD or implant (5.8 percent ages 15-19 and 9.9 percent ages 20-24 year).² According to both EDHS surveys, Ethiopian youth preferred short-acting methods, with injectables being the most popular.²⁴ Young people in Ethiopia experience high unmet need and total demand for FP.²⁴ Because Ethiopian youth account for such a large proportion of Ethiopia’s total population, meeting their RH and FP needs could translate into significant improvements in Ethiopians’ health and well-being and their countries’ economic growth and development.

Ethiopia’s Healthcare System⁵

The FMOH introduced a three-tier healthcare delivery system nearly a decade ago:

- **Level One** represents primary care composed of a primary hospital (for 60,000–100,000 people), health centers (for 15,000–25,000), and their satellite health posts (for 3,000–5,000 people) connected to each other by a referral system. The primary hospital, health centers, and health posts form a primary healthcare unit.
- **Level Two** encompasses secondary care at a general hospital for 1–1.5 million people; and
- **Level Three** designates tertiary care at a specialized hospital for 3.5–5 million people.
The FMOH and the RHBs focus mainly on policy, strategy, and technical support while zone and woreda health offices manage and coordinate the operation of the zonal and district (woreda) health systems under their jurisdiction. The RHBs are responsible for general and primary hospitals, health centers, and health posts, and private-sector health facilities in their regions. Health professional training institutions, established by the regional government, ensure that professionals who are engaged in public health services operate by national guidelines and standards.

The primary healthcare system is the community’s entry point into the healthcare system and typically provides general preventive, curative, and promotive services. The devolution of power to regional governments has resulted in the shifting of decision-making for public services from the national level to the regional level, and even down to the district level.5

Health services in Ethiopia are financed from four sources 5-6—the federal and regional governments; grants and loans from bilateral and multilateral donors; non-governmental organizations (NGOs); and private contributions denoted by out-of-pocket payments. The FMOH has adopted a healthcare financing strategy that focuses on efficiency of allocation and utilization of public health resources, mobilization of additional resources from international donors and development partners, retention and utilization of user fee revenues at health facilities, the introduction of private wings in public hospitals, and public and community-based health insurances.

Ratification of the Healthcare Financing Reform Proclamation in 1998; and subsequent regulation by the regional governments and city councils were the first steps towards the collection of user fees for funding health facility activities. Operational manuals describing the fee revenue collection process, financial administration, accounting, auditing, and procurement of goods and services were distributed to facilitate financial reform implementation. In addition, functional health facility governance boards with key representatives from health, finance, community, and other relevant sectors were established and empowered with decision-making for how health facility-generated funds are used. Despite significant improvement over the years, healthcare financing continues to be a major challenge.5-6

**IFHP+: Meeting Young Ethiopians’ Contraceptive Needs**

IFHP+ used an integrated model to strengthen RH and MNCH services for rural and underserved populations in Ethiopia. IFHP+’s integrated model operated in 300 woredas in Amhara; Oromia; SNNP; Tigray; parts of Beneshangul Gumuz and Somali regions. During its implementation period, the EDHS of 20067, 20114 and 20162 showed a sustained rising trend in mCPR in the Amhara and Tigray regions (see Figure 1).
Figure 1. Trends in modern contraceptive prevalence rate among young Ethiopians; 2005-2016, Ethiopia Demographic and Health Surveys

![Graph showing trends in contraceptive prevalence rate among young Ethiopians between 2005 and 2016 in Amhara and Tigray regions. The graph illustrates an increase in prevalence from 16% to 33% in 2005, and a further increase to 21% in 2011, with a significant jump to 35% in 2016 for Tigray.]

Data Sources:


IFHP+ targeted youth with an AYRH program. A key feature of the AYRH program was the incorporation of YFS units in health centers at 248 sites across six regions including parts of Beneshangul Gumuz and Somali regions. In IFHP+ woredas, there has been significant improvements in AYRH indicators, largely due to the project's attention to the provision of YFS that include provision and counseling on LARCs. Previously, at YFS units, young people were counseled on all contraceptives, but were referred to the main FP unit for LARCs. Because Ethiopian youth account for such a large proportion of Ethiopia’s total population, offering youth the full range of contraceptives—including LARCs—could have a significant impact on stymieing unintended teenage pregnancies, translating into significant improvements in young Ethiopians’ health and well-being and contributing to the country’s economic growth and development. Consequently, IFHP+ developed an evidence-based strategy to convince policymakers and technical staff at the regional, zonal, and woreda levels to strengthen the provision of YFS at IFHP+ sites by including LARCs provision. Steps to developing and operationalizing that strategy follow.
Testing and Scaling Up a YFS model for Expanded Method Choice

Phase 1—Testing a strengthened YFS delivery model (April 2014–August 2015)

With assistance from the USAID-funded E2A Project, IFHP+ conducted a study that tested a model offering expanded contraceptive choice—including LARCs—to youth in the same place that they receive other youth-friendly RH services. A three-pronged approach comprised the service delivery model:9-10

- **Supply:** competency-based skills training for YFS-trained providers on LARCs insertion, removal, and infection control.
- **Demand:** refresher training for peer educators to counsel (dispel myths and misperceptions) youth on safety and effectiveness of LARCs and refer them for services.
- **Supportive Supervision:** supportive supervision on data collection by the project’s M&E Officers and IFHP+’s AYRH and M&E officers, as well as supportive supervision for services by IFHP+ technical staff in addition to the Regional Health Office technical staff.

The model was tested at IFHP+-supported YFS units in Amhara and Tigray regions.9-10 A fully functioning YFS unit includes a separate room, supplies and commodities, Information, Education, and Communication (IEC) materials, and trained YFS providers and peer educators who provide integrated FP/RH services.8 Results of the pilot test show that training YFS providers to counsel on and provide all contraceptive methods, including LARCs, in one location with other RH services—referred to in this report as a ‘one-stop shop’—resulted in higher LARCs uptake among all sexually active young women including those delaying their first pregnancy.9-10

IFHP+ disseminated results nationally in August 2015 to representatives of the Amhara and Tigray RHBS, FMOH, members of the Ethiopia Society of Obstetricians and Gynecologist, and other high-level stakeholders. Based on study results, IFHP+ urged the FMOH and RHBS to scale up the ‘tested’ model to other YFS units by training all YFS providers to offer LARCs at YFS units,9 replacing the practice at the time of referring youth for LARCs to the MNCH unit where FP services are offered to the general population.

Phase 2—Scaling up a Strengthened YFS Delivery Model (September 2015–December 2016)

IFHP+, in collaboration with the Amhara and Tigray RHBS, scaled up the tested model to 55 YFS units in Amhara and 52 YFS units in Tigray. IFHP+ also worked with the Oromia and SNNP RHBS to scale up the model to an additional 75 YFS units, 49 in Oromia and 26 in SNNP. Scaling up entailed geographic expansion, i.e., the process of bringing a new, although proven intervention, to a larger number of YFS units and thereby serve more young people on a sustained basis. Because not all health centers had YFS units, scaling up was restricted to those health centers that did. At the 182 YFS units, the YFS providers were trained to provide LARCs services, and the peer educators were trained to dispel myths and misperceptions about LARCs. At all sites, routine supportive supervision carried out by IFHP+ and RHB technical staff continued, however, scale-up sites did not receive supportive supervision for data collection. It is important to note that addressing systemic health systems challenges, including staff
turnovers and absences, poor quality of care, commodity security issues, and data quality problems were not components of the strengthened YFS delivery model.

**Phase 3—The Retrospective Assessment on Scale-Up**

Many FP/RH practices are known to be effective and acceptable, but they have not been scaled up. Other practices have been scaled up without a well-defined systematic scale-up plan, and still others have been scaled up in segments and not as a fully tested model. There is often a weak connection between advanced technical knowledge and its translation into policies, programs, and action. This is largely due to the absence of systematic planning; the use of systematic scaling-up approaches; a lack of country ownership; and the lack of rigorous documentation of the process and outcome of scaling up a ‘tested’ approach. There is a small evidence base on the necessary conditions for developing scale-up plans for FP/RH practices, however, there is not robust evidence for the application of the scale-up plans. Evidence is particularly lacking on factors, barriers, and challenges encountered during scale-up that affect success or failure. To help fill this evidence gap, E2A, in collaboration with *Transform: Primary Health Care Project* (the IFHP+ follow-on) conducted a retrospective assessment of scaling up the tested model. The findings of the assessment are detailed in this report.

**Assessment Objective**

The primary objective of the assessment was to assess the factors/elements that contributed to or inhibited the scale-up of the tested model to YFS units in Amhara and Tigray under IFHP+ and REST/Tigray

**Scaling-Up Approaches**

The process for testing and scaling up the service-delivery model for YFS described in this report did not align with any one specific systematic scale-up framework. However, review of three systematic scale-up frameworks—ExpandNet’s *Nine steps for developing a scaling-up strategy*, the *Complex Adaptive Systems (CAS)/Paina and Peters framework*, and the *AIDED/Perez-Escamilla framework*—show that several factors are necessary for successfully scaling up (geographically expanding) a ‘tested’ service-delivery model. We looked at the relevant elements of these frameworks within the context of Ethiopia’s health system to arrive at the following six elements. These elements were used to organize the assessment’s findings. The elements are: 11-13

1. Stakeholder engagement
2. Roles and responsibilities
3. Supportive policy environment
4. Mobilizing financial resources
5. Quality of voluntary FP services (counseling and service provision)
6. Data availability and use

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*IFHP+ project operational activities concluded in December 2016 with close-out completed by March 31, 2017; Transform: Primary Health Care Project commenced operations from January 2017.*

*Because it is retrospective, IFHP+ and REST are referred to as the “implementing partners” in this report, and not *Transform: Primary Health Care Project.*
These six elements intrinsically play a role in planning and implementing a scale-up strategy. The six elements do not contribute to scaling up independently; rather, the interplay between these elements, coupled with their relationship to inherent systemic health systems strengthening limitations, influenced how the model is scaled up. For example, without a supportive policy environment, it would be difficult to invest in strengthened YFS, secure financial commitment for YFS, and engage stakeholders for their support. Definitions of these six elements are found in the introduction to the results section of this assessment.

**Background on E2A and Rationale for the Retrospective Assessment**

E2A is USAID’s global flagship project for strengthening quality FP/RH service delivery. To meet its objectives of strengthening service delivery and increasing access to and use of FP services, E2A works through an “evidence to action cycle.” The “evidence to action cycle” ensures interventions are tailored to the diverse needs of the communities the project serves, while at the same time, includes best and promising practices that can be scaled up to meet the needs of larger populations beyond those original pilot communities. This continuous, cyclical process is participatory and relies on close collaboration with global, regional, national, and local partners to strengthen service delivery specifically and health systems more broadly to enable effective implementation and scale up to increase access to, and use of, contraceptives. The phased approach to testing the model (Phase 1), scaling up the model (Phase 2), and conducting a retrospective analysis of the facilitators and barriers to the scale up process (Phase 3) is illustrative of the E2A cyclical approach (see Figure 2). Findings from the assessment will contribute to the knowledge base in Ethiopia and globally about factors that facilitate or hinder the scale up of a “tested” service delivery model offering expanded contraceptive choice to adolescents and youth.
Figure 2. E2A’s approach to generating, disseminating, and implementing an evidence-based, action-oriented learning strategy
Methodology: The Retrospective Assessment of Scale-Up

Overview
This retrospective assessment of scale-up sought to determine what worked and what did not work in scaling up the tested service-delivery model to YFS units in Amhara and Tigray. The research team identified barriers to scale-up and how they were addressed. The assessment ascertained the roles and responsibilities of senior management and technical staff and examined collaboration within IFHP+ and respective regional, zonal, woreda and health center teams.

Study Design
This retrospective assessment on scale-up used a mix of quantitative and qualitative data-collection methods—KII and data extraction from HMIS FP registers. The assessment was conducted in two regions of Ethiopia where the service-delivery model was tested, Amhara and Tigray. These regions were purposively selected from the four regions where IFHP+ (and subsequently Transform: Primary Health Care Project) maintains fully operational YFS programs. They were selected based on feasibility and practicality, enabling day-to-day project oversight management.

Sampling
The Amhara and Tigray primary health care delivery systems constituted the sampling frames for each region (see Figure 3). E2A applied a purposive, multi-stage sampling strategy to select the individual woreda-health center dyad unit in each region.

Figure 3. Ethiopia’s Primary Health Care Delivery System

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f Senior manager and technical staff at Center/Addis Ababa and regional/Amhara and Tigray offices

g Amhara; Oromia; Southern Nations, Nationalities and Peoples (SNNP) and Tigray.

h Pathfinder International directly manages IFHP+ and subsequently Transform: Primary Health Care programs in Amhara and Tigray regions.
Administratively, there are 11 zones, 167 woredas, and 520 health centers in the Amhara region, and 7 zones, 52 woredas, and 218 health centers in the Tigray region. As of December 2016, the tested service-delivery model had been scaled up to 6 zones, 47 woredas and 55 health centers in Amhara supported by IFHP+, and 6 zones, 31 woredas and 52 health centers in Tigray (See Figure 4).

Figure 4. Flow chart illustrating the total number of zones, woredas and health centers in the primary health care delivery systems of Amhara and Tigray (first row), cascading to the sampled zones, woredas and health centers (fifth row).

Not all zones or woredas in each region were transferred from IFHP+ to Transform: Primary Health Care Project. E2A, therefore, limited the sampling frame to only those zones, woredas, and health centers transferred to Transform: Primary Health Care Project. Furthermore, zones, woredas, and health centers designated as ‘high-risk,’ in terms of security, were also excluded. Finally, the 20 YFS units/health centers where the model was tested (10 intervention and 10 non-intervention health facilities) were excluded, although the woredas and zones where those health centers are located were included. (See Appendix 1 for further details).

Tigray

In Tigray, YFS units that were not supported by IFHP+, but had functional YFS units with YFS-trained providers were included as scale-up sites and therefore included in the sample.

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1 IFHP+ concluded its field operations as of December 2016
1 Transform: Primary Health Care Project commenced operations as of January 2017
**Cluster 1 (IFHP+ supported)**

In total, 5 zones, 12 woredas, and 12 health centers comprised the final sampling frame of IFHP+-supported YFS units in Tigray (Cluster 1 Tigray sites). E2A randomly selected 2 zones and within each zone, 1 woreda, and within each woreda, 1 health center, to achieve a sample of 2 zones aligned to its 2 woredas, and subsequently aligned to 2 health centers.

**Cluster 2 (not supported by IFHP+)**

In total, 2 zones, 4 woredas, and 4 health centers comprised the final sampling frame of YFS units not supported by IFHP+ (Cluster 2 Tigray sites). E2A randomly selected 2 zones and within each zone, 1 woreda, and within the woreda, 1 health center, to achieve our sample of 2 zones, 2 woredas, and 2 health centers. Of the 4 health centers, two were IFHP+-supported and two were not supported by IFHP+. One IFHP+-supported health center and one health center not supported by IFHP+ were in the same woreda and zone.

**Amhara**

In Amhara, only health centers with YFS units supported by IFHP+ were included as scale-up sites. In total, 4 zones, 16 woredas, and 16 health centers comprised the sampling frame. E2A randomly selected 1 woreda in each zone, and 1 health center in each woreda for a final sample of 4 zones, 4 woredas, and 4 health centers.

**Qualitative Data Collection: Key Informant Interviews**

The KIIs were designed to elicit information on the factors that contributed to successful scale-up of the tested service delivery model to YFS units, challenges and barriers faced, and resolutions to those barriers. E2A interviewed senior management and technical staff at each health administrative and service delivery level (region, zone, woreda and health center), and Transform: Primary Health Care Project (center and regional offices). Interviews were conducted with staff directly involved in the development and/or implementation of scale-up plans, irrespective of whether they were working in the same position as when the model was scaled up or had transferred to a different position at the time of the assessment.

While the administrative organograms in both regions were similar—consisting of zonal, woreda and health center levels—operationally, Tigray’s organogram excludes zonal staff. Consequently, Tigray KIIs excluded senior management and technical staff at the zonal level. Tigray KIIs included REST senior management and technical staff, as REST is the non-IFHP+ implementing partner in this region. The research team conducted 56 KIIs: 43 public-sector and 13 implementing partner interviews (see Tables 1 and 2).
The KIIs commenced with introductions and information about the purpose of the interviews. Respondents were briefed about the need for confidentiality and asked to participate through an informed consent process. Respondents were assured of confidentiality, the right to withdraw from the interview, and the right to decline to respond to any questions. Information on respondents’ educational qualifications and professional positions held prior to December 2016 and after were recorded. Each KII was facilitated with a guide that contained a series of questions aligned with the assessment’s main elements, including respondents’ reflections on successes/achievements, challenges, and barriers. To facilitate the flow of questions, initially, the respondent was asked to generally describe the events that happened at their offices/health facility/YFS unit, followed by a series of probing questions aligned to the study’s main elements of interest. All KIIs were recorded.

Qualitative data-collection instruments consisted of three different KII guides for (1) senior management and technical staff at RHBs, and zonal, and woreda health offices; (2) senior management and technical staff at health centers; and (3) senior management and technical staff at implementing partners’ regional and central offices.

**Quantitative Data Collection: Family Planning Registers**

Ethiopia’s HMIS includes a column on age in its FP registers. This allows for monthly submission of age-disaggregated data on FP uptake from all health centers to the woreda health office. The research team reviewed FP registers at the YFS units of the eight health centers in Amhara and Tigray to extract FP service utilization data for the six months prior to training month, the training month itself, and six months after the training month, for a total of 13 months. The LARCs training for YFS providers occurred at different points in time, between September 2015 and December 2016, for each of the eight
health centers. For each selected health center, the training month was identified, and relevant pages of the FP register were scanned accordingly. Relevant data (age, acceptor status/new vs. repeat, method uptake) were extracted from these scanned pages and transferred to Excel spreadsheets to ensure standardized data extraction across all eight health centers.

**Training and Pretesting of Tools**

Two research teams recruited from the regional universities in Amhara and Tigray collected the data. Three researchers comprised each team, one senior and two junior faculty (see Appendix 2). All the researchers participated in a five-day training workshop conducted by E2A and Pathfinder/Ethiopia, which sought to achieve the following objectives:

- Develop a common understanding of the study objectives, including the main elements of interest;
- Become familiar with the data-collection instruments; relate instruments to study objectives and revise draft instruments as needed;
- Review study processes, including the identification and recruitment of respondents and administration of study instruments;
- Develop a shared understanding of the ethical and confidentiality issues involved in conducting the study;
- Develop a shared understanding of the research teams’ roles and responsibilities (senior and junior research staff);
- Pilot-test the interview tools;
- Share information and learn from each other about how best to conduct the study.

The KII guides were pre-tested on days three and four of the training to determine clarity, flow, and cultural appropriateness of the questions. The pre-test was conducted in Oromia region. During the pre-test, the KII guides were administered at the regional, zonal, woreda, and health center levels. Each research team had the opportunity to conduct an interview with senior management and technical staff. Based on the observations during the pre-test, the survey instruments were revised and re-worded as needed. The finalized KII guides were subsequently reviewed on the last training day in plenary session. Templates for transcription were drafted and discussed with the research teams.

**Data Collection**

Identification and recruitment of the key informants commenced during the five-day training workshop and continued during the data-collection period. Senior management and technical staff were identified from the sampled sites in Amhara and Tigray based on positions held during the scale-up phase (September 2015-December 2016). These positions included:

**Amhara:**

1. RHB: Deputy Head and MNCH expert
2. Zone: Head and MNCH expert
3. Woreda: Head/deputy head, MNCH officer, and FP/RH officer
4. Health Center: Head and LARCs-trained YFS provider
5. IFHP+: Regional manager, youth RH officer, M&E officer, and FP officer

**Tigray:**

1. RHB: Deputy head, MNCH focal person, FP/RH focal person, and youth/adolescent health focal person
2. Woreda: Head/deputy head; and MNCH and FP/RH focal persons
3. Health Center: Head and LARCs-trained YFS provider
4. IFHP+: Regional manager, youth officer, and FP officer
5. REST: Head, youth officer, and MNCH/FP officer

In addition, researchers conducted three KIIs with Pathfinder International senior management and technical staff based in Pathfinder’s Addis Ababa office. Interviews were conducted with the senior country director, senior adolescent and youth advisor, and senior FP/RH advisor.

The Amhara and Tigray research teams, in collaboration with the *Transform: Primary Health Care Project* co-investigators, were in daily communication during the data-collection period. Nearly all interviews were conducted from August 20 to September 30, 2017. The data collection took longer than anticipated to accommodate a week-long break in early September coinciding with the Ethiopian New Year and some delays in confirming and conducting a few interviews. Three interviews were further delayed and conducted in October in Addis Ababa and Bahir Dar/Amhara. There was one substitution: since the head/deputy head of the Amhara RHB was newly assigned, the research team was directed to interview the RHB Health Promotion and Disease Prevention Process Owner instead.

Each interview was preceded by the process of obtaining informed consent from participants prior to the interview. It was emphasized during the informed consent process that participation in the study was strictly voluntary including an agreement to provide cell phone numbers to enable ease in contacting the respondent if further probing was required. Each interview lasted between 60-90 minutes.

At each health center, relevant pages from the FP registers at the YFS units (as mentioned above) were reviewed. The LARCs training month for each of the sampled health centers was specified to the research team on the last day of the training workshop. The relevant pages were scanned using battery-operated scanners supplied by *Transform: Primary Health Care* center office.

**Data Quality Assurance**

The research team adopted several quality-assurance measures to ensure that the data were of the highest quality. The Amhara and Tigray research teams were trained on the project’s objectives, conducting KIIs, probing, scanning the FP registers, transferring select data from the scanned pages to the Excel spreadsheet, and coding. All KIIs were recorded, transcribed, translated, and reviewed by the lead research team member. These transcriptions were then submitted to E2A for a second round of

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k The previous head/deputy head assigned elsewhere
quality assurance review that, in several cases, necessitated further probing questions conducted on cell phones, as appropriate. The data entered in the Excel spreadsheet was also submitted to E2A for a second round of quality-assurance review.

**Data Management and Analysis**

The KIIs were conducted in Amharic\(^1\) and Tigrinya\(^m\) and transcribed and translated into Microsoft Word on pre-designed templates. No names were included. Each informant was identified by title, location, education, and length of service (before and after September 2015-December 2016 study period). All transcriptions were translated into English and reviewed.

The KII data were analyzed independently for each region using content analysis. The transcripts for each administrative level (region, zone, woreda, and health center) were read and re-read several times and recurring themes within each of the six major thematic areas were identified. These data were triangulated at each administrative level (themes from senior management and technical staff) and across the administrative levels. Furthermore, these recurring themes were also triangulated with the information gleaned from the implementing partners (IFHP+ and REST) transcripts to provide a holistic picture of the processes involved, including successes and challenges faced during scale-up.

FP register data were analyzed for two, six-month time periods: prior to, and following the LARCs training month. While data were extracted for the training month to maintain continuity in data extraction and data entry, training month data were excluded from subsequent analysis. E2A developed the data-analysis plan that informed the types of tables generated. The researchers developed frequency tables that illustrated the aggregated six-month distribution of new FP acceptors by variables of interest (age, method type), and conducted bivariate analyses that explored the relationships between these variables. Researchers performed t-tests to compare LARCs uptake six-months prior to, and six months after, the training month at each health center and across all health centers in each region. Finally, the KII findings were triangulated with the FP service statistics, where relevant, to provide a holistic analysis of the processes, challenges, and barriers to scaling up.

**Ethical Considerations**

E2A obtained ethical approval from the appropriate ethics review boards in the United States and Ethiopia (Amhara and Tigray). After obtaining approval, data collection took place. IFHP+/Transform: Primary Health Care regional managers approached the RHB head/deputy head, in Amhara and Tigray, to formally apprise them of the assessment prior to data collection and seek their assistance with informing the key informants at sampled zones, woredas, and health centers and compiling FP service statistics. During data collection, all KII respondents were briefed on the assessment objectives, their roles and rights, and their confidentiality. KIIs and data extraction from FP registers were conducted only after all key informant participants and Director/Health Centers had given consent.

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\(^{1}\) KIs conducted in Amhara region and Addis Ababa

\(^{m}\) KIs conducted in Tigray region
Researchers managed the informed consent process. Before starting interviews, a summary of the study and the role of the participant was read out loud by the interviewer. The objectives and nature of the study were clearly explained to the participant. Each participant was assured of confidentiality; names were not recorded in the KII guide, and only phone numbers and titles were recorded. Researchers let key informants know that participation in the study was completely voluntary and that there was no penalty for refusing to participate. The participants were given opportunities to ask questions before completing the informed consent process.

The protection of participants was strictly adhered to during data transfer and storage. Team members with access to the data were trained on the importance of maintaining confidentiality and implications of violating confidentiality. Audio tapes and electronic data were stored and saved on USB drives kept in a locked cabinet. After five years of secure storage, all data will be destroyed. Paper records will be shredded. Electronic records will be destroyed by any of the following methods: shredding, crushing, or incineration; high-level overwriting that renders the data unrecoverable; or degaussing/demagnetizing. Participants’ confidentiality will be protected throughout the destruction processes.

**Study Limitations**

A major limitation of this study is the non-representativeness of the sample due to its qualitative design. Qualitative research involves the collection, analysis, and interpretation of data that yield rich, context-specific data that is not easily reduced to numbers. However, qualitative research quality is heavily dependent on the individual skills of the interviewer and is more easily influenced by the researcher's personal biases and idiosyncrasies than quantitative research. Rigor is more difficult to maintain, assess, and demonstrate with qualitative data. In addition, analysis of the data involved transcribing recorded interviews and discussions into Amharic and Tigrinya, and then translating the transcripts into English. Consequently, some of the richer contextual data may have been lost in the process of transcription and translation. Furthermore, much of the data collected were retrospective in nature concerning training, meetings, decisions made, challenges faced, and events that had already taken place. Consequently, information from respondents relied on their recall of events which might have taken place up to two years earlier and may be incomplete, altered, or not well recalled.

A second limitation is the variability across health centers in Tigray related to the peer educator programs. The two REST-supported health centers in our study sample, to the best of our knowledge, did not include a peer educators’ program, while the IFHP+ health centers in Tigray and Amhara did. This variability might have influenced LARCs uptake at the Tigray health centers and reflect peer educators’ contributions in dispelling myths and misperceptions about LARCs, creating awareness about LARCs, and encouraging adolescents and youth to seek LARCs at their respective YFS units.

The study was not designed to draw inferences or generalize about the process and outcome of the scale-up approach beyond these two regions. Rather, it was an exploratory study to determine what worked and what did not work, and barriers and challenges addressed in the development and implementation of the scale-up approach. Notwithstanding the lack of generalizability, it is anticipated that assessment results will provide insight into successes and challenges faced when scaling up the YFS model to additional health centers in the same regions, other regions in Ethiopia, and other countries.
Results

Introduction
The results presented in this section convey information on what worked and what did not work, in planning for scale-up of the tested service-delivery model and scaling it up to additional health centers from September 2015 to December 2016. This section presents qualitative data, drawn from KIIs with public-sector stakeholders and implementing partners, and quantitative data on LARCs uptake at sampled health centers in Tigray and Amhara. Results are organized by region. Within each set of regional results, qualitative data from KIIs are analyzed and presented by each of the six scaling-up elements, as defined below. Quantitative data on LARCs uptake is corroborated by key informants in both regions. Each section on regional results includes highlights of the main challenges to scaling up and conclusions, as elicited by the KIIs. This section concludes with analysis and presentation of KIIs with IFHP+ central level staff, based in Addis Ababa.

Scaling-Up Elements
The scaling-up elements are intrinsic parts of planning and implementing a scale-up strategy. The success of the scaling-up strategy depends on the way these elements interact with one another. For example, without a supportive policy environment, it will be difficult to invest in strengthened YFS, secure financial commitment for YFS, and engage stakeholders for their support. On the other hand, even with a supportive policy environment, stakeholder engagement will not result in successful scale-up of YFS if individual stakeholders have their own agendas and lack a common understanding of the importance of scaling up YFS. Because of the way the elements interact with one another, it is difficult to discern the contribution of each element to scaling up separately. Each scaling-up element is defined below.

Stakeholder engagement is the process by which organizations involve people who may be affected by the decisions made or can influence the implementation of decisions to develop a common understanding and agree on solutions that help drive long-term sustainability. In scale-up planning and implementation, engineering stakeholder engagement and buy-in, especially public-sector buy-in, is a necessary element for successful scale-up.

Roles and responsibilities describe the specific function(s) and associated responsibilities in performing the designated function(s). Clarity in roles and responsibilities among individuals at each of the primary health delivery tiers and implementing partners is a necessary element for successful scale-up.

Supportive policy environment pertains to accessible national policy and/or guidelines supporting the intervention being scaled up. In scale-up planning and implementation, a supportive policy environment is necessary, and stakeholders must be aware of that policy environment.

Mobilizing financial resources reflects an abiding interest, obligation, and responsibility for contributing funds for scale-up implementation and integrating those costs in annual budgetary expenditures. Mobilizing financial resources and its integration in national, regional, and sub-regional annual budgetary outlays is a necessary element for successful scale-up and sustainability.
Investing in youth-friendly FP/RH programs pertains to the abiding interest and pledge to contribute funds for scale-up implementation. Ensuring public-sector and implementing partners pledge to fully support implementation expenditures is a necessary factor for successful scale-up and sustainability.

Quality of voluntary FP services (counseling and service provision) directly influences contraceptive uptake at service-delivery outlets. For young clients, quality of care includes ensuring a separate space to maintain privacy and confidentiality and skilled service providers that offer YFS for expanded method choice at one site. Addressing youth needs, in addition to broader quality of care issues, is a necessary factor for successful scale-up and sustainability.

Data availability and use are implementation factors directly influencing contraceptive uptake. Utilization of quality data can help to assess performance and arrive at solutions for addressing poor performance. Ensuring that public-sector and implementing partners provide supportive supervision to ensure quality, age-disaggregated data collection, analysis, and review at each of the primary healthcare delivery tiers is a necessary factor for successful scale-up and sustainability.

Four of the six elements—stakeholder engagement, roles and responsibilities, a supportive policy environment, and mobilizing financial resources — primarily contribute to the processes involved in gaining and sustaining buy-in. Two elements—quality of voluntary FP services (counseling and service provision) and data availability and use—contribute primarily to the implementation of tested model in the new sites.

It is important to note that, in the analysis of assessment results, it was difficult to discern the actual contribution that each of the six elements, individually, had on scaling up the tested service-delivery model. Each element while necessary during planning and execution phases are not sufficient parameters in demonstrating successful scale-up and; further confounded by the overarching health systems strengthening building blocks challenges. The results that follow present potential contribution of each element to the success of scale-up.

Results: Tigray
The Tigray primary healthcare delivery system is limited to two administrative levels—RHB and woreda (no zonal level)—and to three service delivery levels (health posts, health centers, and primary hospitals). The research team conducted 17 KIIs with senior management and technical staff at administrative and service-delivery levels. The team conducted three KIIs with senior management and two senior technical staffs at the RHB office. The RHB head/deputy head assigned the disease prevention and health promotion advisor, who was most closely associated with program implementation, as the main key informant. The research team conducted six KIIs, one with a senior manager and one with a senior technical staff member in each of the three sampled woredas. At the four selected health centers, the research team conducted eight KIIs, with one director and one YFS provider per health center. Two of the health centers were supported by IFHP and two were supported by REST.

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* MNCH+FP Head; Youth Advisor
* One woreda shared with IFHP+ and REST
* Two health centers - IFHP+ supported; two health centers - REST supported
KII's were conducted with IFHP+ and REST senior management and appropriate technical staff. Six interviews were conducted with a senior manager and two technical staff members from each of the implementing partners.  

**Stakeholder Engagement**

The research team examined how stakeholders engaged across the two health administrative levels. The RHB's technical working group consisted of two RHB members and one member from each development partner, including UNFPA, UNICEF, IFHP+/Pathfinder International, L10K/John Snow International, REST, Organization for Social Services for Aids in Ethiopia (OSSA), and the Family Guidance Association of Ethiopia (FGAE). At woreda level, the woreda management and health technical staff are directly involved in managing the implementation of health-related activities as directed by the RHB. They collaborate with public-sector stakeholders including the offices and bureaus of education, youth affairs, women's affairs, as well as NGOs, including IFHP+ and REST.

The primary healthcare service provision tier is made up of primary hospitals, health centers, and health posts that are governed by the primary hospital/health center management and its board under woreda guidance. Stakeholders therefore include not only health center administration, but also woreda and RHB stakeholders whose responsibilities include upgrading facilities, adding additional services, and evaluating quality of care. Health centers were responsible for internally managing staffing and supply-side shortages. NGO contributions include training costs, television, and coffee ceremony materials.

"The main push […] for implementing scale-up […] is from the district/woreda office and regional health bureau" – Director/IFHP+- supported health center

"Government is the main lead who takes the program to be implemented" – Director/REST-supported health center

"Material support including television, microphones, coffee ceremony materials contributed by NGOs” – YFS Provider/IFHP+-supported Health Center

"If family planning was out of stock the health facility brought it to the youth friendly service from other places" – YFS Provider/IFHP+-supported Health Center

IFHP+ presented the study results and the scale-up plan for review to the RHB technical working group, per RHB protocol. The RHB’s deputy head, chairperson of the technical working group, spearheaded the approval process,

"[…RHB…] led the committee in approving the project" - Senior Manager/RHB

Approval was based on several additional factors, including collaboration across development partners, project duration, and positive contribution in improving the health and well-being of young persons. Following IFHP+’s approval of the scale-up plan, the RHB technical working group continued to oversee the project implementation in its quarterly meetings, per RHB protocol.

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q FP Officer and Youth Officer
“Helpful for the public sector to work in collaboration with partners and particularly IFHP+” – Senior Manager/RHB

“[Its scale-up plan] approval was based on the contribution it will have for the youth” – Senior Technical/RHB

IFHP+ supported the initial scaling-up phase at the selected woredas. However, after IFHP+ phased out, woreda stakeholders encouraged health center directors to convince their respective health administrative boards to integrate the provision of LARCs in YFS units. Results were encouraging: seven health centers and a primary hospital had trained the incumbent YFS provider on LARCs.

‘Take an initiative to convince the Board, the administrative body for the health facility, to implement the integration of LARCs in YFS unit” - Senior Manager/Woreda

“Seven health centers and one primary hospital providing LARCs services in YFS unit” - Senior Manager/Woreda

Continued woreda management interaction with health center directors and YFS focal persons facilitated sustainability and further scaling-up. RHB and woreda management advocated for and oversaw geographic expansion activities.

“A demand by the woreda and the regional health bureau to sustain and scale-up the service in the remaining health facilities” – Senior Manager/Woreda

“Woreda health office established a responsible body to run the activities and to allocate resources as needed” – Senior Manager/Woreda

Woreda KIIIs noted several learnings gained while negotiating the scaling-up process. These included allocating woreda budget for scale-up and recognizing the wide-ranging benefits of comprehensive and holistic FP services that address young persons’ RH needs, and that these benefits far outweigh financial investments.

“Allocating woreda’s own budgetary resources if we agree that the service is vital for youth” – Senior Manager/Woreda

“The budget was allocated by the health facility’s Board that gives us a lesson that the benefits of establishing and provision of YFS outweighs the cost that we would expend” - Senior Manager/Woreda

Implementing partners identified the same key stakeholders as integral to scale-up process—RHB, UNICEF, UNFPA, Pathfinder International, REST, and FGAE. However, implementing partners reported that although several partners were working on similar youth-related activities, they were not communicating or coordinating their activities across all woredas. This lack of coordination encouraged the use of the RHB technical working group as a venue for collaboration. The technical working group had been established several years ago by Pathfinder International/Ethiopia. Technical working group members arrived at a common understanding of the importance of expanding the YFS model, jointly
developed scaling-up plans, and conducted review meetings on AYRH and related health issues. RHBs’ improved coordination and planning cascaded to lower administrative and health center levels.

“"We have created the common understanding among government officials and health care providers"” – Senior Technical/IFHP+ Regional Office

“"The plan [...] scale-up plan [...] would be developed at the regional level first in reference to the catchment population for the specific woredas and this would be cascaded to the lower level i.e. to the woreda and community level. Then the plan of the partners would be aligned to the regional plan and cascaded to the woreda level experts. Then the plan would be again aligned at the woreda level with the woreda level health office” – Senior Technical/REST

Quarterly joint stakeholder review meetings were the venue for intensive collaboration and promoting mutual understanding of achievements, barriers faced, and resolutions to those barriers. A significant advantage stemming from these review meetings was strengthened collaboration among stakeholders that served to align partner activities and avoid overlap.

“"Review meetings were held in the presence of the representatives of these partners. The achievements and the limitation related to the implementation of activities would be discussed and ways forward would be set"” - Senior Technical/REST

“"The strengthening of integration among partners and the public sector at regional, woreda and facility level was one component of the scale-up”” – Senior Technical/IFHP+ Regional Office

**Roles and Responsibilities**

The RHB served as the primary entity responsible for overseeing the implementation of the approved scale-up plan. This effort was in alignment under its mandate to facilitate a favorable environment for policy and programmatic discussions. The RHB reviewed operational guidelines related to the provision of LARCs, and developed a “roadmap” for implementation, selecting woredas and health centers for implementation and avoiding duplication among development partners. Members of the RHB’s technical working group agreed to the roadmap.

“"The technical committee has also developed a road map to indicate which partners need to be involved in which woredas to reduce overlaps of the interventions"” – Senior Technical/RHB

RHB key informants recognized that ensuring adequate and sustained funding for healthcare provider training is paramount. Also, they noted that there was only one development partner that worked in the field of AYRH, creating a substantial budgetary constraint for the implementing partner. RHB’s recognized its mandate to seek additional funds from FMOH as AYRH services offered at the YFS units are a high priority.

“"Only one implementing partner that works in adolescent and youth health service; and it is difficult to cover the expenses of all the training given on its own”” – Senior Technical/RHB

*r Referring to IFHP+
“It is our responsibility to request funds from the federal government so that there isn’t a gap in providing training” - Senior Technical/RHB

“Whether IFHP+ stays or not, the regional health bureau considers the service […] YFS […] as its main agenda” – Senior Technical/RHB

The woreda management and technical staff were largely responsible for implementing the scale-up plans, whereas IFHP+ was responsible for training and supportive supervision. There was no formal written description of roles and responsibilities of the NGOs/implementing partners and woreda management. However, prior to new activity/program implementation, discussions were held at the woreda monthly review meetings to reach consensus on roles and responsibilities. This internal consensus-building process enabled government ‘ownership’ of the scale-up process. In Ethiopia, implementing partners do not “own” interventions; rather, they introduce and strengthen interventions and facilitate their smooth transition to the government when the intervention concludes. It is woreda management that oversees implementation, resolves challenges, and puts measures in place toward sustainability.

“They […]IFHP+ […] are supporting us to introduce and implement the services to the community but the program is not their own” - Senior Technical/Woreda.

“[…]IFHP+ role is to […] establish and strengthen the service. Services cannot be sustainable if they are based only on supports […] financial and technical provided by implementing partners […]” – Senior Technical/Woreda

Local and international partners acknowledged that the public sector was the main ‘owner’ of health-related activities and alluded to the fact that scaling-up of new programs was the primary domain of the public sector. Implementing partners provided technical assistance to strengthen the public sector. Although responsibilities of the government and implementing partners are not codified in writing, there is general agreement among the RHB’s technical working group members what each partner’s role should be. In this way, the RHB serves as a coordinating body.

“The public sector itself is the main agent to implement the services. Therefore, the partners would support the public sector” - Senior Technical/REST

“The main focus of the development partners is strengthening the public sector, scaling up of the services part is the task of the public sector” - Senior Technical/REST

“No partner can work without the involvement of the regional health bureau” – Senior Technical/REST

At the health center level, the director and YFS provider have clearly defined roles. However, the roles and responsibilities of stakeholders, including the woreda health office, the RHB and implementing partner, are not formally recorded. A KI clarified that program activities were implemented even though a formal description of stakeholder activities was not accessible to health center staff.

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1 Comprising representatives of woreda departments; chaired by the woreda administrative head
“They [...] health center director and clinical staff [...] have their own job description responsibility” – Director/IFHP+-supported Health Center

“There was not a clear specification of what activities to be done by each stakeholder” – Director/IFHP+-supported Health Center

“It doesn’t mean that different activities weren’t being done, but there was no formal division of activities among stakeholders” – Director/IFHP+-supported Health Center

Woreda staff mentioned that AYRH remains a low priority, contributing to continued gaps in YFS provision. They mentioned that providers were not trained to provide YFS at the YFS unit, and technical staff had not been participating in IFHP+ review meetings. These gaps were specifically highlighted to the woreda management during IFHP+ close-out phase review meetings. The gaps identified were addressed.

“The attention and focus we had for the youth friendly service was low; the woreda health office had a lot on its plate and was reluctant to do its role” – Senior Manager/Woreda

“We took accountability for our mistakes” – Senior Technical/Woreda

Health center staff conveyed that lack of coordination among stakeholders, overlap of program activities, and burdensome workload were significant challenges to smooth implementation of activities. For example, the LARCs training was one of several facility-based activities implemented simultaneously. Key informants attributed these challenges to lack of clarity and poor communication regarding the roles and responsibilities of the implementing partners in health facilities. Furthermore, as noted by an informant, the stakeholders (public sector and implementing partners) are knowledgeable about their roles and responsibilities but these are not communicated to the service provision tier, thereby creating obstacles to clinic activities. The recommendation suggested by the informant was well-articulated roles and responsibilities of partners and that this information should be communicated to health facilities.

“The projects were running their own programs on their own timetables. There was an overlapping of activities” – Director/IFHP+-supported Health Center

“The activities done by the health facility or Pathfinder or woreda health office were not well coordinated. So, there should be a clear description and division of activities among each stakeholder; else there will be so many gaps in our program activities” – Director/IFHP+-supported Health Center

“Two different supervisors from, let’s say Pathfinder and Li0K, may come to the health facility in the same time for similar activity. So, what could be seen from this is if the different partners involved had a clear description of what programs they were running and when different activities had to be done it could have reduced the work burden” – Director/IFHP+-supported Health Center

**Supportive Policy Environment**

Ethiopia’s policy environment over the past decade has been largely supportive of offering the full range of contraceptives, including LARCs, to adolescents and youth. The 2007-2015 AYRH Strategy, the current National Adolescent and Youth Health Strategy (2016-2020), and national FP guidelines are
supportive of young people’s access to full contraceptive choice. The shift from a national policy focused on AYRH to one focused on adolescent and youth health more generally signifies the deep interest and commitment of the Ethiopian government to young persons’ health and well-being. During RHB quarterly review meetings, it was confirmed that national policy and guidelines are supportive of offering LARCs at YFS units. KIIIs revealed that, as a reflection of the policy environment, all sectors of Ethiopian society are supportive of increased access to FP, and particularly that religious leaders serve as FP advocates. However, KIIIs confirmed that despite a policy environment supportive of young people ages 10-24 years accessing a full range of contraception, providers have been hesitant to provide FP services to their youngest clients ages 10-15 years. Those 15-24 years, on the other hand, were offered LARCs without any negative repercussions.

“There wasn’t any problem regarding the policy or with the guidelines” - Senior Technical/Woreda

“The policy that existed was in favor of the program” – Director/IFHP+-supported Health Center

“The guidelines specify that youth ages at 10-24 years are eligible […] for LARCs[…] and providers had been asking on the inclusion of 10-15 years aged youth. It is in the guidelines; also, their right to get FP, as it is specified in the FP guidelines. However, the issue was not as serious to prevent providing LARCs services for the targeted age group […]15-24 years…” – Senior Technical/RHB

“There is no opposing policy. I gave IUCD for two girls and implants, but I did not get any opposing idea” – YFS Provider/REST-supported Health Center.

“Regional health bureaus ask this program always because youth is the important part of the population” – YFS Provider/IFHP+-supported Health Center

Health centers adhered to the policy that health centers have training manuals and updated guidelines on hand.

“The guidelines manual did not have anything which affected the working environment” – Director/REST-supported Health Center

“Anyone who received training will return to the health center with the training manual; then the manual belongs to the health center” – YFS Provider/IFHP+-supported Health Center

While public sector key informants recognized that national policy and guidelines support expanded method choice for young persons, they acknowledged that implementation of those supportive policies through strengthened YFS was contingent upon commitment and efforts to address young people’s FP/RH needs. Implementing partners, on the other hand, alluded to a lack of awareness among providers that created barriers to the implementation of the scale-up plan.

“There isn’t anything that is against the youth friendly service. Rather there is a supportive working environment and what is expected is for us to work. Huge inter-sectoral work is needed to save young peoples’ lives” – Senior Technical/RHB

“What is required is our commitment and efforts to implement them […]scale-up plan…” – Senior Technical/Woreda
“No one was opposed to the scale-up program; obstacles were created due to lack of awareness and knowledge gap […] at the service provider level…” - Senior Technical/IFHP+ Regional Office

Mobilizing Financial Resources

The Ethiopian government’s commitment to improving the health and well-being of adolescents and youth is exhibited through policies and guidelines focused on YFS. These policies and guidelines contain directives supporting a multi-sectoral and integrated approach to YFS, reforms to health sector development and healthcare financing that make YFS a priority. Ethiopia endorsed a healthcare financing strategy to improve quality and equity in 1998, which was officially rolled out in Tigray during 2008-2011. The strategy emphasized revenue retention and increased financial autonomy at health facilities through the introduction of a financial governance system at each facility. The health facility administration board has the authority to raise internal revenues and generate income. Public sector and implementing partner key informants at all administrative levels were aware of the health care financing policy.

“There is a federal level proclamation that indicates that each health facility needs to mobilize resource by itself and allocate budget for the services they do want to strengthen. Accordingly, they can invest it in activities related to strengthening LARCs” – Senior Technical/RHB

“The health facilities are expected to generate income through healthcare financing” – Senior Manager/IFHP+ Regional Office

“Government’s focus and attention about youth friendly service; its […] government’s […] consensus to provide separate healthcare provision for adolescent and youth” – Senior Technical/RHB

The budgetary policy mandates that 70-80 percent of healthcare expenditures go to essential drugs, and 20-30 percent of spending to quality improvement/preventive services. Strengthening and promotion of LARCs provision falls under the latter category. However, convincing the woreda management to draw on the preventive services budget line for YFS, including LARCs strengthening, remains challenging. There are only a few health centers that have used the preventive services budget for strengthening YFS. These health centers are under woreda managers who approached the RHB, expressed difficulty in implementing the LARCs training with YFS providers due to budgetary constraints, and secured additional funding to scale-up the LARCs training.

“The health facilities legislation dictates that 70% of the budget should be allocated for drug-related costs while the remaining 30% is the area where health facilities could plan for activities other than drugs including LARCs strengthening and promotion. Therefore, using some money from the 30% of revenue to fulfill commodities and materials for YFS needs much effort to convince the board […] woreda-based management board […] and needs attention. In this regard, many health facilities use a very limited amount of it and almost none in many of the facilities” – Senior Manager/Woreda

“Health facilities could plan for activities other than drugs supply including LARCs strengthening and promotion” - Senior Manager/Woreda.

Financial integration of government and partner contributions happens at RHBs. KIIs with public sector and implementing partners revealed a consensus that the government provides a majority of financial
support to health interventions, including those focused on AYRH. Implementing partners’ contributions are significantly smaller. The RHB plays the lead role in advising and directing partners to specific geographic locations according to the RHB implementation/action plan. However, the RHB cannot mandate partner contributions to pre-selected geographic locations; rather the implementing partner’s jurisdiction and interests play a substantial role in the final decision-making process. The RHB quarterly review meetings are the venue for decision-making on resource allocation and planning of government and partner contributions. As part of these discussions, the government presents the overall budget and requests partner contributions in terms of budget, geographic coverage, and health services. Decisions arising from the quarterly review meetings seek to avoid duplication of resources and build an integrated regional action plan for implementation. The RHB is empowered to seek additional federal funding for poorly performing health services by substantiating those requests with HMIS data reviewed during RHB internal quarterly review meetings.

“Majority of the investment is by government; share of partner is very small” – Senior Manager/RHB

“We [...] government [...] explain what the government can cover, and we request partners to do what they can” – Senior Manager/RHB

“We [...] government [...] can’t force the partners to work in a certain area, if they [...]partners [...] are interested they could help; otherwise, the regional health bureau tries to take care of it” – Senior Technical/RHB

“As a region we don’t refuse any partner. But, we work to be integrated and then if it is the same activity to avoid duplication of effort we assign them to a different geographical location” – Senior Manager/RHB

The woreda administrative board, as part of its mandate, oversees the health facility budgetary allocation and income-generation activities, providing guidance to health facilities on prioritization of services, resource allocation, and sometimes reallocation of financial resources; for example, from nutrition to FP, and more specifically, to YFS. Implementing partners specifically mentioned the woreda advisory committee’s role as a mechanism for reviewing health center performance and providing guidance on low-performance sectors. These committee meetings are the platform for discussions and problem-solving and have helped to align budgetary allocation to health center performance. Large capital and operating expenditures, such as construction costs, furniture, salaries, commodities, and supplies are generally disbursed by the woreda health office. However, woredas were hesitant to allocate resources for the construction of separate YFS units as they viewed the YFS units as less of a priority than other health-related construction costs, such as creating new maternity waiting rooms.

“Some amount of fund allocated to support nutrition activities in the woreda could be reallocated for FP; these decisions are made by the woreda head and the woreda sector heads” – Senior Technical/Woreda

“The role of the woreda advisory committee is in evaluating every health program activities such as family planning, delivery, immunization, nutrition, and others. The committee sits and discusses how to solve the problems that exist” – Senior Technical/REST
Since the health center has many problems like needing a waiting room for mothers and a house for the guard, it is very difficult to get a timely response from the district health office head.” – YFS Provider/REST-supported Health Center.

At health facilities, funds for service provision are available from two sources: federal funds disbursed by RHB and health center-generated funds disbursed by the health center's administrative board. The health center-generated funds are a result of the healthcare financing guidelines that empowers the health center administrative board to raise and allocate funds through various income-generating activities, such as telethons, personal donations, garden activities, entrance fees for plays hosted by peer educators, out-of-pocket payments, personal contributions and soliciting donor support. These funds can be used to cover recurring expenditures and sustain YFS. These funds often go to things like televisions, coffee ceremonies, and community mobilization.

"The health facilities are administrated by the Board consisted of the director for the health center, kebele leader, school teacher and other representatives of the community. The board meet on quarterly based and they also call the community for fundraising and resource mobilization. Then, the health facility can use a small amount of the revenue for such activities based on the mutual decision of the board members. For example, if the medical director proposed that there need to allocate money for a coffee ceremony for peer educators, the board can discuss on and approve it” – Senior Manager/Woreda

"Some well offs in the community also donate money for the refreshment activities [of peer educators]” - Senior Technical/Woreda

“We, the health providers, were contributing to the service even financially to sustain it” – YFS Provider/REST -supported Health Center

“The youth play dramas that have entrance fees and they use the money for different purposes, like for the coffee ceremony programs” – YFS Provider/IFHP+-supported Health Center

“Our YFS room is very small. Also, we do not have material, waiting room, card room, and inpatient for that we conducted a telethon and collected around 4 million birr” – Director/REST-supported Health Center

Woreda and health facility budgets do not have separate FP or YFS budget line item that hampers sustainability and quality of YFS. They only contain a more general budget line for “preventive services” (such as MNCH, FP, immunization, RH, nutrition, malaria, and tuberculosis). Because preventive services are free, a budget line for YFS is not deemed necessary. Understanding the perceptions of woreda and health facility staff about financial resources available for FP service delivery, inclusive of YFS, highlights challenges faced in securing resources for services considered “low priority” by management.

“Prevention services are offered free. There is no need to allocate budget for them” – Senior Technical/Woreda

“There is no budget line and budget code to allocate for specific activities like strengthening FP; … The allocation is for all prevention activities, including MNCH” - Senior Technical/Woreda

Each health facility is administratively managed by a Board comprising director of the health center, kebele leader, school teacher and community representatives.
“All supply of family planning is from the regional health bureau. All MNCH services are free, so there is no specific budget” – YFS Provider/IFHP+-supported Health Center

“It is unthinkable … cognizant of the critical shortage of the financial resources, it would not be possible to allocate budget for specific services like FP. The allocation would be for overall prevention activities in the woreda” – Senior Manager/Woreda

“Nothing was done in securing a budget for the youth friendly clinic, this has led to service provision gaps” – Director/IFHP+ -supported Health Center

“Our finance system did not have separate support or budget to YFS. Drugs and supplies are dispatched based on the government system. Then sent to YFS” – Director/REST-supported Health Center

Senior management and service providers at health centers were cognizant that addressing the special needs of young persons through YFS is a RHB priority. However, they said budgetary constraints and adherence to financial protocols were impediments.

“There isn’t such a financial protocol, which specifies the list of activities that could be supported by the budget, that recommends allocating budget specifically to activities related to family planning. But the regional health bureau recommends having a budget plan for the youth friendly service.” – Director/REST-supported Health Center

“Even if it was informally recommended to our health facility to have a specific budget plan for the youth friendly service, it is not possible to implement it without receiving a formal letter that says to do so. Because doing things out of line with the financial protocol can have its own risks. So, we don’t have a specific budget plan just for the youth friendly service” – Director/REST-supported Health Center

“And even if the health facility decided to financially support the peer educators it might be against the rules and regulations of the financial protocol and budget flow” – Director/IFHP+ -supported Health Center

Implementing partner staff from IFHP+ and REST mentioned that interest from woreda and health center managers in addressing young people’s health affected how well YFS were supported. In some instances, community contributions offset budgetary constraints. They mentioned that woredas’ investments in youth-specific activities varied by facility, reflecting the commitment of the woreda and community surrounding the facility.

“It is difficult to get budget and generate income for YFS only because woreda leaders and health center managers have to, first of all, understand the advantages that the youth could be benefited” – Senior Technical/IFHP+ Regional Office

“Woreda always suffered shortage of budget and unable to address to YFS issue” – Senior Technical/IFHP+ Regional Office

“The youth friendly service was included in the [woreda] plans but there still wasn’t a budget that was secured for it. And this shows the low attention given to the youth” – Senior Technical/REST
“Good examples of health centers where community mobilization and income generation has resulted in woreda administration budgetary allocation supplemented by local investments/funding” – Senior Technical/IFHP+ Regional Office

To scale-up the tested model, implementing partners provided financial support for review meetings and provider and peer educator trainings inclusive of per diems. As an informant remarked, despite the commitment to YFS, the public sector’s limited financial resources are not commensurate with contributions from implementing partners. The additional costs for training YFS providers and peer educators are primarily borne by implementing partners. For example, per diem (travel compensation) for participation in trainings and/or review meetings was unaffordable for the public sector, creating disruptions in community mobilization and awareness raising; and delays in per diem disbursements; implementing partners disbursed per diems at the training/meeting venue whereas public sector per diems were disbursed at the respective woredas.

“Even if we are committed to providing youth friendly services, such obstacles […] non-existent YFS budget line item […] hinder us from going far” – Director/REST-supported Health Center

“For review meetings conducted at kebele level, the attendants may need to come to the woreda to get the per diem” – Senior Manager/Woreda

“When you come to the woreda context there would not be much amount of budget to run as was done by the partner” – Senior Manager/Woreda

Despite a lack of a budget line for strengthening YFS, budgetary allocation for capacity building and biannual review meeting workshops are included for all health-related activities. This creates an approved funding stream for AYRH and LARCs training, including trainings for peer educators.

“They […] do have a budget allocation for overall capacity building and hosting review meeting workshops on biannual and sometimes quarterly basis” – Senior Technical/REST

Although the reformed health financing law and national AYRH strategy should have galvanized the public sector to address young persons’ health, these policies have not significantly influenced health centers’ budgetary allocations. Woreda and health facility administration often remain hesitant to allocating funds for YFS, implying that there will need to be continued and sustained advocacy for funding YFS. However, over the past year, RHBs have renewed their commitment to YFS, exhibited most recently by the inclusion of a performance monitoring ranking indicator for LARCs uptake among women of reproductive age including adolescents and youth.

“But health facilities are reluctant to put a separate budget to improve and secure YFS from their income” – Senior Technical/IFHP+ Regional Office

“HFs retains their revenue and improving the understanding of the need to strengthen YFS unit using their resource is another focus. Thus, influencing the allocation of resources to the YFS is the task that needs to be the attention of the public sector” – Senior Manager/IFHP+ Regional Office

u Peer educators are volunteers, do not receive a salary; quarterly meetings per diems to cover travel costs are the only monetary compensation offered
v LARCs performance ranking: Green ≥ 33%; yellow 24%-33%; and Red <24%.
“YFS is becoming a center of evaluation for health facilities and woredas in the region” - Senior Manager/RHB

Key informants suggested resolutions to addressing financial difficulties. These included: (1) creating awareness of the need for a YFS budget line item across the health administrative levels, particularly at the woreda and health facility levels; (2) seeking implementing partners’ contributions for LARCs training; (3) requesting compensation from woreda management for preventive services that are offered free of cost; (4) tapping into the health insurance funds for YFS strengthening support; and (5) using facility-led income-generation funds.

“The first challenge is creating awareness on the need to allocate budget for the interventions. The other issues would be budgetary shortages to allocate for every activity, each would be a challenge for the facilities” – Senior Technical/RHB

“So, the woreda provides compensation funds for such activities that are free; and there is health insurance. But the free services may have their own challenges. Some promising activities have been done” - Senior Technical/Woreda

IFHP+ held close-out meetings at regional and woreda levels. The organization presented the impact of YFS, that included LARCs provision, with data generated from testing the service-delivery model in Amhara and Tigray. These presentations elicited positive reactions from senior management and technical staff for sustaining and scaling up these services. This resulted in woreda management allocating resources for YFS, including LARCs provision, to scale up the tested service-delivery model.

“From the discussions raised during the closing of the LARCs and youth program by IFHP+, there was a demand by the woreda and the regional health bureau to sustain and scale up the service in the remaining health facilities. Thus, the woreda health office have discussed to establish a responsible body to run the activities and to allocate the resources needed for the activities by the woreda” - Senior Manager/Woreda

**Quality of Voluntary FP Services (Counseling and Service Provision)**

Senior management, technical staff, and service providers elaborated on the quality of voluntary FP services following the LARCs training for YFS providers. They reported improved privacy and confidentiality, availability of YFS-trained staff counseling for short- and long-acting methods, and the provision of services that offer adolescents and youth full access to full contraceptive choice in a ‘one-stop shop.’ After the training, informants noted improvements in providers’ attitudes, confidence in interacting with young clients, and counseling and service provision, including facilitating informed decision making.

**Privacy and confidentiality:** Private and confidential YFS need to be offered in a separate room where young persons can receive preventive RH services, including LARCs. Key informants at all levels noted that maintaining privacy and confidentiality is essential for meeting the RH needs of young clients. For example, one senior woreda staff member explained that young clients’ acceptability of LARCs rose when they learned that those services were offered at a separate YFS unit in a ‘one-stop shop.’ Prior to YFS providers being trained in the provision of LARCs, young clients were referred to the MNCH unit if
they opted for LARCs, potentially breaching confidentiality and dissuading young clients from using LARCs.

“When assessing clients’ satisfaction, the adolescents and youth claim that they don’t want to go to different rooms to utilize services. They want to utilize all services in one room.... this maintains the confidentiality of the services to clients” – Director/IFHP+-supported Health Center

“The peer educators are bringing the youths in for service by telling them the YFS provider will be the only person who knows services he/she has received. The youth do not want to see other faces in other rooms. They prefer to get the services in one room and by one provider because it minimizes the possibility of disclosure. Even the peer educators report that the youth frequently asked them who will be the one who will provide the services and want to be sure that the services will be kept confidential. Then, when the peers assured them of the service’s confidentiality, the youth tend to use the RH/FP services” - Senior Technical/Woreda

FP services: Prior to training the YFS providers on the provision of LARCs, providers did not provide balanced counseling on full method choice. Instead, they restricted their counseling to short-acting methods. According to key informants, a client would often select her method of choice before visiting the YFS unit. The YFS provider would then provide the chosen method without following the balanced counseling protocol.

“Regarding the counseling, there was providers’ tendency to counsel clients for methods that the provider was able to provide. There was a gap in counseling for all FP options and the clients were influenced to choose only among the short-acting FP methods. When we look at variations in the trend of LARCs use within clusters and HFs, the difference was a consequence of the provider’s counseling skill.” - Senior Technical/Woreda

“Health extension workers ask what method the mother wanted. If it was an injectable, they provided that without counseling. And the same was true in the health centers” - Senior Technical/Woreda

Key informants recognized that quality counseling entailed counseling on potential side-effects, and that discussing side-effects could influence a client’s decision to accept or not accept a LARC. Furthermore, key informants were cognizant that if a client was not aware of the side-effects of a LARC, it might influence her continuity of the method, resulting in removal or misunderstanding about common side-effects.

“If the quality of counseling is low, it is evident that the client will be less satisfied. If the client is dissatisfied, then the trend of the LARCs use would go down” - Senior Manager/Woreda

“If a woman has inserted LARCs method and if she is not told that there could be minimal side effects she may get worried about the bleeding she experienced. Then she may decide to remove it immediately. The problem is not only that she would remove it, but, also, she would misunderstand the side effects and communicate with her peers that the specific method comes with side effects. Their peers will not use the methods because they saw that their peer suffered from its side effects. This all was happening due to poor counseling” - Senior Manager/Woreda
“Some providers advise the young teenagers to not use long-acting family planning methods. This was as a result of both lack of skill and lack of commitment to provide the long-acting methods” - Senior Technical/Woreda

Counseling was not the only limiting factor in terms of quality of care. Providers’ lack of skills in providing LARCs were highlighted as impediments in offering young people access to full contraceptive choice. The YFS training for providers, previously, and the LARCs training, conducted during scale-up of the tested service-delivery model, enabled the YFS unit to deliver quality counseling and service provision for expanded method choice. Senior management and technical staff from health centers, RHBs, and implementing partners said that ability to offer young people expanded method choice in a ‘one-stop shop’ unit has contributed to increased LARCs uptake, reflecting improvements in quality of care.

“But after I took the training my approach and the way I deal with the youth improved” – YFS Provider/IFHP+-supported Health Center

“We make everything available and near to them, so they are getting all the information and the service accordingly. The integration of services in one place has also played a major role in improving the quality of the family planning service” – Director/IFHP+-supported Health Center

“The increment in the utilization of long-acting can clearly show us the improvement in the quality of YFS” – Senior Technical/IFHP+ Regional Office

RHB staff perceived the impracticality of maintaining privacy and confidentiality, particularly when using balanced counseling with heavy client volumes. RHB technical staff recommended that facility-based supervision by RHBs and performance reviews by implementing partners be conducted jointly, rather than limiting the RHBs role to standalone visits at more high-visibility events, such as opening and closing workshops. The joint supervisory approach could potentially improve the public sector’s capacity in supportive supervision, enabling continuation of high-quality FP counseling and service provision after the program has ended.

“It is too difficult for me to say that privacy of the client is maintained even currently,…. there would be time constraints in providing the full counseling because other clients are still waiting outside the room” – Senior Technical/RHB

“The partners tend to go to the facilities directly rather than jointly undertaking the supervision activities with the actors at the regional level. This likely reduces the effectiveness of efforts to bring the capacity of the public sector to the optimal level. I personally would say that the supervisions, the feedbacks, and the performance review meetings organized by the partners at the facility level would be more effective if there were a regional focal person for the service. Thus, the joint implementations needn’t be limited during the opening and closing workshops” – Senior Technical/RHB

Data Availability and Use

Health facilities’ MNCH/FP and YFS units maintain national FP registers, disaggregating data by age, “acceptor status (new and repeat), x place of residence, and method type. The MNCH/FP and YFS units

Age Groups: <15, 15-19, 20-24 and 25-49
Acceptor Status: new, repeat
transfer their data to the HMIS reporting format so that it can be monitored by the health facility. Monthly data from service-delivery points, including health facilities, are then aggregated in the government’s ‘Monthly Service Delivery Report Form’ and submitted to the respective woredas. At woredas, the data are reviewed, compiled, and submitted to the RHB on a quarterly basis. The FMOH recently updated its HMIS to include 122 indicators inclusive of age-disaggregated data. Performance review committees meet monthly at the health facility and woreda levels and quarterly at the RHB. Key informants acknowledged that data generated from the HMIS was used for decision-making at each health administrative and service-delivery level.

“We are using data for decision-making” - Senior Manager/RHB

“The first issue in quarterly meetings […]performance review meeting[…] is whether we are achieving the rate […]LARCs utilization rate[…] or not. Our plans will then be based on this. If the utilization rate is low, we have to improve and expand the services. The data is useful for planning and decision making” - Senior Technical/Woreda

Performance review frequency, feedback, and availability of age and method specific disaggregated data varied by administrative level. RHBs conduct quarterly performance reviews of woredas and health facilities. They provide written and oral feedback to the respective woredas to strengthen program performance. Implementing partners corroborated that quarterly regional review meetings served as the platform for performance monitoring of woredas, in terms of low- and high-performing services.

“As part of it […]performance review[…] we send the feedback to the woredas in a written document as well as a phone conversation about the possible factors that hinder strengthening the FP service. We also ask which of the health facilities in the woreda is contributing to low performance and which are high-performing” - Senior Technical/RHB

Informants mentioned several limitations of RHBs’ performance reviews. These include a lack of data disaggregated by health facility, age, and type of method accepted (LARC versus short-acting method).

“We are analyzing the data at the woreda level. Thus, we can’t identify the trends in service use among the youth per facility. Besides, though there is age-disaggregated data, the analysis of the data at the regional level is not age-disaggregated, which hinders analyzing the trend of service utilization among the youth” - Senior Technical/RHB

The woreda HMIS performance review committee7 is composed of focal persons from all service units and the health center director and is led by the HMIS focal person. The performance review committee conducts performance reviews of health facilities monthly. They focus on accuracy and quality of data, and monitor FP service utilization, including uptake of LARCs and short-acting methods. They communicate feedback to the health facilities quarterly or monthly, targeting poorly performing clusters and health facilities for mid-course correction in their annual action plans. Although the FP registers have separate columns for residence and age, when the data are compiled for the woreda, they are not disaggregated by age.

7 HMIS performance review committee/Woreda: a four-member team comprising woreda health office head, MNCH expert, planning and development expert, treatment and care expert
“We have a monthly meeting of the HMIS committee that is led by the focal person ahead of the data reporting to the woreda health office. So, we discuss all the services done and registered in the health facility in that particular month. The committee is comprised of focal persons from all service units, so the data is evaluated according to the plan of the specific units” - Director/REST-supported Health Center

“The family planning data is handled according to the FP register and is disaggregated by age and place of residence. But much hasn’t been done in using this data for decision-making. But we track the progress and compare the trend of utilizing long acting and short acting family planning methods by holding a meeting and discussing it” - Director/REST-supported Health Center

“The main aim of the feedback we provide to the HFs is to let the HFs identify their gaps and weakness according to their plan in the fiscal year. We analyze the data disaggregated by cluster and HFs, and then we provide them feedback. The regularity of the feedback could depend on the issue and urgency of the event. It could be monthly and for few services it could be quarterly. Thus, the HFs would revisit their plan and act accordingly” – Senior Technical/Woreda

“An action plan about future activities is drafted after assessing and supervising health facilities. The health facility management, comprising the director and the supervisor, draft the action plan immediately” – Senior Technical/Woreda

Informants noted the effectiveness of the monthly performance review meetings in monitoring LARCs uptake among young clients at health centers. However, they said because the meetings are not compulsory, staff sometimes miss them due to competing priorities. Furthermore, facilities submit monthly HMIS reports to the woreda health office routinely, however, there have been delays and inconsistencies that hamper timely data utilization for decision-making at health facilities.

“The reason is that we would not be able to identify the gap in the performance of family planning in general and LARCS use among the youth in particular. Thus, we would not be able to detect the bottleneck for the implementation to re-correct the interventions targeted to improve it” – YF Service provider/REST-supported Health Center

“There was a problem in its […] monthly performance review meetings […] consistency due to other overlapping activities in the health facility” – Director/IFHP+-supported Health Center

“Even though feedbacks about issues related to adolescents or HIV testing or family planning utilization are received from woreda health office they are not timely because the feedback for the first quarter may be back received at the third quarter. Even there could be feedback of two successive quarters in one, which is less important to consider taking measurement based on the feedback” – Director/IFHP+-supported Health Center

The woreda HMIS performance review committee conducts quality-control assessments quarterly. The RHB conducts supportive supervision bi-annually in response to the review of service-delivery data from woredas.

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* Performance reviews are conducted at woreda level and informed by monthly report forms submitted by health centers. Quality control assessments are visits by the woreda staff to the health center.
“We assess health centers every three months though it is supposed to happen every month. The woreda health office and health center HMIS experts assess and cross-check the data to assess its quality” - Senior Manager/Woreda.

“Regional health bureau conducts supervision twice a year. Supervision of each health facility sometimes includes house-to-house visits” - Senior Technical/Woreda

Implementing partners mentioned that data availability and use at health centers and woredas can be poor. Compiling and submitting the monthly reporting form tends to be of lower priority than providing clinical and preventive health services. The monthly form is often submitted to the woreda without review and further discussion at the health center.

“The attention towards data availability and use becomes less when you come down to the lowest level […]health centers…]” - Senior Manager/IFHP+ Regional Office

LARCs Uptake
This section describes uptake of contraceptives, including LARCs, by adolescents and youth at health facilities at the four health centers in Tigray where the tested service-delivery model was scaled up. Data referenced in this section were extracted from FP registers, comparing time periods six months before the training month and six months after the training month. Where applicable, quantitative data from health centers were corroborated by KIIIs with staff from those same health centers and woreda staff where the health centers are located.

A total of 1,028 new clients accepted a modern contraceptive method at the four health centers in the assessment sample after providers had received LARCs training: 603 six months prior to the training month and 425 six months after the training month, a decline of 29.5 percent [p-value 0.00]. Generally, new acceptors were younger (15-19 years), although there were non-significant differences in new acceptors by age group (15-19 and 20-24 years). Among the 1,028 new acceptors, injectables were by far the most preferred method (47.8% to 55.3% pre- to post-training). Uptake of implants declined slightly (41% to 39% pre- to post-training). At a REST-supported health center uptake of IUDs increased pre-training (1) to post-training (5); none of the other three health centers reported IUD uptake either before or after LARCs training. Non-significant differences are noted comparing LARCs acceptors (before = 246; after = 170) and short-acting method acceptorsaa (before = 356; after = 255). Statistically significant differences are noted for only one REST-supported health center: the total number of new acceptors of LARCs (before = 12; after = 24) and short-acting methods [before = 67; after = 47] [p-value=0.01]. The total number of new LARCs acceptors equates to 15.2% of new LARCs acceptors pre-training to 33.8% post-training in this health center. (See Table 3).

**aa** Condoms (male) not included – none reported during the 13-month study period.
### Table 3: Frequency distribution of new acceptors by age and method uptake in Tigray, disaggregated by intervention period

<table>
<thead>
<tr>
<th>Health Center</th>
<th>IFHP+ Led</th>
<th>REST Led</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intervention Period</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Before</strong></td>
<td><strong>After</strong></td>
<td><strong>P value</strong></td>
<td><strong>Before</strong></td>
</tr>
<tr>
<td>New Acceptors</td>
<td>191</td>
<td>60.6</td>
<td>125</td>
</tr>
<tr>
<td>Age (years):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15-19</td>
<td>105</td>
<td>55</td>
<td>55</td>
</tr>
<tr>
<td>20 – 24</td>
<td>86</td>
<td>45</td>
<td>70</td>
</tr>
<tr>
<td>Specific Methods:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>n=191</td>
<td>n=125</td>
<td>n=261</td>
<td>n=173</td>
</tr>
<tr>
<td>Implants</td>
<td>97</td>
<td>50.8</td>
<td>52</td>
</tr>
<tr>
<td>IUDs</td>
<td>0</td>
<td>NA</td>
<td>0</td>
</tr>
<tr>
<td>Injectables</td>
<td>85</td>
<td>44.5</td>
<td>63</td>
</tr>
<tr>
<td>OCs³</td>
<td>6</td>
<td>3.1</td>
<td>6</td>
</tr>
<tr>
<td>Condoms/Male</td>
<td>3</td>
<td>1.6</td>
<td>4</td>
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<tr>
<td>Method Category:</td>
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<td></td>
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</tr>
<tr>
<td>LARCs⁴</td>
<td>97</td>
<td>50.8</td>
<td>52</td>
</tr>
<tr>
<td>Short-Acting⁴</td>
<td>94</td>
<td>49.2</td>
<td>73</td>
</tr>
</tbody>
</table>

1. Intervention period: six months before (Before); six months after (After) LARCs training
2. Missing Information [FP method type] = 1
3. OCs: Oral Contraceptives
4. LARCs: Implants and intrauterine devices
5. Short-Acting: Injectables, oral contraceptives, and condoms (male); emergency contraceptives not reported by any health center
A provider from the REST-supported health centers where the statistically significant difference was noted confirmed this quantitative finding.

“Currently, everyone younger than 25 years receives the service here in the YFS. If they need an implant I take them to other room for insertion. So, comparing with the past, this time it is convenient because they come directly to this place […] then I counsel them to receive the service. It is helpful now” – YFS Provider/REST-supported Health Center

None of the IFHP+-supported health centers showed statistically significant increases in LARCs uptake post-training, however, the respective woreda health offices and health center staff perceived that LARCs utilization had increased.

“The health centers, which have trained providers for LARC, are making a difference in improving the method mix. Besides, I could say that there is a transformation from the pill to Implanon in method of choice for FP” – Senior Manager/Woreda

The perception of the director of an IFHP+-supported health center that uptake of LARCs had increased among youth at the health center, particularly adolescents, although unsubstantiated by the quantitative data, perhaps reflected how the informant viewed the peer educators’ roles among community youth. Data from pre- and post-training indicated a decline in LARCs uptake among adolescents 15-19 years (55% accepted a LARC pre-training, while 45% did so post-training).\textsuperscript{bb}

“After the implementation of the LARC project the utilization of long-acting family planning methods which was common among the older women has also increased among younger women and the overall coverage of long-acting family planning methods has also increased. And if we try to see the age difference, there is an increase in the utilization of long-acting family planning methods among adolescents” – Director/IFHP+-supported Health Center

“And people also consult the peer educators about what they did. They treat them like health care professionals. For example, they say, “I engaged in an unsafe behavior yesterday, so what should I do?” So, what we can see from this and what I observed is the peer educators can solve the problems of their nearby community. So, before there was the trend of highly utilizing short-acting family planning methods like that of the one used every three months and the like but now there is an increase in the utilization of long-acting family planning methods” – Director/IFHP+-supported Health Center

Generally, informants at all levels of the health system, as well as implementing partners, indicated that the competency-based training of providers had contributed to an increase in LARCs uptake. They noted that the training on LARCs provision enabled providers to offer young clients the full range of contraceptive methods in one location, the YFS unit. Informants noted a decline in the use of post-abortion care services and pregnancy rates, indicating that LARCs provision has increased. Implementing partners said that scaling up the model (namely, the LARCs competency-based training) contributed to a common understanding among public-sector technical and management staff as to the value of offering full access to full contraceptive choice among adolescents and youth.

\textsuperscript{bb} Results not shown; available on request
“The first lesson that we have learned is that the LARCs service has increased during the implementation compared to the prior to the service” - Senior Technical/RHB

“There is a big difference in the utilization of long-acting reversible family planning methods before and after the implementation of the LARC project. One before the implementation of the LARC project there was a high occurrence of underage pregnancy. And the reason for the occurrence of the underage pregnancies was awareness creation activities were only given for older people in the community or the parents, and the parents didn’t want to discuss the issue of family planning or to educate their children about it” – Senior Manager/Woreda

“I have observed a decline in the abortion and post abortion service in the health center following the LARCs service in the facility. Before the implementation of the LARCs, demand for abortion services was high but following the YFS services, the need to get such services gets declines from time to time” - YFS Provider/REST-supported Health Center

A major advantage of mixed methods evaluation studies is that the quantitative and qualitative findings corroborate and thereby provide a more holistic picture of the evaluation results. Our findings indicate some contradictions between the qualitative and quantitative results. For example, public sector and implementing partner stakeholders perceived an increase in LARCs uptake among new acceptors post-LARCs training even though the quantitative HMIS data did not show statistically significant LARCs increase among new acceptors, except in one of the four YFS study units. These qualitative results may indicate a social desirability response bias – the tendency of respondents to answer questions that will be viewed favorably by others. In addition, the quantitative findings indicating the lack of statistically significant increase in LARCs uptake could possibly reflect a ceiling effect – LARCs uptake among new acceptors had reached a pre-determined level. Irrespective of social desirability bias or ceiling effect, the low concurrence between our qualitative and quantitative findings might also reflect other contextual factors including seasonal variability, low peer educator influence, LARCs trained youth-friendly providers influence, staffing shortages, commodity insecurity among other quality of care issues. A combination of these confounding factors might have contributed to the conflicting qualitative and quantitative findings.

Challenges

Scale-Up

Informants noted several challenges encountered during the scale-up phase despite the intensive pre-planning process overseen by the RHB and woreda health office. These are related to the six elements necessary for scaling up based on the current literature.11-13

- Financial constraints that stem from no budget line item specifically dedicated to FP, or more specifically, YFS. Lack of budgetary allocations result in a lack of resources for constructing a separate YFS unit; and offering, training, and review meetings;
- Competing high-profile interests at the RHB, woreda and/or health center levels;
- Inadequate YFS emphasis during routine supportive supervision visits.
Health Systems

Systemic challenges related to the creation of a separate space/room for YFS, the health workforce, health information systems, and access to FP commodities were acknowledged as overarching health systems concerns. These challenges, as listed below, were beyond what was addressed during the 16-month scale-up planning and implementation phase of the project.

- Availability of a separate space for the YFS unit, ensuring privacy and confidentiality;
- Availability of YFS coverage with LARCs-trained YFS providers 24/7;
- Staff turnover impacting YFS coverage with LARCs-trained YFS providers 24/7;
- Staff preferences influencing YFS coverage with LARCs-trained YFS providers 24/7;
- Heavy workload influencing YFS coverage with LARCs-trained YFS providers 24/7;
- Persistent data quality challenges (under- and/or over-reporting, accurate recording), lack of competency in record keeping, and insufficient data disaggregation (by age group for contraceptive uptake).

Conclusions

In Tigray, an expressed commitment at all levels of the health system to AYRH—national, regional, woreda, and health center—was the main driver for scaling up a service-delivery model that expands contraceptive choice for adolescents and youth—even if budgetary allocations did not always mirror this commitment. Scientifically robust evidence from pilot testing the model and its contribution to LARCs uptake also encouraged scale-up of the tested model in Tigray.

The E2A and IFHP+ collaborative approach involved working closely with Tigray RHBs in assessing the rationale for training YFS providers to provide LARCs and disseminating the results regionally and nationally to facilitate ‘ownership’ of the model by RHBs, woredas, and health centers. The RHB technical working group, spearheaded by IFHP+/Pathfinder International several years ago, was the conduit for technical discussions and formal program approvals. IFHP+ senior technical staff, representing the principal stakeholder for strengthening the YFS model, respected the public sector’s formal process for stakeholder engagement by presenting the findings of the “tested” model and scale-up strategy to the RHB technical working group to garner interest, commitment, and approval at the highest regional policy-making body. IFHP+ subsequently engaged stakeholders at lower health administrative levels, ensuring shared decision-making across the public-sector primary healthcare system. However, broader health systems strengthening challenges, such as room shortages and staff availability, were acknowledged challenges that hampered scaling-up.

RHB support for the tested model indicated that RHB staff approached the federal government for additional funding to continue provider training post-IFHP+ close-out. RHB support cascaded down to woredas, which encouraged health center administrative boards to scale-up the strengthened YFS model to additional health facilities. Woreda management worked closely with health centers. Woreda and health center staff, therefore, held similar views that AYRH was a priority and efforts to address AYRH needed to be improved through the public sector. Furthermore, woredas created a youth-focused
advisory body within its administrative structure to oversee youth-related health activities including resource allocation.

Despite the supportive policy environment toward expanding contraceptive choice for youth, RHB, woreda, and health center staff described similar implementation challenges in translating policy to action that necessitated commitment and combined efforts. These related to room shortages, trained staff turnover, heavy workload, competing activities, supportive supervision, and financial obligations. While these health systems challenges were acknowledged, they continued to affect service delivery despite concerted efforts by woreda and RHB management. Health centers must balance curative and preventive services, as guided by health center directors and health center administrative board.

In Ethiopia, the lack of a budget line item for YFS hinders the existence of fully functioning YFS units. During scale-up of the tested service-delivery model, implementing partners contributed financial support for trainings and associated per diems, a means of financial support that will not be sustainable in the long-term. In the absence of specific and sustainable funding for YFS, translating the national and regional policies that are supportive of AYRH into action remains a challenge. As a stopgap measure to resource challenges, some health centers and woredas generated their own revenues that contributed to constructing YFS units and maintaining YFS. As a temporary solution, public-sector and implementing partner resources could be pooled toward improving low-performance health centers and locations. However viable, this solution is not a sustainable means of scaling up fully functioning YFS. Further advocacy efforts with senior woreda and health center administration and their respective boards will be essential to achieve true sustainability and scale-up of YFS, including the provision of LARCs.

Improving the quality of voluntary FP services offered during YFS has been contingent upon client privacy and confidentiality, addressing staff turnover and heavy workloads, and providing supportive supervision at YFS units. To fully and sustainably scale-up the tested service-delivery model to all health centers, these fundamental health systems strengthening concerns must be addressed.

The HMIS served as the evidence platform for performance monitoring at the health center, woreda, and RHB levels, with feedback given to the lower levels. Generally, this feedback mechanism worked very well, though delayed feedback hampered timely 'corrective' action at health centers. A HMIS with age-disaggregated FP utilization data will be integral to improving and expanding YFS that offer LARCs. Contraceptive uptake service statistics findings were inconclusive. LARCs uptake increased significantly among new acceptors at one REST-supported health center, rising from 15% to 34% (p-value 0.01) of all new acceptors, but declined a bit at two health centers and increased insignificantly at one health center. This indicates that challenges such as staff turnovers, commodity shortages, and other quality of care barriers might have hindered LARCs uptake.

In conclusion, Tigray has successfully increased the number of YFS units offering LARCs to young persons. However, achieving the RHB’s goal of strengthened YFS units in all health centers will take time, as confirmed by an implementing partner: “It needs time to fully fund [... the YFS strengthened service delivery model...] by the government capacity” – Senior Technical/IFHP+ Regional Office.
Results: Amhara

The research team conducted 26 KIIs with senior management and technical staff at regional, zonal, woreda, and health center levels. The team conducted two interviews at the RHB office with the disease prevention and health promotion advisor, as advised by the newly appointed RHB head. The team conducted eight KIIs at the zonal level, eight KIIs at the woreda level, and eight KIIs at health centers, consisting of one senior manager and one senior technical staff member from each of the four sampled zones, woredas, and health centers. IFHP+ was the only implementing partner that conducted LARCs training for YFS providers in Amhara. The research team conducted four KIIs with IFHP+ staff, one senior manager and three technical staff.

Stakeholder Engagement

According to KIIs, the RHB is staffed by a head, deputy head, and senior technical staff. Senior MNCH, youth RH, and health promotion and disease prevention advisors work within the MNCH unit, which is responsible for planning, implementing, and evaluating MNCH activities regionally. The zonal department’s management and technical staff are directly responsible for managing, in line with formal RHB guidance, implementation of health-related activities for all health facilities in their zones. Woreda management and technical staff have managerial and supervisory authority over all health centers in their respective woredas. Each health center has a youth team: the health center director, YFS provider, and a peer educator. Health centers implement plans approved by the RHB, and zonal and woreda health offices.

“There is an administrative structure that owns the MNCH service with officers. There is also a youth reproductive health officer. These officers are the ones who are responsible for planning, implementation, and evaluation of any MNCH service including LARC” – Senior Manager/RHB

“There are structurally defined persons responsible for managing LARCs at the district health office including the MNCH officer of the district health office, the head of the health center, the YFS provider, and peer educators’ representative” – Senior Manager/Woreda

In Amhara, four steps comprise the process for stakeholder engagement in scale-up. The process engages implementing partners and the different public-sector actors at each step. Those steps are described below.

Step 1: After formal review, discussions, and approvals of the scale-up plan by RHB senior management, a formal letter is sent to the respective zonal health departments which oversee the health centers where the intervention will potentially be scaled up.

Step 2: The implementing partner visits the respective zonal health department offices with the RHB approval letter and holds a second round of discussions with the zonal department senior management. After approvals, the zonal health office sends a formal letter to the respective woreda health offices.

cc FP Officer, Youth Officer and Measurement, Evaluation Learning Officer

dd Zones limited to those containing IFHP+ YFS units
departments which have jurisdiction over the health centers where the intervention will potentially be scaled up.

**Step 3:** The implementing partner meets with the respective woreda health department officials to discuss, identify, and select the health centers that are to be included in the scale-up plan.

**Step 4:** Woreda health offices formally advise health centers to scale-up the intervention—in this case, LARCs training for YFS providers.

“The implementing organization has to communicate with the regional health bureau about their plan. It is after the agreement that the lower health administrative levels are communicated by the regional health bureau” – Senior Manager/Woreda

“I think it is the regional health bureau who pushed the implementation once the implementing partner showed the need” – Senior Technical/IFHP+ Regional Office

“The district health office wrote a letter to the health center to let them know about the program and recruit one health professional per health center for the training” – Senior Technical/Woreda

The purpose of discussions between IFHP+ and the deputy head, MNCH officer, and disease prevention and health promotion officer from the RHB was two-fold: dissemination of the ‘tested’ pilot results within the context of AYRH as a priority intervention and presentation of the plan for scaling up the tested service-delivery model.

“The fact that adolescent reproductive health problems are major public health problems and among the priority areas for intervention, made our implementation plan timely and a major gap-filling intervention to the regional health bureau. The regional health bureau acknowledged the problem and welcomed our plan to support the region in LARCs training” – Senior Technical/IFHP+ Regional Office

During these discussions, stakeholders confirmed that the scale-up plan conformed with federal and regional AYRH guidance. The RHB deputy head signed the formal agreement and informed the senior technical staff to move forward with the scale-up plan.

“It was the regional bureau deputy head who signed the agreement document (memorandum of understanding)” – Senior Technical/RHB

“The IFHP+ representatives discussed with the regional health bureau head and reached agreement. Then the MNCH officer was informed by the regional health bureau head to discuss the plan with the implementer” – Senior Technical/RHB

“There was a communication with the regional health bureau to inform the pilot result and the need for scale-up. The service was started after the approval by regional health bureau and next lower level health administration offices” – Senior Technical/IFHP+ Regional Office

The formal approval letter (memorandum of understanding) from the RHB, enabled IFHP+ to hold implementation planning discussions with the senior management and technical staff at the zonal level.
The approved implementation plan was thereafter formally integrated within the work of the zonal MNCH office, where coordination of all MNCH/FP activities are housed.

“The activity was integrated with the MNCH coordinating office and that person is responsible for the processes” – Senior Manager/Zone

IFHP+ held subsequent discussions with selected woredas where IFHP+ operated YFS units, as directed in the formal approval letter from the respective zonal offices. It is significant to note that woreda management are empowered with the flexibility to reject the RHB and zonal approvals based on internal discussions about imminent health needs. In this situation, the woreda health office deemed the tested service-delivery model necessary for addressing the RH needs of young people and consequently approved.

“If we felt it was unnecessary, we had the right to reject the plan. However, the implementation of the LARC at the YFS unit was a much-needed service” – Senior Manager/Woreda

IFHP+ visited the selected health centers, equipped with the woreda approval letters, to select providers for the LARCs training.

“When Pathfinder representatives […] came to our health center to discuss their plan, they already had agreed with the regional health bureau, discussed the plan with the zonal health department and the district health office. That means the plan was approved by the regional health bureau and communicated to the zonal health department and district health office. I, as a health center staff, was given a letter to attend the training” – YFS Provider/Health Center

“The health center is here to implement what has been planned based on the demands, needs, and feedback given by the district health office” – YFS Provider/Health Center

Respective MNCH teams at zonal and woreda health offices managed the scale-up plan. However, KIIIs did not point to any specific entity or individual that was responsible for implementation of the scale-up plan.

“There was no resource team that was established to manage the LARCs implementation specifically” – Senior Technical/IFHP+ Regional Office

Informants confirmed that the stakeholder engagement and four-step approval process was key to galvanizing sustainability. Woreda KIIIs pointed out that after IFHP+ ended, other organizations did not support LARCs training of YFS providers. However, the government has stepped in to assume ownership of ensuring YFS providers receive LARCs training, indicating government ownership of the tested service-delivery model. Zonal and woreda senior management and technical staff were of the view that RHBs must invest in training service providers to ensure strengthened YFS across regions.

“The health sector has to invest for the young people’s reproductive health and make the service available at all health facilities” – Senior Manager/Woreda

“The health sector has to own the LARC service for young people at all health facilities and plan for training, supply, and supervision” – Senior Technical/Woreda
“We have owned the LARC service and we are trying to make it sustainable through training more professionals” – Senior Technical/RHB

Roles and Responsibilities
Prior to implementing the scale-up plan, the RHB in Amhara and IFHP+ agreed to roles and responsibilities. This facilitated a common understanding of the roles and responsibilities at the health administrative and service-delivery levels and created a collaborative environment. Roles and responsibilities were developed in line with national guidelines. KIIIs confirmed that these guidelines designated the public sector as the main driver for all health activities. International organizations, such as Pathfinder International’s IFHP+, played a supportive role.

“There is a national guideline that helps to avoid a mix up of roles and responsibilities. We had a common understanding of the program, not only with IFHP, but also with other implementing organizations over many years” – Senior Manager/RHB

“The owner of the service was and is the health sector. Our role is to support to improve quality and coverage.” – Senior Manager/IFHP+ Regional

“Our role is to fill the gap. It is owned by the health administration” – Senior Technical/IFHP+ Regional

IFHP+, as the main implementing partner for youth RH programs, primarily served in a supportive role, equipping YFS units with appropriate furniture, supplies, and commodities, as necessary. The implementing partner’s roles were mutually agreed to at the health center, woreda, zonal, and regional levels, facilitating mutual understanding and collaboration across all levels.

“Accordingly, the roles of the IFHP in the LARCs implementation were training health professionals and peer educators, supplying the commodities for FP, furnishing the YFS centers, giving other resources such as TVs, coffee tables, incentives to peer educators, and supervising the service.” – Senior Manager/RHB

“The roles played by the stakeholder […]IFHP[…] were giving training to the health professionals, equipping the YFS centers, supplying with the LARCs, and supervision of the program” – Senior Technical/Woreda

Although a trusted working relationship existed between IFHP+ and the public health system in Amhara, informants offered examples where misunderstandings occurred and were mutually resolved. For example, IFHP+ supervisory visits were to be conducted jointly with the respective woreda technical team, but the supervisory visit schedule conflicted with prior woreda team appointments. This schedule conflict was resolved through dialogue. A zonal informant noted that there were a few instances where IFHP+ directly communicated with the woreda health office about the trainings without first consulting the zonal management. This was unacceptable, as it is the zonal department’s training officer who must be first informed of training activities conducted within the zonal jurisdiction. IFHP+ staff also alluded to staff turnovers and stock-outs that disrupted YFS continuation; these challenges were immediately addressed.

“We had a common understanding and collaborative activities” – Senior Technical/Woreda
“We had to miss some appointment with them for discussion, evaluation, and supervision because of emergency situations we have been facing and overlap of activities. We commented that they have to let us know ahead of time” – Senior Technical/Woreda

“Some problems were created for example calling directly to the district without the knowledge of the zone. We discussed and solved this. There is a training officer at the zonal level. Any training has to be communicated through this person” - Senior Manager/Zone

Supportive Policy Environment
The AYRH Strategy (2007-2015), the National Adolescent and Youth Health Strategy (2016-2020), and national FP guidelines support young people’s access to the full range of contraceptive methods, including LARCs. Although all public sector and implementing partner KIs confirmed awareness of the supportive policy environment for advancing AYRH, and in particular expanded method choice for young people, support for fully functioning YFS units that offer full contraceptive choice to adolescents and youth faced challenges.

“The policy of the government is that all clients including young people have the right to access FP service and the method they choose based on the information given to them. With this in mind, the regional health bureau is responsible to make the service available at all health facilities with trained health professionals assigned in the YFS unit. There is always a problem at the implementation level. There is no problem with the policy and strategy…… there had not been challenges to operational policies such as norms, guidelines, and rules” - Senior Technical/RHB

“The policy is supportive. It is the right of the public including young people to have access to FP services based on their needs and wants. There was nothing contradictory to the policy with respect to the implementation of the LARC” – Senior Technical/Zone

“The policy outlines that all reproductive age people have to have access to different contraceptive methods and it is their right to choose and use a method based on information” – Senior Technical/Woreda.

“The policy is supportive, and there was no conflict of interest or there was nothing contradictory to the policy” – Senior Manager/IFHP+ Regional

Informants from the public sector and IFHP+ mentioned that lack of commitment to providing YFS inclusive of LARCs services in a ‘one-stop shop’ and inadequate budgetary allocations to AYRH as the main challenges impeding scale-up and sustainability of the tested service-delivery model.

“It was the lack of attention to the youth reproductive health service that was a barrier” – Director/Health Center

“Resource allocation to the YFS and reproductive health services of the young people is limited. This may be related to budget limitation and prioritizing other health problems over youth reproductive health service, or lack of commitment” – Senior Technical/Woreda

“The implementation may not be as per the policy and guidelines because of budgetary limitations” – Senior Technical/Zone
“We may have budget limitation to create access to sustainable resources to the young people”
– Senior Technical/RHB

IFHP+ staff elaborated that the public sector’s fallback plan, in recognition of budgetary limitations, is encouraging NGOs to fund AYRH programs.

“There are gaps with the implementation and strategy. For example, there should be YFS centers at all health facilities but when it comes to reality there is a budget constraint. The public sector practically gives little attention to YFS and wants it to be done by external bodies such as NGOs” – Senior Technical/IFHP+ Regional

At the service-delivery level, KIIIs acknowledged that there had been lack of services aligned with the needs, aspirations, and reproductive rights of young persons, although YFS providers were aware of the national policies and guidelines. YFS providers acknowledged that scale-up of the LARCs training for YFS providers helped to address these gaps.

“It is the right of the client to choose and receive a method they wanted” – YFS Provider/Health Center

“There were no strategies to address the contraceptive needs of the young people before the training. The policy and the family planning guidelines had not been implemented at the health facility level” – Director/Health Center

**Mobilizing financial resources**

Ethiopia passed its new healthcare financing law in 1998. Financial reform was rolled out in Amhara from 2005-2006. Since then, health centers have been able to generate their own funds and allocate them as the health center board deems appropriate, though not the zonal offices.

“We are not in a position to secure funds or order any resource. The district level is responsible for asking and securing financing for implementation. Some health centers use their health care financing scheme to strengthen the LARC service at the YFS units” – Senior Manager/Zone

“The health center has financed the construction of the YFS unit. It was covered by the income generated by the health center” – Senior Technical/Woreda

Health budgetary allocations are formulated at the RHB. Contributions from implementing partners complements the federally allocated regional budget. The LARCs training for YFS providers was planned and paid for by IFHP+.

“The budget is allocated for health at the regional administrative level” – Senior Technical/RHB

“The YFS and LARCs are part of the activities of the health bureau and the different administrative levels including the health centers through health care financing” – Senior Manager/RHB

“This includes FP services irrespective of who supports the service. Therefore, the LARC training and implementation was also part of strengthening the FP service” – Senior Technical/RHB

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**LARCs commodities “due to delay in requesting or other procurement process.”**
The training on LARCs was scheduled and financed by the implementing partner. – Senior Manager/Woreda

The zonal and woreda health offices function as an administrative body. They have no independent financial resources to allocate to health-related activities, including strengthening YFS units. The RHB allocates budget for staff salaries to both offices. The zonal and woreda health offices can request additional funds from the RHB for specific activities such as LARCs training for the YFS providers. However, only the woreda can procure funds. Woreda administration plays a key role in maximizing cost-efficiency for activities such as in-service trainings.

There is no budget allocated in the name of the zonal health department. Therefore, the zonal health department can’t finance any activity including LARC. – Senior Technical/Zone

We can raise the need for financial services, but it doesn’t mean we can secure finance. – Senior Technical/Zone

On the other hand, health center budgetary allocations come from two sources: public sources disbursed by woreda administration and health center-based income-generation activities. For large capital investments, such as construction costs for the YFS units, funds have been secured through both these sources. For recurring expenses, such as in-service clinical trainings, funds have been procured through donors and implementing partners. KIIIs acknowledged that IFHP+ supported LARCs training costs, although the peer educators’ refresher training was supported by internal health center resources.

When there is a need to secure finance, we request the district administration … the district administration covered the cost of building a YFS unit. – Director/Health Center

The health center constructed the YFS unit with the support of the district administration. The money for constructing the YFS was given by the district administration to the health center. – YFS provider/Health Center

We constructed a YFS at the health center using our internal revenue. – Director/Health Center

There was no financial commitment especially for the LARC implementation because it was financially supported by the implementing partner. We used our health care financing for refresher training. – Director/Health Center

There is no budget line item in the public health system budget for strengthening YFS. LARCS training therefore proceeded by availing existing resources.

We, as a zonal health department, didn’t invest on the LARC service. – Senior Manager/Zone

We didn’t invest for the LARCs services. – Senior Technical/Woreda

We implemented [LARCs services] with the available infrastructure and resources. – Senior Manager/Woreda
Investments were not made directly to the health sector, but, instead, to multi-sectoral collaborations that helped to fill budgetary gaps. For example, in several situations, health centers collaborated with the youth and women affairs sectors to cover the construction costs of creating YFS units.

“Some health centers have constructed YFS centers with the support of the district administrations and health offices. They discussed with different sectors including youth offices and women’s affairs to convince the district administrative offices to support the service. They have been successful in doing so” – Senior Manager/RHB

Financial support from IFHP+ has mainly funded capacity building, supportive supervision, and review meetings. IFHP+ has also helped to furnish the YFS unit and replenish FP commodities stock-outs. IFHP+ staff acknowledged that public sector special investments were not obligated; rather, budgetary allocations for LARCs training was pre-determined during IFHP+ internal budgetary planning phase.

“We had predetermined and pre-planned budget for the program. That guided the implementation process” – Senior Technical/IFHP+ Regional

“We did what we planned according to the available budget” – Senior Manager/IFHP+ Regional Office

Financial constraints were recognized as a barrier to the implementation of a ‘one-stop shop’ YFS unit offering expanded method choice in all health centers. KIIIs with woreda staff perceived that financial responsibility rests with the public sector, although this results in some budgetary constraints. The RHB, cognizant of the need to advance AYRH, approached implementing partners such as IPAS, UNFPA, and Pathfinder, to meet these budgetary deficits.

“It is the responsibility of the government to finance the service […]LARCs training…]. However, there is the limitation of budget” – Senior Technical/Woreda.

“We clearly showed the gaps, clearly based on the identified needs” – Senior Technical/RHB

KIIIs with public-sector stakeholders acknowledged the low commitment of the health system to AYRH, though implementing partner key informant remarked that there were some instances where health centers constructed new rooms for YFS units signaling their commitment and ownership of YFS.

“There is lack of attention to youth reproductive health problems at all levels. It is not considered as one of the most important health issues” – Senior Technical/Woreda

“The lowest priority of the health service is that of youth reproductive health” – Senior Manager/Zone
“There were problems with commitment from the health sector’s side to secure financial commitment” – Senior Technical/ IFHP+ Regional Office

**Quality of Voluntary FP Services (Counseling and Service Provision)**

Informants considered four factors that influence the quality of FP/RH services that offer full contraceptive choice: providers (training, including trainee selection and LARCs insertion and removal skills, commitment, gender, availability, and staff turnover); separate space (privacy and confidentiality);
commodity security; and supportive supervision with timely feedback. The key informants provided valuable insights about how the public sector is working to advance AYRH in line with national goals.

Providers
Nationally approved, standardized, competency-based LARCs training conducted by regional trainers is essential to advancing full access to full contraceptive choice among young persons. IFHP+ supported competency-based LARCs training, conducted by regional trainers, which improved provider counseling and LARCs insertion and removal skills.

“There were some gaps in insertion and counseling skills. We have detected misplaced implants, inserted deep into the muscles” – Senior Technical/Zone
“The training has created opportunity for better counseling and skill of inserting contraceptives” – Senior Manager/Woreda

“We made the training comprehensive and practical. We gave the training for two weeks, which included theoretical and practical sessions. We evaluated the trainees at the end and found that there were improvements in the domains (knowledge, attitude, and skill). We supervised the service and gave feedback” – Senior Technical/IFHP+ Regional Office

“We have taken good training that equipped us with the confidence and skill of counseling and inserting the methods” – YFS Provider/Health Center

However, it was noted that simply conducting competency-based LARCs training was not sufficient to achieve quality improvement. The approach to trainee selection was equally important. Informants from woreda and zonal health offices said they intentionally selected motivated, high-performing providers committed to working at YFS units for a minimum of one-year post-training. In addition, female service providers were selected, acknowledging gender sensitivities, particularly among younger clients.

“We tried to select better performing and motivated health professionals for the training” – Senior Technical/RHB

“A trained health professional should work for at least a year at the YFS […]unit…]” – Senior Manager/Zone

“As much as possible, we try to carefully select providers for training. We prioritized those who are motivated and show interest and willingness to practice in reproductive health services for young women” – Senior Technical/Zone

Staff turnover and availability
Informants reported that it was important YFS providers be available to young clients outside routine clinic times and on weekends. However, staff turnover continued to impede quality. IFHP+ staff and RHB management both mentioned that additional providers should be trained in LARCs service provision to offset YFS disruptions.
“The providers were giving the service out of office hours and on the weekends” – Senior Technical/Woreda

“We also have unavoidable staff turnover and interruption of the service” – Senior Manager/Woreda

“We tried to communicate this with the health administrators and train more health professionals. We discussed with the regional health bureau about training more health professionals per health facility. This may help the service to continue in the absence of a trained professional. If a client comes to the health center to use a FP method but there is no provider, this would cause a disappointment” – Senior Manager/IFHP+ Regional Office

Separate space
Two key YFS tenets are privacy and confidentiality. Informants at all levels of the public health system in Amhara acknowledged the importance of upholding these tenets. Offering young people privacy and confidentiality means they can receive preventive services, including LARCs, in a separate room. Health centers created separate rooms to cater solely to the RH needs of adolescents and youth. They were furnished with the aim of creating an attractive environment for young people. Health centers further ensured privacy by creating a separate entrance that enabled young clients to enter the YFS unit directly rather than through the general health center entrance.

“Maintaining privacy and confidentiality, separating the service and permanently assigning provider, and sustainable supply […] are youth-friendly quality of care that […] have been improved” – Senior Technical/Zone

“We recommended that the health facility […] YFS unit[…] be neat and conducive to the service” – Senior Technical/RHB

“The rooms are separated to let the clients feel at ease and comfortable. There is a backdoor for the young people to enter into the room” – YFS Provider/Health Center

Commodity security
However, the creation of a separate space hindered quality of care if providers’ attitudes and commodity security were not simultaneously addressed. Informants reported that providers were trained and encouraged to be caring and respectful to their young clients, and efforts were made to ensure commodity security at YFS units.

“We inform the providers to be caring, respectful and compassionate” – Senior Manager/Zone

“The resources especially contraceptive methods are supplied sustainability” – YFS Provider/Health Center

Supportive supervision with timely feedback
Supportive supervision with timely feedback was considered important to maintaining quality of care and improving FP counseling and service provision by public sector key informants
“We tried to make the methods of FP uninterrupted through supportive supervision and feedback” – Senior Technical/Woreda

“The supportive supervision by the district health office and the implementing partner helped us improve our counseling as we receive feedback from the supervisors” – YFS provider/Health Center

“Through our periodic supervision, we made sure the availability of the commodities for FP” – Senior Technical/IFHP+ Regional Office

An informant from the RHB summed up how YFS were strengthened to improve quality of care for young people.

“The accomplishments include the provision of the service in separate rooms with adequately trained providers and sustainable supplies. Increasing public awareness about the benefits of LARCs for the young women has increased the uptake of the methods. We have also made the service sustainable” – Senior Technical/RHB

Data Availability and Use

National FP registers are maintained in the MNCH/FP and YFS units at health centers. FP register data are disaggregated by age, method type, acceptor status, and place of residence. Data are aggregated and submitted monthly to the woreda health office using the government’s ‘Monthly Service Delivery Report Form’. Woreda health office staff review, compile, and submit the data to the zonal health department. At zonal health departments, data are analyzed, reviewed, and submitted to the RHB.

“The registry is kept at the health facilities and the activities are compiled and reported to the regional health bureau through the district health offices and zonal health departments every three months” – Senior Manager/RHB

“We receive reports from the districts monthly and quarterly” – Senior Manager/Zone

“We receive reports from the health centers weekly” – Senior Manager/Woreda

“We receive from the health centers quarterly” – Senior Technical/Woreda

Performance review committee meetings are hosted at the health center, woreda, zone, and the RHB. Informants acknowledged that data generated from the HMIS were used for decision-making at each health administrative and service-delivery level. The weekly, monthly, and quarterly performance reviews are the platforms where the compiled data are analyzed for assessing low- and high-performing services, planning and resource allocation, and data utilization for evidence-based informed decision-making such as commodity stock-outs, staff transfers, and other resource constraints. In addition, health center performance reviews assess contraceptive use. The expected contraceptive use rate at health centers is equally proportional: half LARCs acceptors and half short-acting methods new

Age Groups: <15, 15-19, 20 - 24 and 25-49
Acceptor Status: new, repeat
acceptors. Performance reviews evaluate this ratio to assess progress, identify shortfalls, probe for reasons, and rectify.

“Method shortages, staff transfers, and other resource constraints. We plan for improvement based on the identified problems and their causes” – Senior Technical/RHB

“We examine the data to find out which methods are increasing, and which ones are decreasing. We try to investigate the reasons” – Senior Technical/Woreda

“The expected service use is 50% for LARC and 50% for short-acting contraceptives. We evaluate this to compare with the plan and find out problems for correction. For example, if coverage of one of the methods is lower than expected or what had been previously, we try to find out the reasons and try to solve it” – Director/Health Center

The compilation, aggregation, and analysis for age-disaggregated metrics related to contraceptive uptake hampered efficient performance reviews at RHB, zonal, and woreda levels. Informants acknowledged that age-disaggregated data are entered in FP registers maintained at YFS units and the main FP unit, although the monthly HMIS reporting format does not allow for age-disaggregated data by method type. This limitation in the reporting format was considered as a major stumbling block. Health centers cannot report the methods young people are choosing and therefore the data cannot be used efficiently and effectively for planning the provision of contraceptives at YFS units.

“The short-acting methods and LARCs at the YFS units were not reported separately. That means the FP services at the YFS units were reported together with the overall FP service at the health centers” – Senior Technical/Zone

“The format […]FP register[…] is method-based and age categorized but there is not a separate reporting format for the young people to compile and interpret” – Director/Health Center

“The reporting format had a limitation that it didn’t include age disaggregation for each method” – Senior Technical/IFHP+ Regional Office

“In order to use the data for future planning, the report has to include all the necessary information about the family planning service including methods and age distribution per method” – Senior Manager/Zone

In addition, government reporting formats are not consistent across facilities, woredas, and zones, though attempts are being made to make the reporting formats consistent. This lack of uniformity further hinders data utilization for evidence-based decision-making. Unavailability of the national FP registers also compromises documentation quality, as service providers must record FP utilization in notebooks.

“The reporting system is not consistent across the facilities and there are mix-ups of services and age classifications. This makes it difficult to identify problems and plan solutions. We are trying to make the reporting formats similar and consistent across the region” – Senior Manager/RHB

“There was a shortage of registration book which forces us to use plain papers for reporting” – YFS Provider/Health Center

IFHP+, does not have an independent health information tracking system for its programmatic needs. IFHP+-supported health centers concurrently submit on government-issued HMIS forms to the woreda
health office and to IFHP+ regional office. IFHP+ collates health center reports and submits to the IFHP+ center office. The standardized reporting format enables compilation, analysis, and interpretation. Data analysis is conducted to identify low contraceptive use rates and for procurement forecasting by IFHP+.

“The report from health facilities comes to the regional office and we send this to the central office monthly” – Senior Manager/IFHP+ Regional Office

**LARCS Uptake**
This section describes uptake of contraceptives, including LARCs, by adolescents and youth at health facilities at the four health centers in Amhara where the tested service-delivery model was scaled up. Data referenced in this section were extracted from FP registers. Where applicable, quantitative data from health centers are corroborated by KII with those same health centers, and with perceptions of zonal and woreda staff where the health center is located.

A total of 812 new clients accepted a modern contraceptive method at the four health centers in the assessment sample after providers had been trained on LARCs; 447 six months prior to the training month and 365 six months after the training month, a decline of 18.3 percent \( p\text{-value} 0.00 \). Generally, new acceptors were younger (15-19 years), although there were non-significant differences in new acceptors by age group (15-19 and 20-24 years). Among the 812 new acceptors, injectables were by far the most preferred method (54.7% to 61.9% pre- to post-training). Uptake of implants remain consistent (32% to 32.7% pre- to post-training). Non-significant differences are noted comparing LARCs acceptors (before = 145; after = 117) and short-acting method acceptors\(^{nh}\) (before = 356; after = 255). Statistically significant differences are noted for only one health center: the total number of new acceptors of LARCs (before = 66; after = 37) and short-acting methods (before = 112; after = 36) \( p\text{-value}=0.05 \); LARCs uptake increasing from 37.1% to 50.7% among all new acceptors. There were non-significant differences in the other three health centers. (See Table 4 on the following page)

\(^{nh}\) Condoms (male) not included – none reported during the 13-month study period.
Table 4: Frequency distribution of new acceptors by age and method uptake in Amhara, disaggregated by intervention period

<table>
<thead>
<tr>
<th>Intervention Period¹</th>
<th>Health Center – 1 Before</th>
<th>%</th>
<th>Health Center – 1 After</th>
<th>%</th>
<th>P Value</th>
<th>Health Center – 2 Before</th>
<th>%</th>
<th>Health Center – 2 After</th>
<th>%</th>
<th>P Value</th>
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<th>%</th>
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<th>%</th>
<th>P Value</th>
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<th>%</th>
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<td>54 41.5</td>
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<td>155 55.6</td>
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<td>15–19</td>
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<td>245 54.8</td>
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<td>95 53.4</td>
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<td>202 45.2</td>
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<td>299 67.3</td>
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<td>243 67.5</td>
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</tr>
</tbody>
</table>

1. Intervention period: six months before (Before); six months after (After) LARCs training
2. Missing Information [FP method type] = 8
3. OCs: Oral Contraceptives
4. ECs: Emergency Contraceptives
5. LARCs: Implants and intrauterine devices
6. Short-Acting: Injectables, oral contraceptives and emergency contraceptives; condoms (male) not reported by any health center

ASSESSMENT OF SCALE-UP: Expanding Voluntary Contraceptive Methods to include LARCs in Youth-Friendly Service Units
Informants at regional, zonal, woreda and health center levels indicated that scaling up the tested service-delivery model contributed to an increase in LARCs uptake. The RHB senior technical staff member remarked that LARCs uptake improved from practically zero. Other informants remarked that LARCs coverage had increased as indicated by a decline in maternal mortality from unsafe abortions, increased awareness, and attitude change among providers.

“At the regional level, there is increasing uptake of LARC by the young girls from almost nothing. This is one achievement” – Senior Technical/RHB

“We saved lives. There were deaths of young women due to unsafe abortion. We also improved the performance of the health centers with respect to youth reproductive health. We have created access to the population to youth reproductive health” – Senior Manager/Woreda

“The awareness and the utilization of LARCs have increased. We are now giving a better service for the young women in terms of LARCs and counseling. There is a significant improvement in the utilization of the LARCs by the young women since the opening of the service following the training” – Director/Health Center

Most informants perceived increased uptake of LARCs, although a statistically significant difference in LARCs uptake was observed in only one health center. None of the other three health centers showed a statistically significant increase in LARCs uptake post-training, and at one health center, LARCs uptake declined from 28.6% to 21.3% of all new acceptors (p-value 0.17).

“The accomplishments include increased coverage/demand of the LARC. We solved to some extent the problems of the youth. We have attracted many young people to the service. This has improved the quality and coverage of reproductive health services in general and LARCs in particular” – Senior Manager/Zone.

“The coverage of LARCs, in general, has increased because many young women started to use LARC” – Senior Manager/Woreda

“The young people are now seeking service. The uptake of LARC has increased. The increasing awareness and change of attitude towards LARC are achievements” – Director/Health Center

“The coverage of LARC was almost zero. We have increased the coverage although we didn’t achieve what we wanted to. Our plan is to make LARC coverage 50% of the FP” – Senior Manager/Zone

A major advantage of mixed methods evaluation studies is that the quantitative and qualitative findings corroborate and thereby provide a more holistic picture of the evaluation results. Our findings indicate some contradictions between the qualitative and quantitative results. For example, public sector and implementing partner stakeholders perceived an increase in LARCs uptake among new acceptors post-LARCs training even though the quantitative HMIS data did not show statistically significant LARCs increase among new acceptors, except in one of the four YFS study units. These qualitative results may indicate a social desirability response bias – the tendency of respondents to answer questions that will be viewed favorably by others. In addition, the quantitative findings indicating the lack of statistically significant increase in LARCs uptake could possibly reflect a ceiling effect – LARCs uptake among new acceptors had reached a pre-determined level. Irrespective of social desirability bias or ceiling effect, the
low concurrence between our qualitative and quantitative findings might also reflect other contextual factors including seasonal variability, low peer educator influence, LARCs trained youth-friendly providers influence, staffing shortages, commodity insecurity among other quality of care issues. A combination of these confounding factors might have contributed to the conflicting qualitative and quantitative findings.

**Challenges**

**Scale-Up**

Informants noted several challenges encountered during the scale-up phase despite the intensive pre-planning process overseen by the RHB and woreda health office. These are related to the six elements necessary for scaling up based on the current literature.\(^1\)\(^2\)\(^3\)

- Low commitment, poor attention, and financial constraints that stem from no budget line item specifically dedicated to FP, or more specifically, YFS.
- Lack of budgetary allocations resulting in lack of resources for skills training, commodity security.
- Myths and misconceptions about LARCs service provision for young persons.

**Health Systems**

Systemic challenges related to lack a separate space/room for YFS, health workforce, health information systems, and access to FP commodities were acknowledged as overarching health systems concerns beyond the scope of the 16-month scaling-up planning and implementation phase.

- Infrastructural factors including lack of availability of electricity, adequate water supply, and additional rooms;
- Availability and quality of YFS coverage with LARCs-trained YFS providers 24/7;
- Staff turnover impacting YFS coverage with LARCs-trained YFS providers 24/7;
- Staff preferences, commitment, and motivation, influencing YFS coverage with LARCs-trained YFS providers 24/7;
- Persistent data quality challenges (under- and/or over-reporting, accurate recording), lack of competency in record keeping, quality of reporting formats, and insufficient data disaggregation (by age group for contraceptive uptake).

**Conclusions**

High abortion rates, high unmet need, privacy and confidentiality, and provider bias were the ‘push’ factors that influenced national and regional stakeholders to support the strengthening of YFS to include the provision of LARCs in Amhara. The notion of a ‘one-stop shop’ where young clients are counseled and receive the method of their choice without being referred to the main FP clinic in the MNCH unit was a solution to addressing provider-client confidentiality. The ability to address confidentiality issues in the provision of YFS to youth contributed to RHB’s enthusiasm for scaling up the tested service-delivery model. FMOH policy created a conducive and supportive environment for scaling up the model, which had proved successful in increasing LARCs uptake among youth during the pilot phase (Phase 1).
IFHP+ worked collaboratively with the public health system to facilitate the scale-up process. IFHP+ and the different administrative levels of the public health system in Amhara already had an established and trusted relationship, providing a strong foundation for scale-up of the tested service-delivery model. Both IFHP+ and public-sector stakeholders had a mutual understanding of their roles and responsibilities in the scaling-up process, developed during their decade-long working relationship. For example, IFHP+ obtained formal approvals successively from each health administrative level—RHB, zone, and woreda—contributing to the success of the scaling-up process. Adherence to this formal approval process facilitated productive scale-up planning and management in the short-term, and government ownership and sustainability in the long-term. The woreda health office ultimately assumed responsibility for deciding to accept scale-up of LARCs training to YFS providers without delay.

Informants noted that national policy and guidelines are supportive to young people’s access to the full range of contraceptive methods, however, implementation of those policies and guidelines had been hindered due to budgetary constraints. KIIs with public-sector stakeholders and IFHP+ indicated that all public-sector partners, from RHB to health centers, have some interest in supporting fully functioning YFS units that offer full contraceptive choice to young people. However, translating this commitment to financial obligation (annual budget expenditures) proved challenging. During the scale-up, IFHP+ provided financial resources for LARCs training and addressing LARCs stock-outs directly. Woreda health offices and health centers also collaborated to address budgetary gaps, procuring funds for YFS unit construction costs in some health centers. This type of collaboration within the public health sector indicates a shift toward government ownership. However, galvanizing financial contributions and its integration in national, regional and sub-regional annual budgetary outlays remains a challenge, reflecting the disparity between a supportive policy environment for AYRH services, and the level of commitment related to their implementation. Continued and sustained advocacy efforts at all administrative levels of the public health will be necessary to continue to advance AYRH in Ethiopia.

Additional implementation challenges stem from the low commitment of woredas and health centers to prioritizing contraceptive choice for youth. This resulted in room shortages for YFS, with greater priority given to other clinical units; trained staff turnover; commodity insecurity; competing activities; and irregular supportive supervision. Scaling up the tested service-delivery model was successful in focusing on many of these issues. However, to scale up to all health centers regionally and ensure sustainability, these fundamental health systems strengthening concerns must be addressed. The HMIS reporting formats are aggregated and submitted monthly by each health center to their respective woreda office, where the data are reviewed, collated, and transmitted to the zonal health department and thereafter to the RHB. Performance reviews were used to assess low and high performance, identify contributing factors to performance, and draft responsive action plans. Generally, this feedback mechanism functioned well for data flow and internal reviews at each of the three tiers of the primary healthcare system. Supportive supervisory visits complemented this performance monitoring system, addressing data quality in terms of incomplete records, and over- or under-reporting. Instituting weekly reporting of ‘high-value’ indicators, such as LARCs utilization, for zonal health department review is an excellent example of timely data utilization for decision-making. However, a significant continuing challenge for effectively using LARCs uptake data among young persons as a performance indicator is the absence of age-disaggregated contraceptive uptake data at higher administrative levels.
Contraceptive uptake service statistics, comparing six months before and six months after YFS providers received LARCs training, was ambiguous: LARCs uptake increased significantly in one facility, rising from 37.0% to 51.0% (p-value 0.05), but remained essentially the same in the other three facilities. These statistics indicate that, perhaps, systemic health facility challenges, such as staff turnover, commodity shortages, and other quality care barriers continue to hinder LARCs uptake at YFS units. Informants from zonal and woreda health offices noted the goal of continuing in-service training to achieve strengthened YFS at all health centers in Amhara. The RHB confirmed this goal. Although this is a positive goal and exhibits commitment of the public-health system to continue scaling up the tested service-delivery model, fundamental health systems concerns must be addressed, including: lack of human resources, poor quality of care, and lack of age-disaggregated FP utilization data in the HMIS reporting format.

In conclusion, Amhara has successfully increased the number of strengthened YFS units offering expanded method choice to young persons. However, the public health sector needs to exhibit increased commitment and financial resources to YFS that include LARCs services in order to see significant increases in LARCs uptake among youth.

Results: Central-Level Implementing Partner Staff (IFHP+/Pathfinder International)
Pathfinder International, through its USAID-supported projects, IFHP+ and subsequently Transform: Primary Health Care Project, is a lead implementing partner of FP/RH programs in Amhara and Tigray. Pathfinder has a central office in Addis Ababa (herein referred to as ‘central office’) and regional offices in Bahir Dar, Amhara and Mekelle, Tigray. The central office oversees and provides supportive technical assistance to regional staff. Strategies, such as testing and scaling up the strengthened YFS model, are agreed upon at regional and central levels and subsequently included in regional and central workplans and budgets.

In addition to interviews conducted with IFHP+ senior management and technical staff at regional offices, the research team conducted interviews with senior management and technical staff at the IFHP+ central office. The team conducted three KIIIs with senior management (1) and technical staff (2) at the central office. The results of those KIIIs, describing the processes, achievements, and challenges encountered when scaling up the tested service-delivery model, are presented in this section.

Stakeholder Engagement
Stakeholders from the FMOH contribute to the policy environment for the provision of YFS, whereas RHBs implement FMOH policy and guidelines. The main stakeholders involved in scaling up the tested service-delivery model, other than IFHP+, were the public-sector administration, including regional, zonal, woreda, and health center staff, as well as peer educators.

“The issues that we would undertake with the FMOH, focused mostly on designing strategy, guidelines and documents. However, the regions are implementers and we were working with them […] RHBs […] closely than with the FMOH in the program” – Senior Technical/IFHP+ Central Office

“There were regional health bureaus in both regions. There were also woreda health offices and the facility itself. These are the main stakeholders” – Senior Technical/IFHP+ Central Office
**Roles and Responsibilities**
Implementing partner and public health system roles and responsibilities related to scale-up of the tested service-delivery model were not explicitly stated. Rather, roles and responsibilities were identified based on IFHP+’s prior experience. In other words, the decade-long working relationship between IFHP+ and the public health system contributed to a mutual understanding of roles and responsibilities for scale-up. To plan for scale-up, joint planning activities were conducted between RHB and IFHP+ central and regional staff - the RHB selected the trainees and trainer and jointly conducted supportive supervisory visits.

“There was joint planning with regional level IFHP+ Office and the respective regional health bureaus” – Senior Technical/IFHP+ Central Office

“In common understanding, the regional health bureaus have a role of facilitating training including selecting the trainee and trainer, including our activities in their supervision and follow up and the like. This works not only for LARCs but also for other services” - Senior Technical/IFHP+ Central Office

**Supportive Policy Environment**
The Adolescent and Youth Health Strategy (2016-2020) and national FP guidelines are supportive of young people’s access to the full range of contraception, including LARCs, and there is widespread understanding within the public health system of young people’s RH needs. However, services have not always been implemented in a way that has addressed those needs.

“Our family planning guideline has no confusion and there is no clear restriction on youth in accessing LARCs. The WHO guideline indicates that there is no restriction of LARCs by age and it does not exclude or put other alternatives for youth. Rather, everyone of reproductive age is eligible for LARCs” – Senior Manager/IFHP+ Central Office

“It may also be that the misperception is at both levels, i.e. health authorities (Ministry of Health) and service providers levels, that impedes the implementation of the LARCs and the youth program at the facility level” – Senior Manager/IFHP+ Central Office

Key informants noted that challenges faced during the scale-up included differing understandings across geographical regions about the importance of offering LARCs to youth. IFHP+ made concerted efforts to allay such misunderstandings by referring to WHO Medical Eligibility Criteria and related FMOH policy and guidelines. They lead discussions with woreda and health center staff to dispel myths and misperceptions.

“We have distributed the guidelines and policy-related documents to each facility. We also have discussed these documents with facility and woreda level managers, including eligibility of the youth for the services, to clarify misconceptions and bias” – Senior Technical/IFHP+ Central Office

**Mobilizing financial resources**
Although the federal government invests in healthcare financing for activities focused on youth’s RH needs, it is not fully understood that inability to address the RH needs of young people is a major contributor to poor health outcomes in Ethiopia. Considering that young men and women are joining
the workforce in growing numbers, and that young women are at high risk for unintended pregnancy, unsafe abortions, and maternal mortality, their health, broadly, and FP/RH needs, specifically, must be considered high priority and addressed within a federal budget and with its own line item to reap the benefits of the demographic dividend.

“The need and issue of the youth is far from being addressed regarding reproductive health” – Senior Manager/IFHP+ Central Office

“Family planning needs to be a budgeted program and it shouldn’t be dependent on the willingness of development partners” – Senior Technical/IFHP+ Central Office

“In a country with 33 million youth age group, the expectation of gaining the benefits of family planning in the demographic dividend, would not be possible without investing in [...] the youth” – Senior Manager/IFHP+ Central Office

IFHP+ financial contributions were relatively small in comparison to public sector financial contributions. IFHP+’s contribution was limited to training costs and commodity provision to allay commodity stock-outs. The public sector’s contribution included staffing, salaries, infrastructure, and supportive supervision.

“In the terms of securing financial commitment, though we do not calculate it, our support to the public sector is like a drop in the ocean. The ocean is the public sector because the health providers are there, the facility is already there” – Senior Manager/IFHP+ Central Office

“The public sector is one who pays the monthly salaries of the health workers and the one who fulfills the commodity needs for YFS unit” – Senior Manager/IFHP+ Central Office

With the promulgation of the healthcare financing policy,5-6 health centers generate and utilize funds under the guidance of the health center’s administrative board. However, operationally, it is difficult to convince the board to use the health center-generated funds to address young people’s FP/RH needs.

“There is little understanding of the need to utilize the health care financing and other income generating activities for issues related to strengthening RH and FP services. They also face difficulties in convincing the board of the facilities to use the money for FP” – Senior Technical/IFHP+ Central Office

IFHP+ incorporated elements in its implementation strategy to address sustainability, directly providing technical support to strengthen the government infrastructure.

“We should be clear that it is only technical support that we need to provide. We are different from other partners that provide services out of their own clinics, using their own manpower in their own system. If you do it this way, all these services will end when you terminate the project. Our system is quite different because we understood that we should aim to strengthen the existing public sector” – Senior Manager/IFHP+ Central Office

**Quality of Voluntary FP Services (Counseling and Service Provision)**

KII’s recognized that to provide quality FP counseling and service provision to young people at YFS units, providers must receive competency-based counseling and skills training; there must be a continuous
supply of commodities available; and LARCs-trained YFS staff must be available to young people seeking services. A senior technical staff indicated that the quality of the training program combined with supportive supervision were essential for delivering quality FP services.

“There was no shortage of money and resources that could compromise the quality of the trainings. There is also a follow-up during and after the training. The value of counseling is equally important as the value given for the service provision” – Senior Technical/IFHP+ Central Office

Staff turnover, and supply and commodity shortages ultimately hindered the provision of quality LARCs services. KIIs noted that attempts were made to alleviate staffing and commodity shortages by training more than one YFS provider and ensuring no stock-outs.

“Turnover of trained providers is the greatest […]challenge…], which causes discontinuation of the services” – Senior Manager/IFHP+ Central Office

“Two providers would be trained to fill the gap if one is out for different reasons. Efforts would be also be made to make commodities and supplies available in situations where there would be a shortage of the methods at the facility level” – Senior Technical/IFHP+ Central Office

Data Availability and Use

Data from the HMIS format are compiled from IFHP+ programs and submitted to regional and central levels quarterly. At the central office, the HMIS compiled data and data from other sources were used for planning purposes. Data quality, in terms of over-reporting and lack of age-disaggregated method-specific data, were identified as barriers to analyzing and interpreting contraceptive uptake by method type.

“There are gaps when you crosscheck the data that was reported from the facility with what is actually registered. Often, what is reported is higher than what is registered in the registration book” – Senior Technical/IFHP+ Central Office

“The HMIS data do not have age-disaggregated data. To make it age-disaggregated data, we have been doing a lot with the planning department in the FMOH and they have told us that it will be included in the revised format of HMIS but still it is not incorporated. I do not think that it would be possible at this time. This was posing a challenge to the monitoring and evaluating the trend in service use” – Senior Technical/IFHP+ Central Office

LARCs Uptake

Central-level key informants from IFHP+ said that prior to implementation of the LARCs training, contraceptive uptake at the YFS units skewed toward short-acting methods. This indicated that the YFS providers were not competently trained on providing LARCs services. However, they had been competently trained on balanced counseling, resulting in referrals of clients to the main unit or another facility to access LARCs.

“When we observed the existing YFS units we were working with, we looked at the availability and uptake of the youth friendly service, we found that most the services were inclined to provide short-acting FP methods. But in principle, it is assumed that the YFS should include all choices of FP within a room. The service providers had basic skills and took basic training on YFS. However, when it comes to
LARC, the providers had a shortage of skills on that and clients needed to be referred to other clinics to get LARC. Even the preference was to go to other places than the health facility. Thus, the uptake for LARC was low” – Senior Manager/IFHP+ Central Office

In line with the FMOH policy guidelines reflecting WHO’s Medical Eligibility Criteria, documented low LARCs uptake at the YFS units, and IFHP+’s emphasis on evidence-based programming, IFHP+ in collaboration with E2A, embarked on testing a service delivery strengthening model – ‘tested model’ – as the first step in the ‘evidence to action’ cycle (Phase 1).

“To synthesize the evidence about LARCs with ‘evidence to action’. What we did is, we included LARCs to existing YFS […] units […] to examine the uptake of the service” – Senior Manager/IFHP+ Central Office

Conclusions

The main implementing partner, IFHP+ acknowledged that inadequate AYRH investments, unintended pregnancy and unsafe abortion, were the driving forces for IFHP+’s targeted focus on addressing young persons’ RH/FP needs as high priority. Strengthening the YF service delivery model to include LARCs harmonized with IFHP+ overall ‘evidence to action’ and ‘implementation strategy’ approach: ‘testing’ the model in public-sector YFS units (Phase 1), disseminating the results at regional and national venues, and jointly planning and implementing scale-up with the respective regional public health administration (Phase 2) (See Figure 2). In addition, the close collaboration and mutual understanding of the roles and responsibilities of senior management and technical staff at regional public sector administrative and service delivery levels boosted ownership and sustainability of the YF strengthened service delivery model. Policy and guidelines regarding young persons’ access to the full range of contraceptive methods are reflected in FMOH strategy and FP guidelines, though translating the national guidelines to implementation service were subject to misperceptions by technical/administrative and service providers at the regional, sub-regional, and service delivery level. However, as informants observed, IFHP+ staff addressed these through discussions with appropriate staff at all regional administrative and service delivery levels.

IFHP+’s financial contribution, in comparison to the public-sector outlays, is relatively minor and geared to covering training costs, supportive supervision and addressing commodity shortages – signifying IFHP+’s implementation approach. While the health care financing policy has empowered health facilities to generate and utilize the funds according to their needs, challenges in appropriating these funds for AYRH services at the facility level continue. Concerted efforts must continue to also improve national investments in AYRH to reap the demographic dividend benefits.

The HMIS quarterly reporting data from IFHP+ cluster areas and regional offices were routinely utilized during planning and re-planning of activities based on the interpretation of the data generated in the quarterly cluster and regional M&E reports. While data quality concerns were mentioned, the major stumbling block was the lack of age-disaggregated FP data that hindered monitoring trends in young clients’ contraceptive uptake by method type—despite repeated efforts by IFHP+ technical staff to encourage the FMOH planning department to include such age-disaggregated data in the monthly reporting formats.
In conclusion, IFHP+, conforming with its ‘evidence to action’ and ‘implementation strategy approach’ ethos, has encouraged the RHB and lower administrative levels to strengthen and sustain the YF strengthened service delivery model and continue advocating for further expansion to all health centers, while remaining aware of implementation challenges. It is encouraging to note that the FMOH has recently decided to include age disaggregation in its DHIS2 enabling age-disaggregated data availability per health administrative level\(^\text{ii}\).

\(^\text{ii}\) Personal communication: Dr. Mengistu Asnake
Crosscutting Challenges: Amhara and Tigray

Informants noted several challenges encountered during the scale-up phase despite the intensive pre-planning process overseen by the respective RHB, zonal and woreda health offices. These are related to the elements necessary for scaling up based on the current literature.11-13

Scale-Up Challenges

- Low commitment, poor attention, and financial constraints that stem from no budget line item specifically dedicated to family planning or, more specifically, YFS;
- Lack of budgetary allocations result in a lack of resources for constructing a separate YFS unit, commodity security, skills training, and offering per diems for trainings and review meetings;
- Competing high-profile interests at the RHB, woreda and/or health center levels;
- Inadequate emphasis on YFS during routine supportive supervision visits;
- Myths and misconceptions about LARC service provision for young persons.

Health Systems Challenges

Systemic challenges—beyond the scope of the 16-month scaling-up planning and implementation phase—included the creation of a separate spaces/rooms for YFS, quality of care, health workforce, health information systems, and access to FP commodities.

- Infrastructural factors including lack of availability of electricity, adequate water supply, and additional rooms;
- Availability of a separate space, the YFS unit, ensuring privacy and confidentiality;
- Availability and quality of YFS coverage with LARC-trained YFS providers 24/7;
- Staff turnover impacting YFS coverage with LARC-trained YFS providers 24/7;
- Staff preferences, commitment, and motivation influencing YFS coverage with LARC-trained YFS providers 24/7;
- Heavy workload influencing YFS coverage with LARC-trained YFS providers 24/7;
- Persistent data quality challenges (under- and/or over-reporting, accurate recording), lack of competency in record keeping, quality of reporting formats, and insufficient data disaggregation (by age group for contraceptive uptake).
Crosscutting Conclusions: Amhara and Tigray

The Ethiopian government recognized that the pilot service-delivery model that enabled YFS providers to offer LARCs services to youth at YFS units successfully increased access to and uptake of LARCs among youth. Evidence of success drove the government’s decision to scale-up the model. However, systemic challenges related to quality of care, health workforce, health information systems, and access to FP commodities hindered full scale-up of the tested model at targeted health centers in Amhara and Tigray. Addressing these health systems concerns were beyond the scope of the 16-month scaling-up planning and implementation phase.

This report analyzes and collates the results of KIIs using these six elements necessary for planning for scale-up and implementing the scale-up plan. The interplay among these factors formed the scale-up process; and contributed to achievements and challenges related to the process. These six elements are drawn from three well known systematic scale-up frameworks—ExpandNet’s Nine steps for developing a scaling-up strategy11; CAS/Paina and Peters Framework12; and the AIDED/Perez-Escamilla Framework.13 However, the Ethiopian government did not adhere to any one of these systematic scale-up approaches. Rather, the Ethiopian government’s scaling-up process was organic, driven by operational guidelines and procedures cascading from the highest level (FMOH and RHB) through to the service-delivery level (health center). Key highlights of these six elements disaggregated by public sector primary health care system (regional health bureau, zone, woreda, health center) and implementing partners (center and regional) are shown in Appendix 3.

Stakeholder Engagement: There was no formal resource team established to oversee Phase One (Testing a Strengthened YFS Delivery Model: April 2014 – August 2015) and Phase Two (Scaling up Strengthened Youth Friendly Service Delivery Model: September 2015 – December 2016). Rather, the Ethiopian national health system and healthcare financing reform guidelines and implementation protocols drove the scale-up process.5-6

The FMOH and the RHB focus on policy, strategy, and technical support. The lower administrative levels, zones, and woredas focus on overseeing management and implementation of policy and strategy at health centers.5 Irrespective of region (Amhara and Tigray), administrative (RHB, zone, and woreda) and service delivery (health center) levels, and implementing partners (IFHP+ and REST), the principal stakeholder, government, was directly involved in approving the scale-up plan.

IFHP+ sought formal approval by presenting the results of the pilot and scale-up plan to the RHB’s technical working group. Thereafter, the RHB’s deputy head signed the approval letter that also designated the zones, woredas, and health centers selected for scaling up. IFHP+, after receiving formal approval, visited the respective zones, woredas and health centers to formally discuss implementation of the scale-up plan. The ultimate decision to accept or decline the scale-up plan rested with the woreda health office. Key facilitating factors that supported formal approval included the government’s high priority for addressing the FP/RH needs of youth, evidence from the pilot test, and mutual understanding between IFHP+ and the public health system, a trusted relationship built over a decade.
**Roles and Responsibilities**: No explicit roles and responsibilities were defined for overseeing the management and/or implementation of the scale-up plan. However, the roles and responsibilities of the public health departments and IFHP+ were understood, as elaborated in guidelines and implementation protocols and after years of these partners working together. Any friction during implementation was mutually resolved through dialogue.

**Supportive Policy Environment**: Informants acknowledged a policy environment that supports full access of young people to full contraceptive choice irrespective of age, parity or marital status. However, translation of this policy environment into services for youth, including the scale-up of LARCs training for YFS providers, continues to be challenged by low financial commitment, budgetary concerns, infrastructural weaknesses, shortages of trained staff, provider bias, commodity insecurity, competing administrative and service delivery activities, and irregular supportive supervision. Attempts were made by the public sector and implementing partner to address these challenges through mutual dialogue and understanding, especially during quarterly review meetings. Recognition of these challenges and attempts to resolve them at the administrative and service delivery levels are noteworthy.

**Mobilizing Financial Resources**: Health services in Ethiopia are primarily financed from four sources: the federal and regional governments, grants and loans from bilateral and multilateral donors, NGOs, and private contributions/out-of-pocket payments for services rendered. Despite significant improvement over the years, healthcare financing continues to be a major challenge in Ethiopia. Consequently, it is not surprising that budgetary constraints were a major stumbling block to scaling up the tested service-delivery model. There is no specific budget line item for YFS, and budgetary allocations are split unevenly 70:30/curative: preventive, without delineation for specific preventive services. All MNCH and FP services fall under the preventive services and are provided free of cost. Informants at the zone, woreda, and service-delivery levels cited income-generation activities led by health centers and administered through health administrative boards as a practicable mechanism (YFS units were constructed with health center generated funds) conforming with the healthcare financing reform. However, allocation of the generated funds was subject to decisions made by the health center administrative boards, and needed to comply with defined RHB financial protocols. Woreda, zonal, and RHB departments were encouraged to submit proposals for additional public-sector funds. While instances were reported of successful funding, these were not the norm.

National policy in Ethiopia indicates a commitment to comprehensively addressing young people FP/RH needs. However, programs addressing young people’s FP/RH needs are not adequately funded, and they often compete with funding for curative and emergency services. However, RHBs’ renewed commitment to enabling young people to access full contraceptive choice is an emerging ray of hope.

With regards to macro level financial commitments, it is encouraging to note that Ethiopia remains firmly committed to the 2001 Abuja Declaration, specifically for family planning services. A measure of Ethiopia’s success in leveraging external funding is securing financing from the GFF to contribute to financial gaps reduction for Reproductive, Maternal and Child Nutrition, and Child and Youth Health. In addition, Ethiopia’s FP2020 Commitment 3 pledges to incrementally increase and allocate earmarked budget for FP from the SDG pool fund. Commitment 1 pledges strengthening YFS and referral linkages, including improving collection, analysis, and utilization of age- and sex-disaggregated data on adolescents
and youth – illustrating Ethiopia’s coordinated efforts to improve the health status of its youthful population.

**Quality of Voluntary FP Services (Counseling and Service Provision):** Key informants mentioned four interlinked factors—providers (training, commitment and staff turnover), separate space, sustainable commodities supply, and supportive supervision with timely feedback—as the major contributors to quality LARCs/FP services. There was consensus on these factors among the diverse stakeholders, highlighting heightened awareness of quality of care issues that influence program scale-up and sustainability. One of the cornerstones for achieving sustainable programs at scale is an enabling environment within the context of service delivery and health systems strengthening. As a consequence, these broader health systems strengthening concerns must be addressed to improve the quality of FP/RH services generally and YFS in particular.

**Data Availability and Use:** Key informants from both regions mentioned that data were compiled and used for performance monitoring by the implementing partner and the public health sector. There were minor differences in the frequency (monthly or quarterly) of data submission from FP registers to the next higher administrative level. Performance monitoring issues included lack of data on contraceptive use by method type, forecasting commodity shortfalls, and low performance on a range of performance monitoring indicators. Challenges encountered included poor data quality (over- or under-reporting), and unavailability of age- and method-specific disaggregated data that hampered appropriate interpretation of YFS contraceptive utilization patterns. While the HMIS FP register has an age column, the compiled monthly and/or quarterly format does not. This concern has been raised with FMOH planning division on several occasions, and more recently, has been included in the roll-out of DHIS2.

There were minimal differences in perceptions regarding processes of scale-up planning and implementation and resulting achievements and challenges across zones, woredas, and health centers in Amhara and Tigray (see Appendix 3 for further details). Informants’ perceptions, by and large, indicated an increase in LARCs uptake across the eight health centers, although these perceptions were largely uncorroborated by data from FP registers. At only two health centers (one each in Amhara and Tigray) a statistically significant increase in LARCs uptake was documented.

Sustainability of the strengthened YFS service delivery model in the strengthened YFS units was considered the explicitly desired outcome of the stakeholder engagement process that created and nurtured government ownership and was particularly evident during IFHP+ close-out. Public-sector stakeholders expressed commitment to the tested service-delivery model, but limited financial resources hampered scale-up. Without an obligated budget line item for YFS included in regional, woreda and health center budgets, there will continue to be challenges to sustaining and scaling up the model across the two regions. Additionally, health systems strengthening related to human resources, quality of care, and data availability and use need to be addressed. Strengthening service delivery and national health systems to ensure availability of YFS-trained personnel and commodities at YFS units is paramount to improving RH outcomes, reducing unintended pregnancy and improving maternal health, and achieving Sustainable Development Goal 3.
Recommendations

The recommendations are based on analysis of KIIs and LARCs uptake described in this report. Like the results, the recommendations are grouped into the six scaling-up elements used for analysis of the KIIs. The ultimate goal of these recommendations is to provide guidance to policymakers, YFS program managers, stakeholders, and development partners for improving the effectiveness of national YFS programs.

**Stakeholder Engagement**
Stakeholder engagement, through the established RHB, and their MNCH and FP technical working groups, should be strengthened as a platform for technical deliberations. These deliberations should be continuous, and occur before, during, and after testing and scale-up of health programs to ensure common understanding and adequate resource allocations.

**Roles and Responsibilities**
Ensure mutual understanding of roles and responsibilities and conflict-resolution processes to facilitate scale-up planning and implementation.

**Supportive Policy Environment**
Service-delivery protocols for strengthened YFS should be disseminated to all service providers and senior technical staff at health centers and higher administrative levels. Senior managers then must ensure that providers and senior technical staff have access to and are using the guidelines and protocols. The National Adolescent and Youth Health Strategy (2016-2020),\(^{15}\) broadens the scope of the policy’s previous iteration, ensuring application of emerging evidence-based practices. However, periodically FMOH should consider updating the strategy to ensure the application of newly emerging evidence-based practices and/or new technology.

**Mobilizing Financial Resources**
The FMOH and RHB should ensure that funding allocations are appropriately adjusted to addressing young persons’ FP/RH needs. With its FP2020 commitments and GFF funding, the FMOH and RHBs should ensure that the budgetary allocations are incrementally revised to reach a target of a 60:40/curative:preventive split; thereby increasing budgetary allocation for FP and for youth-friendly FP/RH services. They should also ensure health centers’ administrative boards are strengthened to implement the updated health financing reform law that allows health centers to generate and use their own funds. The FMOH and RHB, in accordance with the National Adolescent and Youth Health Strategy (2016-2020),\(^{15}\) should ensure that investments in youth include resource allocation for youth-friendly FP/RH services. YFS units and YFS-trained providers need to offer an expanded method choice, including LARCs, to young people in a private, confidential, and respectful environment. To effectively harness the demographic dividend of Ethiopia’s youth bulge and achieve Sustainable Development Goal Three over the next 20 to 30 years, socio-economic investments in education, employment and health must also be made that support youth development.
Quality of Voluntary FP Services (Counseling and Service Provision)
Concerted efforts must be made to ensure that the four inter-linked factors—competent and available providers, separate space, commodity security and supportive supervision with timely feedback—that directly impact the quality of FP counseling and service provision generally, and specifically youth-friendly FP/RH services are addressed. The RHBs, zones, woredas, and health centers must be tasked with resolving lingering quality of care issues through strengthened supportive supervision, training, addressing human resources and commodity security.

Data Availability and Use
Continued and sustained advocacy and dialogue with FMOH, development partners, and stakeholders will be important to revising the HMIS reporting format to include age-disaggregated data on FP uptake and accelerating the implementation of the revised format.
References


## Appendices

### Appendix I: Amhara and Tigray Sample

<table>
<thead>
<tr>
<th>#</th>
<th>Region</th>
<th>Zone</th>
<th>Woreda</th>
<th>IFHP+ Supported</th>
<th>REST Supported</th>
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<tr>
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<td>Bubugen</td>
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<td>Raya kobo</td>
<td>Tekulesh</td>
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<td>South Gondar</td>
<td>Andabet</td>
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<td>4</td>
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<td>Ziquala</td>
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**Cluster 1**

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<td>2</td>
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<td>Southern</td>
<td>Raya Azebo</td>
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**Cluster 2**

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<td>Gelebeda</td>
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<tr>
<td>2</td>
<td>Tigray</td>
<td>Raya Azebo</td>
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<td>Chercher</td>
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</table>
Appendix 2: Research Field Teams

Amhara Field Team

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### Appendix 3: Summary Table of Six Scaling-Up Elements disaggregated by public sector primary health care system (regional health bureau, zone, woreda, health center) and implementing partners (central and regional)

<table>
<thead>
<tr>
<th>Levels/Elements</th>
<th>Stakeholder Engagement</th>
<th>Roles &amp; Responsibilities</th>
<th>Supportive Policy Environment</th>
<th>Mobilizing Financial Resources</th>
<th>Quality of FP – Counseling &amp; Services</th>
<th>Data Availability &amp; Use</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Regional Health Bureau</strong></td>
<td>Technical Working Group comprising head, deputy head &amp; senior MNCH technical staff as well as development partners1; Review &amp; approve the geographic expansion plans. No pre-designated “resource team”; the technical working group is the de facto resource team.</td>
<td>Well defined government &amp; implementing partners roles &amp; responsibilities. These include overseeing implementation of the approved expansion plan; reviewing LARC standard operating guidelines, communicating to the lower administrative and service delivery units, and creating a ‘road map’ to avoid redundancy among development partners.</td>
<td>AYRH strategy and national FP guidelines supportive of young persons’ access to the full range of contraception; implementation is RHB responsibility.</td>
<td>Federal and regional financial investments are largely made by government with smaller investments by implementing partners. Financial allocations are made at RHB; financial integration in the context of distribution of financial contributions between the public sector and implementing partners are mutually agreed upon at RHB in the Technical Working Group. Federal and regional levels committed to AY friendly services; multi-sectoral approach, trainings are jointly offered by FMOH and partners.</td>
<td>Addressed by separate space, training, supportive supervision and commodity security; concerted efforts made to address though challenges continue.</td>
<td>Utilize HMIS data for decision making quarterly; performance reviews, feedback.</td>
</tr>
<tr>
<td><strong>Zone2</strong></td>
<td>The RHB approval letter aligned with government policy and high priority, sufficed. No specific individual or administrative body advocated for geographic expansion.</td>
<td>Implementing the scale-up plans; formally communicating to the selected woredas in collaboration with implementing partner; implementing partner role was training &amp; supportive supervision.</td>
<td>Supportive policy and operational guidelines for young persons’ access and rights to full access, full choice.</td>
<td>No jurisdiction on budgetary allocation; pre-determined by RHB and woreda. No jurisdiction on budgetary allocation; purely administrative role.</td>
<td>Addressed by training, selecting motivated trainees, commitment to work at YFS for minimum of one year, creating separate YFS units, supportive supervision and timely feedback.</td>
<td>Utilize HMIS data for decision making quarterly; performance reviews identify low and high health center FP &amp; LARCs performers, feedback given.</td>
</tr>
<tr>
<td><strong>Woreda</strong></td>
<td>The RHB approval letter was necessary but not sufficient; final decision was the woreda management. Health centers identified by woreda management, service providers selected by health center directors.</td>
<td>No formal written roles &amp; responsibilities; consensus reached based on mutual agreement enabled government ‘ownership’; Roles: woreda – health centers and trainee selection, deployment, and rooms/YFS units; Implementing partner - trainings, supportive supervision and FP supplies</td>
<td>Supportive policy &amp; guidelines to full access, full choice.</td>
<td>Health budgetary allocation ratio is 70:30 [curative: preventive]. Public sector responsible for trainings including LARCs. Renewed FMOH &amp; RHB AYRH commitment; performance monitoring indicator – LARCs uptake among VRA; available infrastructure and resources adjusted to accommodate LARCs services.</td>
<td>Addressed through improvement in privacy &amp; confidentiality, balanced counseling, LARCs skills, commodity security, supportive supervision, providing services outside normal clinic hours and weekends, PE demand creation.</td>
<td>Utilize HMIS data for decision making monthly; performance reviews identify low and high health center FP &amp; LARCs performers, Feedback &amp; improvement action plans jointly; HMIS quality control assessments quarterly by HMIS committee.</td>
</tr>
<tr>
<td>Levels/ Elements</td>
<td>Stakeholder Engagement</td>
<td>Roles &amp; Responsibilities</td>
<td>Supportive Policy Environment</td>
<td>Mobilizing Financial Resources</td>
<td>Quality of FP – Counseling &amp; Services</td>
<td>Data Availability &amp; Use</td>
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<tr>
<td>Health Center</td>
<td>Health center administration including administration board directly responsible for service delivery; contingent on approvals from woreda/zone and RHB administrative levels.</td>
<td>Roles: health center staff well defined; implementing partner – different partners specific roles inadequately defined; common AYRH goal enabled common understanding.</td>
<td>Supportive policy, guidelines and training manuals for full access, full choice provision.</td>
<td>Preventive services budgetary allocation by woreda, health financing law supports budget augmentation through health center generated funds. Supportive of AYRH and YFS services; health center generated income invested in YFS services.</td>
<td>Addressed by privacy &amp; confidentiality, dispelling misperceptions, balanced counseling, FP services including LARCs at YFS units.</td>
<td>Method specific age disaggregated data compiled monthly, performance reviews monthly, forecast stock-outs.</td>
</tr>
<tr>
<td>Central Office</td>
<td>FMOH higher level policy making; RHB and lower levels national policy implementers.</td>
<td>Not clearly stated, mutual understanding due to previous experience – joint planning.</td>
<td>Supportive policy in line with WHO's medical eligibility criteria.</td>
<td>FMOH is the principal financial contributor; IFHP+ contribution is restricted to technical assistance - training costs and securing commodities to offset stock-outs. Inadequate AYRH funding to meet RH/FP needs; capitalize on demographic dividend benefits; utilize income generated by health facilities post health care financing policy.</td>
<td>Provision of good quality counseling and training by ensuring sufficient numbers of trained staff and alleviating commodity stock-outs.</td>
<td>Data compiled from HMIS &amp; other national sources, submitted to IFHP+ regional &amp; center offices – used for planning purposes.</td>
</tr>
<tr>
<td>Regional Office</td>
<td>Stakeholders: public sector and implementing partner management and technical staff, UNICEF, UNFPA, REST and FGAE; RHB lead stakeholder; scale-up approval based on Phase One evidence generated; joint planning cascading to lower administrative and service delivery.</td>
<td>Public Sector - main driver reflecting government ownership; implementing partner – technical assistance; No formal description of roles and responsibilities, based on mutual understanding.</td>
<td>Supportive AYRH policy acknowledged.</td>
<td>Implementing partner contribution – training costs, furnishings for YF units and commodity stock-outs. No specific AYRH investments obligated; woreda &amp; health facility community involvement improved post promulgation of the Health Financing Reform for income generation and decision making.</td>
<td>Competency-based LARCs training, supportive supervision, ‘YF units’ certification for ensuring privacy and confidentiality,</td>
<td>Data compiled from HMIS submitted to woreda and IFHP+ regional &amp; center offices – used performance monitoring and procurement forecasting.</td>
</tr>
</tbody>
</table>

2. Zone: Amhara only
3. Center Office: IFHP+ only; the principal stakeholder
4. REST: National stakeholder; Mekelle headquarter