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EXPANDING OPTIONS IN REPRODUCTIVE HEALTH

Research on the Introduction and Transfer of Technologies for Fertility Regulation

AN ASSESSMENT OF REPRODUCTIVE HEALTH NEEDS IN ETHIOPIA

Federal Democratic Republic of Ethiopia Ministry of Health

WORLD HEALTH ORGANIZATION
GENEVA

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AN ASSESSMENT OF REPRODUCTIVE HEALTH NEEDS IN ETHIOPIA

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LIST OF ABBREVIATIONS

AIDS	Acquired immuno-deficiency syndrome
CBD	Community-based distribution
CHA	Community health agent
CYP	Couple years of protection
EPI	Expanded Programme on Immunization
FGAE	Family Guidance Association of Ethiopia
FGM	Female genital mutilation
FHD	Family Health Department
FP	Family planning
GTZ	German Technical Cooperation
HIV	Human immuno-deficiency virus
HRP	UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction
ICPD	International Conference on Population and Development, Cairo, 1994
IEC	Information, education and communication
IUD	Intra-uterine device
MCH	Maternal and child health
MOLSA	Ministry of Labour and Social Affairs
MOH	Ministry of Health
MVA	Manual vacuum aspiration
NFFS	National Family Fertility Survey
NGO	Non-governmental organization
NOP	National Office of Population
SNNPR	Southern Nations, Nationalities and Peoples Region
STD	Sexually transmitted disease
TBA	Traditional birth attendant
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VDRL	Venereal Diseases Research Laboratory
WHO	World Health Organization

SUMMARY

In the years since the 1994 International Conference on Population and Development, countries worldwide have begun to grapple with the implications of applying a broader reproductive health perspective to the design of health sector programmes and policies. In Ethiopia, this challenge became especially critical with the formulation in 1996 of its national Health Sector Development Programme – a 20-year effort to achieve universal access to essential primary health care services. Designed to serve as a framework for technical and financial support to the health sector, the programme is ambitious, with provisions for extending access to primary health care services, enhancing the quality of care, and for improving health sector management.

In 1997, the Family Health Department of the Ministry of Health requested assistance from WHO to operationalize the Health Sector Development Programme in three critical theme areas. The first was to identify areas where the quality of reproductive health care services could be improved. The second was to determine which contraceptive methods could be introduced to appropriately expand choice. And the third was to understand and identify the key issues affecting the integration and management of reproductive health interventions. To achieve these goals, the Ministry chose to apply the WHO Strategy for Contraceptive Introduction, a three-stage programme designed to assist governments enhance contraceptive choice by adopting an analytical framework that addresses user's needs, existing technologies and the service delivery system.

This report documents the findings of a national assessment of reproductive health needs – the first of the three stages of the WHO Strategy. Designed as a strategic planning exercise, the assessment defines policy and research options in the reproductive health field through the involvement of a broad range of stakeholders and participants. The implementation and scaling-up of these options then comprise Stages II and III of the Strategy, respectively.

The present report contains ten chapters. The first describes the methodology used to undertake the assessment, followed by a review of key national reproductive health indicators, including population and fertility, utilization of antenatal, safe delivery and postnatal care services, abortion, STDs including HIV/AIDS, and the availability of health care services. The report then turns to a discussion of the assessment's priority issues. These include the prioritization of the reproductive health concept; gender and the social context of reproductive health; addressing the needs of young people; managing the delivery of reproductive health care services; improving quality of care; and enhancing access to heath care services. The report concludes by examining the implications of these key issues on the question of expanding contraceptive choice and then finally, on the operationalization of a national reproductive health agenda.

Based on field visits to all of Ethiopia's eleven regions, it is clear that public understanding and commitment to the reproductive health concept, even among providers, health administrators and other local decision makers, remains quite mixed. The reasons for this uneven commitment are many. The lack of reliable health information, for example, often makes it impossible to determine the scale or

severity of reproductive health problems. They also limit the ability to determine what progress is being made to confront those risks.

With the recent decentralization of public sector health care services in Ethiopia, operationalization of a reproductive health plan of action will require advocates at the regional level. It will also require leaders and decision makers with the skills and commitment to lobby Regional Councils for funds, put the necessary reproductive health programmes into place, and ensure that they are implemented.

Appreciation of the reproductive health concept also calls for recognition that individual needs arise not only as a consequence of biological circumstances, but of events that may be more culturally, socially, or ethnically defined. A key objective of the assessment was to review the implications of Ethiopia's wide regional and cultural diversity on the reproductive health of its people; and specifically to understand the cultural, religious and even socio-economic processes that differentiate men's and women's roles within society. As the report points out, many of these processes severely affect the health of women and children. Some do so indirectly by differentiating access to information, education and wealth; while others exert a much more direct impact by involving bodily mutilation or by restricting the scope of reproductive decision making.

The chapter on Gender and the Social Context of Reproductive Health focuses on five institutions, commonly described in the literature as "traditional harmful practices". These include female genital mutilation - a practice which is believed to affect at least 73 per cent of the population, abduction, early marriage, the desire for more children, and widow inheritance. Through the report cautions against overly simplistic critiques of potentially complex sociocultural institutions, it does recognize that many institutions do indeed pose severe health risks. Solving these problems will require broad community involvement and co-ordination among community-based institutions, including both key decision making bodies, such as Regional Councils, and institutions at a more grassroots level such as community associations, school clubs, youth centres, and local committees.

The reproductive health needs of young people are examined by looking at the broad societal changes facing this sector of the population; at the health consequences of such changes and at the strategies and service delivery programs currently in place to address them. Of all the environmental factors affecting youth, unemployment has undoubtedly been the most far-reaching, giving way to internal migration, lack of parental support or oversight; and forced idleness. All of these place young people at considerable risk of unwanted pregnancy, unsafe abortion and STDs including HIV/AIDS. Furthermore, their lack of financial resources means that even when young people feel the need to seek health care or address other reproductive health needs, they find themselves unable to afford the costs.

The assessment team made a special effort during its visits to identify and meet with organizations that seek to address the social, economic and health needs of adolescents and young adults. The assessment found that while there is indeed some exemplary work being done in this field, by and large the services available to young people are scarce and inadequate. Addressing the reproductive health needs of youth will require advocates at the regional level.

One of the most serious weaknesses currently facing the public sector health care system is the shortage of human resources attributable to high staff turnover, the

exodus of skilled providers from the public to private sectors, and limited numbers of field-based staff with appropriate technical or sociocultural backgrounds. Furthermore stock-outs of basic supplies and equipment, including essential medicines, basic maternity equipment and basic consumable supplies such as syringes, needles and gloves, are widespread.

A second major service delivery issue addressed by the assessment was the need to bridge the gap between existing services and the 80 per cent of Ethiopia's population who live in rural areas. Within the public sector, narrowing the gap has entailed a number of strategies. One has been the recent construction of new health care facilities, particularly "health stations" which represent the lowest rung of the new health care system. Another strategy has been the establishment of extensive outreach services involving traditional birth attendants, healers and other agents from the communities themselves. Finally, a third strategy has been to build on and complement the interventions of other agencies operating in the same rural communities. In many parts of the country, for example, community-based distribution programmes are becoming entry points for broader reproductive health services; employment-based health care programmes are gradually emerging; health training institutes are delivering health care services to rural communities; private health care providers and pharmacists are serving larger numbers of those with the means to pay; and lastly, there are dramatic increases in the level of collaboration between public sector and non-governmental health care agencies. The assessment team felt that these new linkages, outreach programmes and innovative service delivery mechanisms could help to reduce the gap between existing service delivery facilities and the populations whose access to them is so limited.

The third major service delivery issue to be addressed by the assessment was the quality of available services. To address this issue, the assessment identified four broad programmatic areas that it felt were severely underrepresented in the current range of reproductive health services. These included post-abortion care, STD detection and treatment, antenatal and postnatal care, and emergency obstetric care. On the issue of technical competence, the assessment pointed out that provider knowledge and skills frequently remain inadequate to address the range of reproductive health needs demanded of them. Three factors that could account for this were explored in greater depth: inconsistent training, inadequate monitoring and supervision, and a lack of appropriate technical guidelines or manuals.

Of the key strategic issues encompassed by this assessment, the last to be addressed was how best to expand contraceptive choice through the improved provision of existing methods, the introduction of new methods, and/or the discontinuation of inappropriate of unsafe methods. The assessment found that the range of modern methods theoretically available to clients in Ethiopia was actually quite broad. Over six brands of oral contraceptives are available, in addition to injectable contraceptives, condoms, the IUD, sterilization, foaming tablets, and even Norplant in selected urban areas. And yet despite this apparent broad method availability, Ethiopia evidences neither a high contraceptive prevalence nor a broad method mix. Indeed, over 90 per cent of current family planning clients use either oral or injectable contraceptives.

Using the WHO strategic framework, the assessment concluded that of the methods currently available through the public sector, several appear to have the potential for increased utilization: injectables, condoms, surgical sterilization and,

possibly, Norplant and the IUD. To date, the availability of all these methods suffers from lack of service delivery points, supply shortages, cost concerns, inadequately trained service personnel, as well as from lack of information and from a host of client fears and concerns.

With respect to the introduction of new contraceptive technologies, the assessment identified emergency contraception as playing a potentially critical role in limiting unwanted pregnancies and reducing the need for unsafe abortion. Despite its potential for addressing the reproductive needs of so many women, emergency contraception still remains largely unknown to most providers.

Given the magnitude and range of Ethiopia's reproductive health needs, it is clear that any resolution of those needs will require the involvement and active participation of many players. The health sector will obviously have a pivotal role in this process but as discussed in the chapters on gender and youth, the reproductive health environment is as much influenced by events and decisions within the educational, religious and legal sectors, as it is by the provision of health care services per se. Implementing the research agenda and action steps proposed in this report will therefore require a multisectoral approach - one that draws on the support and involvement of society as a whole.

The final chapter of this report, therefore, concludes with a series of action steps to be taken by the Ministry of Health in moving forward with the development of a programme for action in reproductive health. It recommends, for example, the development of a national reproductive health strategy and the identification of gaps in the national policies on health, population, women and drugs which would be necessary to implement such a strategy. It also calls for greater dissemination of the findings of the present needs assessment and for a wider discussion of the concept of reproductive health at the regional level. And finally, it recommends the involvement of multilateral and bilateral donors in funding the activities, recommendations and research agenda contained in the report.

INTRODUCTION

This report presents the findings of an assessment of reproductive health needs of Ethiopia with special reference to family planning. The assessment was undertaken using a methodology developed through WHO's strategy for contraceptive introduction. Designed to help governments broaden available contraceptive options, the WHO strategy is a three-stage programme to assist in country-level decision making by focusing on user's needs, existing technologies and the service delivery system. Through its application in nine countries to date, the strategy has proven itself to be a flexible and practical tool for defining policy and research needs in the reproductive health field as a whole.

Implementation of the assessment phase of the strategy is based on the principle that any introductory effort should be preceded by a thorough understanding of the reproductive health environment - examining technologies in relation to user's needs and the capability of the service-delivery system to provide quality services. These assessments are strategic planning exercises designed to define policy and research needs in the reproductive health field. They are designed to identify actions that can resolve problems in the current health environment through either policy change and/or research. Hence, the value of the assessment does not derive exclusively from the detail with which it portrays the local health environment but from the extent to which it is able to use existing knowledge and field observations to identify problems and their solutions.

Because of this strategic focus, a needs assessment cannot be, as might be the case in a more descriptive exercise, a technical operation undertaken by a small cadre of specialists. Instead, it is a participatory planning process that involves stakeholders from all national organizations and entities involved in the reproductive health field. These stakeholders select the priority issues for review during the assessment and review the findings, conclusions and recommendations of those involved in the field-based data collection component of the exercise.

Objectives of the Assessment

Following the International Conference on Population and Development (ICPD) held in Cairo in 1994, many countries are facing for the first time the need to assess a broader range of reproductive health issues and their implications for the design and implementation of programmes and policies in the health sector. In doing so, the need for tools, guidelines and frameworks has become especially urgent. In 1997, the Family Health Department of the Ministry of Health turned to the WHO strategy for contraceptive introduction to assist in identifying its national reproductive health priorities and for facilitating the development of a national consensus on an agenda for action.

In recent years, the Government of Ethiopia has taken a number of important steps in defining its overall health care priorities. New policy initiatives in health, population, women's health and drugs, for example, have emphasized the importance of enhancing access to a basic package of quality primary health care services. The Government, through the Ministry of Health, has

also sponsored a number of critical studies such as a Safe Motherhood Needs Assessment and, more recently, an Assessment of Contraceptive Requirements and Logistics Management Needs. It has encouraged greater contraceptive choice through the introduction of new contraceptive technologies and has supported the delivery of quality services at the field level through expanded training activities and the dissemination of support materials.

Of all efforts currently underway to define health care priorities, however, at the centre are those surrounding the development of Ethiopia's Health Sector Development Programme - a 20-year effort to achieve universal access to essential primary health care services by 2017. Designed to serve as a framework for technical and financial support to the health sector over the next two decades, the programme is ambitious, with provisions for extending access to primary health care services, enhancing the quality of such services, and for improving health sector management, to mention but a few.

Implementation of the WHO strategy represents an important step in operationalizing Ethiopia's Development Programme in that it offers a systematic approach for identifying and defining the Programme's "strategic investment components" from a reproductive health perspective. For that reason, the Ministry of Health and National Office of Population requested in 1997 that the World Health Organization and the Population Council assist them in undertaking this reproductive health needs assessment. The assessment was undertaken with the following two broad objectives in mind:

To assess the reproductive health environment from the perspective of user needs, service delivery capabilities, and the feasibility of modifying an existing service delivery system.

The assessment was planned to address the following broad issues: How can quality of care be improved at the service delivery level? What contraceptive methods can be introduced to appropriately expand choice? How can the broader concept of reproductive health be operationalized?

To identify needs for introductory and other operations research and action.

Another feature of the assessment is its orientation for defining research needs in reproductive health. The purpose is not only to recommend programmatic and/or policy changes but also to identify what research, if any, should be subsequently undertaken to explore the feasibility, acceptability and potential impact of implementing such changes.

METHODOLOGY

This chapter reviews the process by which the needs assessment was carried out. Although it documents the methodology of the assessment as a whole, it focuses on the refinements to assessments undertaken in other countries and the development of approaches adopted for the first time.

The Preparatory Phase

Implementation of the needs assessment can be divided into four phases: a preparatory phase, field observation and data collection, analysis and preparation of the assessment report, and a workshop for the dissemination of findings and decision-making about subsequent action steps or further research activities (Spicehandler and Simmons, 1994). The needs assessment is a strategic planning exercise designed to define policy and research needs in the reproductive health field. It is also a participatory process in that it seeks out and incorporates input from all stakeholders, organizations and entities involved in the reproductive health field.

The participation of a wide range of stakeholders began in May 1996 with a one-day Planning Workshop to examine a specially commissioned review of available data and research findings in reproductive health (Beyene, Kidanemariam, Tesfu and Woldeab 1997) and to identify key issues for further examination during a needs assessment. Participants came from a broad range of organizations involved in reproductive health, including health research, women's health advocacy, youth support, community development, and health care delivery.

During the seminar, working groups discussed three major sections of the review: family planning, maternal health and reproductive tract infections. By examining each issue from the perspective of user's needs, the capacity of the service delivery system and the adequacy of existing technology, each group sought to identify gaps in the existing knowledge base and recommend critical issues for further examination at the field level. At the conclusion of the seminar, five overarching issues were identified as core elements to be addressed during the field-based component of the needs assessment. The issues included strengthening integration and coordination of health care service delivery; improving technical competence of providers, generating community support for service delivery, increasing responsiveness of existing services to user/non-user needs and priorities, and expanding resources to meet demand for services.

Preparation of Assessment Instruments

Following the planning workshop, the multidisciplinary assessment team met to develop a research agenda consistent with the workshop's recommendations.[1] They identified key groups to be interviewed during the fieldwork; designed question guides for field interviews; and selected the geographic areas to be visited.

Instrument Design: The design of the interview guides followed a refinement of the methodology adopted by needs assessments in Zambia and Burkina Faso. The first step in the process was a comprehensive review by the assessment team of the five overarching issues identified during the planning workshop. This was followed by an analysis of the categories of people with whom field interviews would be necessary to address the various issues. For each category of respondent, a list was prepared of all the relevant themes. Ultimately, each list became the framework for a single question guide - one each for political leaders/decision makers, health managers, service providers, women, men, young people, and community leaders.

Though time consuming, this approach to instrument design has proven itself well-suited to the requirements of a needs assessment. By reviewing the proceedings of the national planning workshop, the team as a whole is better able to familiarize itself with the details of its general mandate, develop a common understanding of the issues to be addressed and grasp the rationale behind each question in the interview guides. Because the field assessment is a qualitative exercise, familiarity with the issues provides team members with greater confidence in departing from the agreed-upon question guide and allows freedom in following-up new leads not originally envisioned or in rephrasing questions that may be poorly understood by a particular target group.

Geographic Coverage: The selection of geographic regions for the field visits reflected the country's diversity and the political realities of its new health care system - a decentralized structure in which all regional and sub-regional health departments remain accountable to local legislative bodies rather than a central Ministry of Health. Eleven regions were visited during the assessment.

[1] Members of the needs assessment team consisted of the following individuals: Sr Abebetch Teferi (former Head of FHD, Addis Ababa Region), Mr Desta Ayudi (Ministry of Labour and Social Affairs), Dr Fatma Mrisho (UNFPA), Mr Gebremedhin Kidanemariam (Ministry of Health, IEC), Ms Genet Mengistu (National Office of Population), Sr Gete Feyissa (Addis Ababa Regional Health Bureau), Mr Mirgissa Kaba (Jimma Health Sciences Institute), Ms Neima Ahmed (Ministry of Health, DFH), Dr Taye Tokon (Family Guidance Association of Ethiopia), Dr Tekle-Ab Mekbib (Ethiopian Society of Obstetrics and Gynæcology – ESOG), Dr Tesfanesh Belay (Ministry of Health, FHD), Sr Tsigeroman Abera (Ministry of Health, Women and Development), Mr Yohannes Tadesse (Ministry of Health, FHD), and Dr Zeru Gebremariam (Black Lion Hospital).

TABLE 1

SITES VISITED DURING
ETHIOPIA NEEDS ASSESSMENT

REGIONS	SITES VISITED
Tigray	Axum Adwa Adigrat Mekele
Afar	Gewane Logia Mille
Amhara	Woldiya Dessie Dangla Combolcha Debre Tabor Woreta Bahir Dar
Oromia	Asendabo Bedele Gore Jimma Yebu
Somali	Jijiga
Benishangul	Assosa
SNNPR	Awasa Yirgalem
Gambela	Gambela Itang Abobo
Harari	Harar
Dire Dawa	Dire Dawa Melkajebdu
Addis Ababa	Addis Ababa

Field Observation and Data Collection

During the period from 18-31 May 1997, the assessment team conducted interviews, group discussions and clinic observations in both urban and rural areas of the locations listed in Table 1. Altogether, the team met with over 600 people and visited over 100 different facilities, including health centres, schools, hospitals, pharmacies and drug stores.

To make more efficient use of the relatively short field observation period, the Team divided into two subgroups of six to eight persons each. One subgroup visited the northern regions of Tigray, Afar and Amhara and the other visited the central, western, eastern and southern regions of Gambela, Oromia, Somali, Southern Nations, Nationalities and Peoples Region (SNNPR), Harari, Addis Ababa, and Dire Dawa. Because of the distances involved, the latter group found it necessary to divide itself further during the second week of fieldwork so that some of the Team members could visit Somali Region while the others visited the SNNPR. Finally, a third mission, comprising selected members of both subgroups, visited Benishangul.

During the field assessment, three approaches were used to collect information. The first approach entailed interviews with field-based service providers including clinicians, family planning users as well as non-users, policy makers and key administrators, and representatives of women's health advocacy groups. The second approach involved group discussions, particularly among representatives of women's organizations, young people, and men. The third approach involved observation of health facilities to assess, among other things, the process of service delivery, the availability of equipment and space at service delivery sites, and the adequacy of medical storage facilities.

Analysis and Preparation of the Assessment Draft Report

Given the interactive and largely qualitative nature of the research methodology, the analysis of field data in the needs assessment does not take place separately after the observation period, but rather constitutes an integral part of the data collection process itself. At the conclusion of each day of fieldwork, for example, the assessment team sub-groups met to discuss and reflect upon each day's observations. Notes were compared, survey instruments modified and, when feasible, interviews rescheduled to collect information on key issues.

Because of the volume and diversity of field data, and the relatively open format in which they were collected, deciding which observations to include in the final report can remain a daunting task. To ensure that assessment findings and recommendations could go beyond the initially established categories or priorities, the assessment team was given considerable flexibility in deciding what information to collect and from whom as well as where and when to collect it. Hence, a three-day meeting was held at the end of the observation period to give structure to the findings and to ensure that the preparation of the final assessment report followed an inductive, analytical process in which the structure, content and conclusions of the report were constructed from the bottom up.

Three activities were undertaken during the meeting. The first was a consensus building exercise to prioritize field observations based on

FIGURE 1

MAJOR SITES VISITED DURING THE NEEDS ASSESSMENT

the team's own perceptions and the recommendations of the earlier planning workshop. Each team member identified the five most salient points he or she had encountered during the field exercise; presented them to the team; and, when necessary, led a group discussion comparing his or her observations with those of others. By the end of this exercise, approximately fifty points had been presented and discussed at considerable length.

The second activity involved grouping the points into categories which would form the main headings or chapters of the final assessment report. At least ten groupings of ideas were identified. The third activity was to consolidate the ten groupings into workable chapters and then prepare broad outlines for each. Since the team had already identified the general contents of each chapter, the challenge was to structure a coherent discussion that would encompass or link the points identified. In some cases, this led to a consolidation of previously defined headings, in other cases it led to their splitting. By the end of the exercise, the six substantive chapters currently comprising this report had emerged. The preliminary findings of the assessment were then presented to a team charged with developing UNFPA's Programme Review and Development Strategy.

To ensure that preparation of the assessment report remained as open and participatory as the planning and field assessment activities, responsibility for the writing of this report was shared by all members of the assessment team, including the sub-team leaders and two technical advisors from WHO and the Population Council. Team members selected one chapter out of those identified during the three-day session. They then used the detailed outlines to structure and write their respective chapters. Once an initial draft report was completed, it was circulated amongst all team members for comments, suggestions and editing.

Dissemination Workshop

In August 1998, a national workshop was held in Nazareth to present and discuss the findings of the needs assessment. Chaired by representatives from the Family Health Department of the Ministry of Health and the National Office of Population, the workshop was attended by over 75 representatives of the service delivery, academic, non-governmental organizations (NGOs) and international communities, as well as by representatives from each of the Regions visited during the assessment.

In addition to disseminating the preliminary findings and recommendations of the needs assessment, the workshop had the following three objectives:

- to reach consensus among workshop participants as to the accuracy and validity of the assessment findings.
- to prioritize recommendations on the basis of feasibility and impact and identify which groups and sectors should be involved in their implementation; and
- to obtain additional inputs from participants for incorporation into the final needs assessment document.

The agenda included presentations by members of the assessment team of the major findings and discussion by the participants. It linked the findings with the recommendations from the planning workshop, and addressed the utilization and incorporation of the recommendations of the assessment team into the final report.

Participants were asked to respond to the assessment's major findings, recommend ways for improving service delivery at the community level, and identify any other issues in reproductive health that might be addressed in the final assessment report. Working groups were established, each reviewing and commenting on one or more sections of the draft report. The findings of the working sessions were presented and discussed during a plenary session and have been used to modify this report.

INDICATORS OF REPRODUCTIVE HEALTH

Ethiopia is situated in northeastern Africa and covers a land area of approximately 1,112,000 square kilometers. It is the seventh largest country in Africa and is bounded by Eritrea to the north, Sudan to the west, Kenya to the south and by Somalia and the Republic of Djibouti to the east. Administratively, the country is divided into 11 regional states, 62 zones, 523 woredas, and 8 special woredas (Ethiopia, 1997c). Its two main religions are Christianity and Islam, with each representing 61% and 33% of the population respectively. Traditional religious groups account for 5.8% of the total population while other religious affiliations account for less than 1% (Ethiopia, 1984).

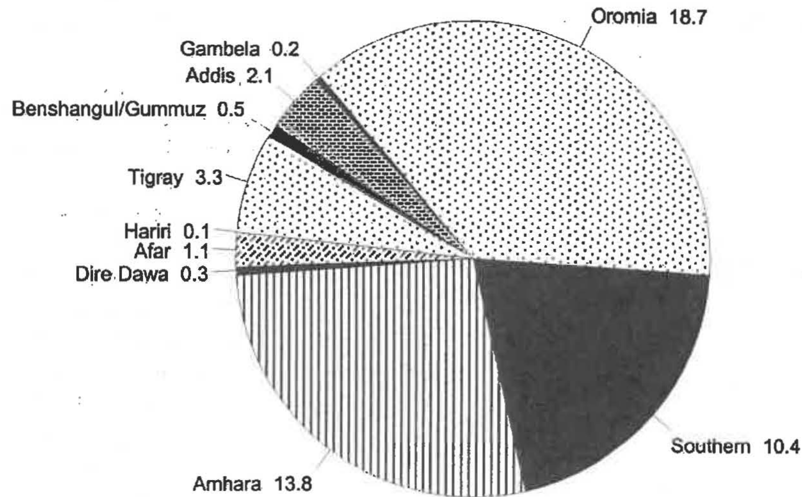
With a per capita income of US$120 in 1995, Ethiopia ranks as one of the poorest countries in the world. Agriculture is the mainstay of the economy, accounting for 50% of GDP in 1992/93, 90% of exports, and 85% of employment. The dependence of agricultural production on rainfall, which suffers from cyclical fluctuations, undermines the stability of the economy. Moreover, the concentration of the country's agricultural population in high-rainfall highland areas has caused serious soil erosion, deforestation, and environmental degradation.

Two decades of recurring drought, internal strife, and constant imbalances between production and consumption have given rise to high infant mortality and low life expectancy. Infant mortality is estimated to be between 105 and 128 per 1,000 live births, and maternal mortality is between 500 and 700 per 100,000 live births (Ethiopia, 1996b). The overall death rate is estimated to be between 15 and 18 per 1,000 population, with a life expectancy at birth of 47 years for males and 50 years for females. Only an estimated 27% of the population has access to safe water, and 10% to latrines. The literacy rate for population aged 10 years and over is 40% for males and 26% for females (Ethiopia, 1997c).

Population

Ethiopia is the third most populous country in Africa after Nigeria and Egypt. The United Nations' 1994 Revision estimated Ethiopia's total population to be about 55 million with an annual growth rate of around 3% (Ethiopia, 1995b). Approximately 85% of the population lives in rural areas (UNDP 1997), while about 4% live in Addis Ababa (Ethiopia, 1995b). As shown in Figure 2, 78% of the country's population is located in the Amhara, Oromia and SNNP regions. Together, Tigray, Afar, and Addis Ababa constitute about 13% of the population, while the remaining regions of Benshangul, Gambela, Hariri, and Dire Dawa make up just over 2% of the total (Ethiopia, 1995b).

FIGURE 2
Population Distribution in Ethiopia,
(Somali Region Excluded)
(in millions)



Source: 1994 Population and Housing Census

Population growth in Ethiopia has increased steadily since the turn of the century. As shown in Figure 3, the growth rate, estimated at less than 0.5% in 1900, increased to 2.0% in the 1950s, to 2.5% during the late 1970s, and to 2.9% in 1984 (Ethiopia, 1984). Currently the population is estimated to be growing at about 3%, one of the highest rates in the world. This steady increase - particularly since the 1980s - has been largely due to the country's youthful population. In 1984 for example, 46% of Ethiopia's population was 15 years and younger. Women of reproductive age (15-49) constitute 44% of the total female population. At the current rate of population growth, the country's population is expected to double in 23 years.

Another factor contributing to the increase in population growth is the fact that although the current health situation is poor, there nevertheless has been a significant decrease in both crude and infant mortality rates as well as a significant increase in life expectancy.

Fertility and Family Planning

The last nationwide population-based survey on contraceptive use was the 1990 National Family and Fertility Survey (Ethiopia, 1993). It suggested a total fertility rate of 7.7 for the whole country: 4.6 for Addis Ababa, 5.8 for all urban areas, and 8.0 for rural areas. The survey also estimated an overall contraceptive prevalence rate of 4.8% among currently married and non-pregnant women aged 15-49. Since then, however, numerous estimates of contraceptive prevalence have been prepared, using indirect measures of family planning use such as extrapolating from contraceptive distribution figures or by comparing service delivery statistics with catchment area estimates. Regardless

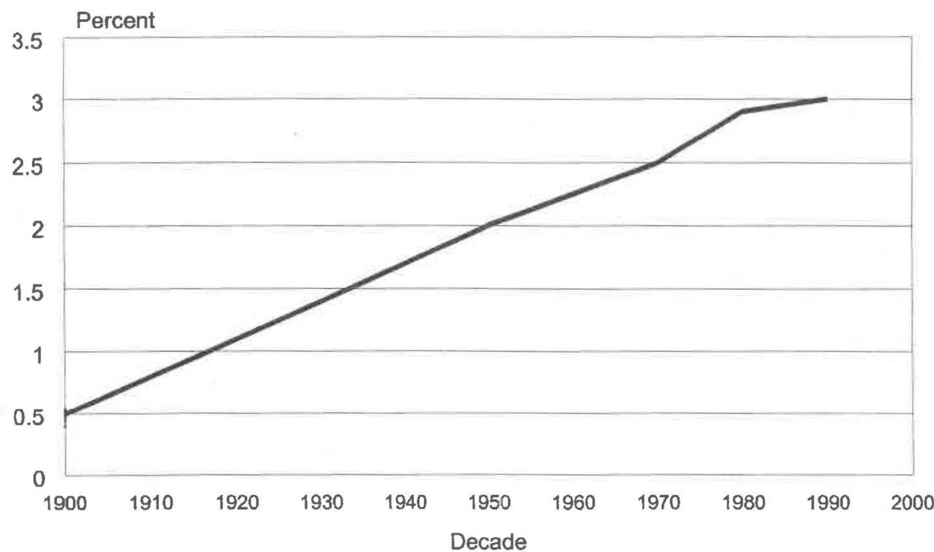
of the approach used, however, overall contraceptive prevalence in Ethiopia is low. Even the most optimistic estimates place it at no more that 11% (Ethiopia, 1997a). There are also considerable discrepancies in prevalence across regions and population groups. In rural areas for example, prevalence is estimated to be as low as 3% while in Addis Ababa it may be as high as 33%.

Antenatal Care, Safe Delivery and Postnatal Care

According to recent government figures, an estimated 30% of pregnant women receive antenatal care, about 10% deliver at health care facilities and only about 3.5% receive postnatal care (Ethiopia, 1997c). The proportion receiving antenatal care, for example, is very low when compared with neighbouring countries like Kenya (90%), Sudan (40%), and Djibouti (75%).

In 1996, a Safe Motherhood Needs Assessment was undertaken by the Ministry of Health with the objective of assessing the availability, use, and quality of antenatal, delivery, family planning and postnatal services (Ethiopia, 1996a). The assessment found that almost 50% of antenatal clients wait until the third trimester before receiving antenatal services and that less than 10% receive antenatal care services during the first trimester. Institutional deliveries at public and private hospitals, health centres and clinics are estimated at 10% for the whole country (Ethiopia, 1997c). This implies that out of 2.9 million deliveries per year, about 2.6 million occur at home with the assistance of family members, traditional birth attendants, or without any assistance at all (Beyene et al, 1997).

FIGURE 3
Population Growth in Ethiopia
1900-1990



Source: Ethiopia, 1984; Ethiopia, 1993

Among women who deliver in health facilities, about half are attended by a nurse or midwife while the rest are attended by physicians and health assistants.

The 1990 National Family Fertility Survey (NFFS) showed that most pregnant women, particularly in rural areas, depend on the assistance of non-medical personnel at delivery. Approximately 65% of births were assisted by relatives and friends, 19% by traditional mid-wives, 1% by community health agents, and only 7% by health personnel. The proportion of women without any type of assistance at delivery was about 8% (Ethiopia, 1993).

Abortion

Abortion is illegal except on certain medical grounds (Haile, 1991). Nonetheless, studies indicate that abortion is widespread and generally performed by untrained persons. Complications due to unsafe abortions constitute one of the main causes of maternal mortality in Addis Ababa (Kwaste et al, 1990) and account for 54% of all direct obstetric deaths (Yoseph, 1989). In 1987, abortion was the most common reason for women's hospitalization, accounting for almost 16% of the recorded cases of hospitalization and almost 10% of hospital deaths (Ethiopia, 1997c).

Studies conducted under the auspices of the Family Guidance Association of Ethiopia (FGAE) indicate that abortion is most common among single women, teenagers, students and factory workers. A recent study of knowledge, attitudes and practices conducted in hospitals in Addis Ababa confirmed that two-thirds of those seeking treatment for incomplete abortions were under 24 years old (Bekele, 1991). Most of these women neither used contraceptives nor knew where to obtain them.

Sexually-Transmitted Diseases (STDs) Including HIV/AIDS

The overall prevalence of STDs in Ethiopia is not known. They evidently are common in big cities, while in rural areas they may be less prevalent. Duncan, et al (1994 and 1997) studied 2,111 women in Addis Ababa attending gynecological outpatient, family planning, antenatal and postnatal clinics. Of the 542 women attending family planning clinics, for example, 64% were seropositive for 3 or more different STDs, and only 4% had no serological evidence of STDs. Of those attending non-family planning clinics, 60% were seropositive to at least 3 or more different STDs, and 6% were seronegative to all (Duncan et al, 1994 and 1997). A survey of male blood donors in northwestern Ethiopia gave a seroprevalence rate for syphilis of 13%, ranging from 21% among soldiers to 7% among farmers (Rahlenbeck et al, 1997).

HIV/AIDS has emerged as a serious public health problem in Ethiopia. The first reported seropositive cases were identified in 1984 while the first AIDS case was reported in 1986. Although the Ethiopian AIDS Control Programme has been operational since 1987, the HIV/AIDS surveillance system is weak and sentinel surveillance activities have not been carried out since 1993.

An HIV serologic survey using a national representative sample has never been carried out in Ethiopia. Nonetheless, data from studies carried out among different population groups suggest that there are probably about 2.5 million people living with HIV. This translates into a national prevalence rate of about 7%.

Because the spread of HIV has followed the main trading routes, there

are still marked discrepancies in seroprevalence among regions as well as population groups. In 1992, for example, seroprevalence among urban blood donors and clients of antenatal clinics was 7% and 11% respectively, while among sex workers it exceeded 50% (Mehret et al, 1996). By contrast, surveys conducted in 1993 among rural villages revealed HIV infection rates of less than 1% (Mehret et al, 1996). Similar studies showed seroprevalence in central Ethiopia to be under 3% (Sahlu et al, 1998). Adult HIV prevalence in rural areas is estimated to be between 3 and 7%, while in urban areas it is estimated to be between 15 and 17%. UNAIDS/Ethiopia estimates that 88% of HIV infections result from heterosexual sex (UNAIDS Ethiopia, 1998).

Despite such regional and population-based differences, monitoring of HIV/AIDS infection trends by the National AIDS Programme has seen a progressive increase in infection levels. A 1991 study carried out at two urban antenatal care facilities, for example, revealed HIV seropositive rates of 3 and 7%. By 1992, these had increased to 11 and 13%; and by 1993, the rates averaged 20%. Studies among male blood donors in northwest Ethiopia have also shown increases from 3.8% in 1989 to 16% 1993 (Assefa et al, 1994). By 1995, seroprevalence rates were found to be as high as 24% among male donors, aged 25-29 years (Rahlenbeck et al, 1997). It is widely believed that the HIV epidemic in Ethiopia has not yet reached a plateau phase (Rahlenbeck et al, 1997; UNAIDS Ethiopia, 1998).

Health Services

In 1996, total health sector expenditures represented less than 3% of GDP. Of this amount, 43% was contributed by the government, 17% by international sources, and 39% from fees for services (Ethiopia, 1996b). Today, approximately 6.5% of government expenditure is allocated to health (Ethiopia, 1998a). On a per capita basis, this works out to be about US$1.20 per person - a minimal sum even by the sub-Saharan average of US$14. In 1996 about 41% of all recurrent expenditures in the health sector were paid to non-governmental providers, mainly private pharmacies, physicians, NGO-operated clinics and other private providers (Ethiopia, 1996b).

Health services cover an estimated 38 to 49% of the population (Ethiopia, 1966b; Ethiopia, 1997c). Until recently, Ethiopia's health system was highly centralized, with services being delivered through vertical programmes. Resources remain heavily concentrated in Addis Ababa and other urban areas, with an emphasis on curative, hospital-based care (Ethiopia, 1996b). According to government statistics, the total outpatient utilization of government health services amounts to roughly 0.25 visits per person per year (Ethiopia, 1996b).

In 1992, a process to reform the health sector was initiated. Under the reforms, Ethiopia's former six-tier system is being reorganized into a four-tier system which includes primary health care units with satellite community health clinics, district hospitals, zonal hospitals and specialized hospitals.[2]

As management of public sector services becomes decentralized, regional, zonal and district/woreda departments will be increasingly strengthened. The central MOH remains responsible for the formulation of national policies and guidelines, as well as the coordination of external assistance, while the regional, zonal and district/woreda departments have direct responsibility for the planning and implementation of health services and programmes, the enforcement of health legislation, the registration and licensing of health personnel, and the collection and interpretation of information. (Ethiopia, 1996b; Ethiopia, 1998a; Ethiopia, 1998b).

[2] Primary health care units (PHCU) and their five satellite health stations are intended to serve a population of 25,000 located within a 10 km radius catchment area. Next is the district hospital, each serving a population of 250,000 and acting as a referral and training centre for 10 primary health care units; the regional hospitals will provide specialized services and training to a population of 1 million each; and the specialized hospitals will provide comprehensive/unitary specialist services and act as a centre for research and post-basic training.

Reproductive Health as a Priority

In 1994, the International Conference on Population and Development (ICPD) signalled a major breakthrough in the way governments and health professionals think about the sexual and reproductive health of men and women. Whereas previous population policy efforts gave priority to the achievement of demographic goals and programmatic targets, the ICPD Programme of Action for the first time placed people's needs at the centre of these efforts. Furthermore, it defined reproductive health, not merely by the absence of disease or infirmity, but rather as:

> "a state of complete physical, mental and social well-being . . .in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so. Implicit in this last condition are the rights of men and women to be informed and have access to safe, effective, affordable and acceptable methods of family planning of their choice . . . and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and child birth and provide couples with the best chance of having a healthy infant. In line with [this] . . . , reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being through preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases."

This emphasis on human needs versus targets has major implications for the way in which governments provide health care services. The reproductive health approach advocates a more comprehensive, holistic response to human reproduction - one that entails explicit collaboration across sectors that previously have been conceived, implemented and evaluated separately. It also presupposes a certain synergy amongst health care services in that the ability to address one set of reproductive health needs is increasingly seen as having a direct impact on the health and well being of individuals throughout their reproductive lives. The reproductive health concept recognizes the degree to which individual needs arise not only as a consequence of purely biological circumstances, but also of events that might be more culturally, socially, or ethically defined. Thus, the scope of reproductive health includes concerns over women's status and the guarantee of human rights. Finally, the concept acknowledges the reproductive health needs of all individuals, including those of men and adolescents.

In recent years, the Federal Democratic Republic of Ethiopia has taken a number of important steps in the direction of implementing a reproductive health approach. New initiatives in policies concerning health, population, women's health, and drugs, for example, have emphasized the importance of enhancing access to health care services via a decentralized state system of governance. The Ministry of Health has sponsored a number of critical studies such as the *Safe Motherhood Needs Assessment* (Ethiopia, 1996a) and, more recently,

the *Assessment of Contraceptive Requirements and Logistics Management Needs* (Ethiopia, 1997a). It has encouraged greater contraceptive choice through the introduction and expansion of new contraceptive technologies and has supported the delivery of quality services at the field level through expanded training activities and the dissemination of support materials such as the recently published *Training Manual for Health Professionals in Reproductive Health.* Finally, it has established reproductive health as a priority area and has made major efforts to incorporate it into existing health programmes.

This report examines the current reproductive health environment in Ethiopia with a view to identifying gaps, weaknesses and problems that can be resolved through policy or programmatic change or by research. It recognizes that the ability to confront these issues can only be realized when there exists a common understanding and appreciation of the principles underlying the concept of reproductive health at all levels. But as this report points out, public opinion on this issue, even among providers, health administrators and other local decision makers, is quite mixed. While many of those visited during the assessment expressed a strong commitment to reproductive health, others demonstrated relative indifference.

Consequently, before proceeding with a more focused discussion on the strengths and weaknesses of actual service delivery, it is critical to address the issue of commitment and to try to understand why the reproductive health concept is often accorded less importance relative to other health needs. Until this issue is addressed and resolved at a regional level, the potential for any sustained support for reproductive health is limited.

Perceptions of Reproductive Health

As in many other countries, discussions with policy makers, administrators and many health care providers suggest that the concept of reproductive health is not widely understood. In many parts of the country, reproductive health is perceived as simply a new name for the sum of what were formerly vertical programmes for addressing maternal and child health, sexually transmitted diseases or even just family planning.

Among those who see reproductive health as synonymous with family planning, the importance they assign to it ultimately depends on how the issue of family planning itself is perceived. Obviously, the consequences of this association have proven most detrimental in areas where "control" over the number or spacing of births is seen as a potential threat to the political or social status quo. In some areas visited by the assessment team, for example, the overriding concern among decision makers and health administrators was to maintain demographic equilibrium among two or more ethnic groups. In their eyes, family planning posed a serious threat to such a balance.

The view that reproductive health simply represents the sum total of what were formerly vertical programmes for addressing maternal and child health, sexually transmitted diseases and family planning fails to recognize any synergy amongst reproductive health services. As noted above, the reproductive health concept assumes that the ability to address one set of reproductive health needs has a direct impact on the health and well being of individuals throughout their reproductive lives. It is this notion of synergy that underlies the importance of estimating STD risk

when selecting contraceptive methods or of exploring family planning needs within the context of postabortion and postnatal care.

The failure to adopt such a holistic perspective is evident with an issue such as unsafe abortion. While providers across the country acknowledge and decry the ever-increasing rates of unsafe abortion, a surprising number did so while insisting that local demand for family planning was minimal. For them, the health consequences of unsafe abortion were of a curative nature, conceptually unrelated either to the wider availability of safe, effective contraception or to expanded programmes of sexual education among young people.

Lack of Information for Decision Making

The lack of reliable data on health conditions in different regions is another important factor contributing to the uneven support and commitment to address reproductive health issues. In none of the areas visited could it be said that adequate health information systems were in place. In some regions, health administrators were able to provide estimates of antenatal care coverage, infant mortality, and demographic indicators such as population under 15, total fertility rate and contraceptive prevalence. In other regions, by contrast, administrators had virtually no information.

Inadequate information leaves health administrators without objective data on which to determine the scale or severity of reproductive health problems; or to gauge the importance of reproductive health problems relative to those for which the clinical consequences may be more immediately visible. When ranking reproductive health risks, for example, emphasis was always placed on those risks typically associated with curative interventions such as abortion or STDs, rather than on the potential problems arising from complications of labour or low birthweight infants.

The consequences of inadequate data go far beyond the inability to determine accurately the gravity of any particular health risk. They also limit the ability to determine what progress, if any, is being made to confront those risks. Again, reproductive health interventions are often disproportionately affected by such weaknesses, because they lag behind so many other interventions, such as immunization programmes, where appropriate data collection procedures have long been in place.

The Consequences of Reproductive Health's Low Priority

The recent decentralization of public sector health care services in Ethiopia has created new challenges in the effort to enhance the availability and quality of reproductive health services. Unlike in the past, for example, when initiatives could at least be partially driven from the centre, such efforts must now be regionally-driven and regionally-owned. For this to happen, however, reproductive health must have advocates and proponents at the regional level. It must have leaders and decision makers with the skills to lobby Regional Councils for funds, put the necessary reproductive health programmes into place, and ensure that they are implemented. Without appropriate information systems or without an adequate understanding of the reproductive health concept itself, then the barriers to an effective service delivery programme will remain substantial.

Decentralization implies new responsibilities for the regions. It also, however, generates new demands on the centre. The centre is often best positioned to communicate and disseminate the lessons learned from reproductive health interventions undertaken within the country and elsewhere. The central level also has access to the resources and skills that regions will need to operationalize the reproductive health concept in ways that are appropriate for them. Although All reproductive health programmes need not necessarily be the same, they must be based on a thorough analysis of local health needs, an understanding of the sociocultural factors that influence those needs, and a pragmatic recognition of the technical, financial and human resources available locally to meet those needs. Assisting regions to undertake this systematic planning exercise, therefore, must become a priority of those with the skills and resources to do so.

Gender and the Social Context of Reproductive Health

"Of all the health challenges that countries face, those posed in relation to sexual and reproductive health are perhaps the most daunting because they involve not only diseases, but also normal components of life such as sexual maturation and pregnancy, surrounded by cultural, social, ethical and religious considerations. In no other aspect of health is the need for broad community involvement, alongside focused and effective interventions, so necessary." (WHO, 1997).

An important goal of the needs assessment was to review the implications of Ethiopia's wide regional and cultural diversity on the reproductive health of its people. The assessment team, therefore, focused attention on the social context of reproductive health, with particular emphasis on those cultural, religious and even socio-economic factors that differentiate men's and women's roles within society. Many of these factors influence health risks indirectly by differentiating access to information, education and wealth. Others, however, exert a much more direct impact by bodily mutilation or by restricting the scope of reproductive decision making. Of the latter, the most widely discussed were early marriage, sexual abduction and bridewealth. It is not within the scope of this report to provide an exhaustive review of these issues or their consequences. However, based on discussions with health care providers, religious leaders, women's health advocates and the community at large, the assessment team concluded that a chapter devoted to these issues would be warranted if only because so many of these are perceived as posing a serious risk to the health of women and children. Clearly, the solutions to these problems will not be achieved through the intervention of any one institution, but rather will require broad community involvement. This chapter, therefore, seeks to explore the opportunities and barriers to such involvement.

Female Genital Mutilation

Female genital mutilation (FGM), sometimes referred to as "female circumcision" or "female genital cutting", is practised in one form or another among at least 73% of Ethiopia's population.[3]

[3] A review of the existing literature on female genital mutilation reveals wide variations in the estimated prevalence of this practice. Some studies (Selassie nd.: 4) have suggested prevalence levels as high as 90 per cent. The figure of 73 per cent cited above was selected because it is the most recent figure for which there is sufficient documentation on the original data sources. The study in question involved both quantitative and qualitative methods and was undertaken among 65 ethnic groups nationwide (National Committee 1998).

Although FGM can be found among Christians and Muslims, the type of FGM practised does vary greatly by region. Clitoridectomy (*sunna*, the removal of the skin fold covering the clitoris), for example, is thought to be the most universal form of FGM in Ethiopia, and is widely practised among the Amhara and Tigrignia speaking peoples. Excision, or radical removal of the clitoris, labia minora and parts of the labia majora is practised among the Gurage as well as in some communities of Tigray, Oromo, and Shankalla. Infibulation, the most radical form of FGM, is largely restricted to the pastoralist populations of Afar and Somali; while Mariam Girz, sometimes described as the "mildest" form of FGM, is practiced mainly in Gojam (Selassie, nd.). Just as there are variations in the types of FGM, so too do variations exist with respect to the age of circumcision. FGM is generally performed by women during the first month after the girl's birth. In Tigray, Afar and Amhara, however, it can be performed within the first year, while in Somali Region, it may be as late as seven or eight years. Other studies have identified certain ethnic groups of SNNPR, where FGM takes place at an even later age (National Committee, 1998).

The physical effects of FGM are severe - particularly those resulting from its more radical forms. They include post-operative haemorrhage, swelling, incontinence resulting from infections, painful menstruation, partial or total amenorrhea, and painful sexual intercourse. Infertility and obstetric complications are also frequently cited complications. Less frequently described are the psychological consequences of the practice.

During the needs assessment, opposition to FGM was widespread among health professionals, among women's health advocates, as well as among religious leaders - both Christian and Muslim. In Afar, for example, where infibulation is widespread, Muslim leaders were quite open in their opposition to the practice. They rejected the notion that it was sanctioned by the Koran or by any other religious doctrines. Similarly, Women's Affairs Bureaux, Regional Committees for Harmful Traditional Practices, Regional Health Bureaux, religious leaders and even grassroots health workers such as TBAs and community health agents (CHAs) were also actively involved in creating awareness of the detrimental consequences of FGM at the community level.

While it is difficult to assess the impact such opposition has had, the assessment team nonetheless felt that changes were taking place, not only in public attitudes, but also in practice. In Afar, for example, a representative of a local women's association noted a shift away from the more severe form of infibulation towards the "milder" clitoridectomy among younger girls. This observation was also supported by a number of recent studies (National Committee, 1998).

Recommendations:

- *Support should be given to in-depth, locality-based studies on harmful traditional practices using rapid appraisal methods and simple operations research so that more targeted and effective interventions can be developed and implemented.*
- *The National Committee on Traditional Practices in Ethiopia and other organizations should be supported to broaden and strengthen community awareness of the harmful consequences of FGM and other related practices.*

- *Greater efforts should be made to educate religious and traditional leaders, policy makers and the general public on the harmful effects of FGM. Government ministries, Women's Bureaux and NGOs should also play an active role in efforts to eradicate this practice.*
- *Mechanisms should be established to facilitate the exchange of experiences and best practices across countries and regions for combating FGM.*
- *All efforts to combat FGM must encompass practical, realistic strategies for educating and providing alternative employment opportunities for those who perform circumcisions.*

Abduction

According to Selassie (nd.), abduction can be defined as a form of wife acquisition invoked "when the would-be bridegroom or bride is unable to marry the person of their choice". In such circumstances, the man forcibly abducts the "bride" with the help of accomplices and then formalizes the marriage through the mediation of elders.

As with early marriage (see below), the rationale and even consequences of abduction vary with the circumstances under which it is employed. In some cases, abduction entails the forced seizure and rape of a young woman against her will. But as studies have pointed out, the practice of abduction is also "part of a complex social relationship related to family formation and the sustainability of ethnic groups" (National Committee, 1998). Some abductions, for example are known to be arranged by the girl herself - ostensibly to circumvent her family's disapproval of the proposed partner. In other cases, it is the girl's family that arranges the abduction, particularly in situations where the family finds itself unable to finance the costs of a formal marriage.

In the SNNPR, where abduction is reported to be especially widespread, the Regional Women's Affairs Bureau singled out the practice as a serious health threat. What concerned them most was the fact that precisely because abduction is so widely accepted, community leaders are inclined to turn a blind eye, even when abuses are carried out under its guise. "It is frustrating. . .", one Women's Affairs representative said, "to see how lightly and slowly the judicial system treats such cases, even when they involve violent abduction and rape. Given community opposition to the involvement of the courts in such instances, it is hard enough just getting victims to raise a formal complaint. When the outcome is poor treatment by the system itself, the typical response is to give up."

Recommendations:

- *There is a need for greater understanding of abduction, its cultural significance , and its impact on the reproductive health of society.*
- *Wherever activities associated with abduction are known to be harmful, greater efforts at IEC and advocacy must be undertaken to alert religious and community leaders, policy makers and the general public to this effect.*

Early Marriage

Throughout Ethiopia, men and women marry at a young age. The 1990 NFFS, for example, found that the mean age at first marriage for females was 15.6 years for the whole country and 16.2 years for Addis Ababa (Ethiopia, 1993).

One factor contributing to this pattern of early marriage is a custom, especially common in northern Ethiopia, in which girls under the age of 15 are married to young men usually no older than 15-19. These, so-called "early" or "child marriages" are essentially "parent-centred arrangements between two families of different lineages" that may be contracted verbally even before the children's birth (Dagne, 1994). Though the institution is believed to have once played a critical economic role in forging alliances among the rich peasant classes and in consolidating ancestral land-holdings, the nationalization of land over the last two decades has made its role today far more ambiguous. Yet it continues to be widely practiced.

Explanations for the persistence of early marriage are diverse and range from the desire to ensure a daughter's virginity; to secure a child's future at an early age; or simply to conform to tradition. Whatever the explanation, many members of the health care sector believe that the consequences of early marriage are largely negative, particularly for young women. By remaining in subservient roles, whether as daughters within the parental household or as early brides, opportunities to develop the psychological and social skills necessary to make decisions and life choices remain severely restricted. These restrictions are compounded further by the fact that young women are denied educational opportunities, even at the primary level.

It is the impact of early marriage on women's health, however, that has attracted attention in recent years. Young women often begin childbearing at an early age, long before they have matured either physically or psychologically. As a result, their risk of obstetric complications is significantly increased. They are, for example, more likely to develop nutritional anemia which increases the risks associated with pregnancy, including post-partum hemorrhage. Adolescent child-bearing is also associated with a higher risk of hypertension which, once again, can lead to maternal and/or fetal death. The most widely described consequence of adolescent pregnancy, however, is obstructed labour, leading to vesico-vaginal fistulas. These are widespread not only in Ethiopia, but also in other African countries where early marriage and early pregnancy are common (Tafari, 1987).

The findings and observations of the assessment team strongly support much of what is being presented in the current literature on early marriage. The team found, for example, that consensus is widespread over the harmful health and social consequences of the practice. Early marriage was singled out by Women's Affairs Bureaux and women's associations as one of the major health problems in Amhara, Tigray, Afar and Gambela. In some areas, girls were routinely engaged at 1 to 2 years of age, married at 10 years, had children soon after menarche, and continued bearing children throughout their reproductive life. Data provided by the Women's Affairs Bureau of Amhara Region, for example, indicated that over three-quarters of all women had entered marital union by 18 years of age and that over half had been married by the age of 14.

The extreme nature of some early marriages, however, was experienced by the assessment team on their visit to a worata clinic in Amhara Region. During informal discussions with a group of MCH clients, a young mother informed the team that the year-old baby she was breastfeeding was already engaged to be married.

Fortunately, the existing literature suggests that patterns of early marriage are slowly changing. An

examination of the mean age at first marriage by calendar year, for example, indicates that age at first marriage has slightly increased over time. Part of this increase may be attributable to a decline in marriage for girls under ten (Dagne, 1994). Whatever the reason, health care providers, decision makers and women's health advocates are continuing their efforts to eliminate this practice. In Amhara Region, for example, the National Committee for Traditional Practices has provided health education to elders, religious leaders, young people and women, stressing the health consequences of early marriage.

Recommendations:

- *Efforts should be undertaken to determine how health care providers, decision makers and women's health advocates, especially at the community level, can create awareness about the need to limit early marriage. This must involve local leaders and more widespread dissemination of information on the health consequences of this practice.*
- *In areas where early marriage is widespread, information should be targeted towards the community so that the health risks and other consequences of early pregnancy are better understood. Appropriate services should be made available to address the health needs that arise from this practice.*

Desire for More Children

In many societies, a woman's status and prestige within the community is determined by the degree to which she meets some culturally-defined concept of fertility. In some cases, that definition may be a function of the number of children she bears; in others, it may relate to the sex of the children or the age at which she first becomes pregnant. Whatever the definition, whenever women's compliance with these ideals places her health at risk, it is important to understand precisely what those risks are and identify how best they can be overcome - either through the provision of appropriate health care services, through efforts to modify the existing cultural norms, or through activities that help women respond to them in a manner that satisfies their own reproductive intentions.

During the visits to Gambela and Benishangul, health care officials often made reference to what they believed were the potentially harmful consequences of bridewealth – a practice in which wealth in some form is transferred, upon marriage, from the groom's family to that of his bride. In those parts of the country where this institution exists, it is believed that women are under considerable pressure to continue bearing children, particularly girl children, since they represent such an important source of wealth to the family. In Gambela, for example, many health care providers singled out bridewealth as the principal reason the demand for permanent contraceptive methods is so low among the native populations. The low demand for short-term methods, on the other hand, was attributed to other cultural factors, particularly the tradition of post-partum sexual abstinence.

While there is no reason to doubt that practices such as bridewealth influence the reproductive health status of areas where it is prevalent, much still remains to be learned about how that influence is exerted and how best to address the needs of those women most directly affected by it.

Where childbearing is important for woman's status and prestige, infertility can also represent a serious problem.

Although the exact levels of infertility in Ethiopia are unclear, a study by Abdulahi Hasen (1989) has found that in Alemaya, 2% of women between the ages of 30 and 39 were childless, while in Addis Ababa and Mettu, the levels were 8% and 16%, respectively. The fact that a substantial proportion of all three groups had only one child may also be indicative of difficulties in becoming pregnant, including cases of secondary infertility attributable to STDs. During the field visits, references to infertility were frequently made, often in conjunction with STDs.

Recommendations:

- *Specific IEC strategies and messages should be designed so that communities are made aware of the health risks and other implications of large family size. Government Ministries, Women's Bureaux, NGOs and community organizations should play an active role in this process.*

Male Dominance

The discussion thus far has focused on practices that place specific constraints on women's ability to make decisions about their reproductive health. However, all of these institutions exist within a broader sociocultural context in which women's decision making abilities in general remain constrained and subjugated to the political, socio-economic, and cultural dominance of men. In some areas, such as Gambela, that dominance is further reinforced by cultural traditions such as bridewealth by which men effectively purchase, and therefore own, the reproductive rights of their wives.

One impact of such dominance was evident in the degree to which women feel able to utilize their knowledge of reproductive health services or even to seek further information about it. Even among women with a fairly broad knowledge of family planning methods, many refused to use them out of fear their husbands would not approve. "He would divorce me immediately" was a common response.

Fear of spousal disapproval and its impact on reproductive decision making are not limited geographically, nor are they restricted to Ethiopia. Lack of spousal communication over reproductive health matters in general may lead many women to assume that their husbands disapprove of family planning, even when that is not the case. Unfortunately, the awareness of such pressure is not reflected in current health education efforts. Instead, such efforts continue to place the burden of reproductive decision making squarely on the shoulders of women by directing dissemination efforts exclusively towards them. To many of the women interviewed during the assessment, the key to greater acceptance and utilization of reproductive health services, including family planning, is greater involvement of men. This could be achieved, they argued, through expanded educational efforts and through a more consistent effort at orienting those efforts towards men.

Recommendations:

- *Research should be undertaken to identify strategies for securing male support for fertility regulation and the use of other reproductive health services. This should include an assessment of men's reproductive health needs and perceptions and how to address them.*

Other Issues

As noted in the introduction to this chapter, time limitations and even the original mandate of the assessment made it impossible to explore fully all of the cultural and socioeconomic factors influencing the reproductive health of men and women in Ethiopia. The issues already addressed in this chapter were singled out, not necessarily because they were the most important or influential, but rather because they were the ones raised most often during interviews in the field.

During the August 1998 Dissemination Workshop, participants from the reproductive health community were able to augment the assessment team's findings by identifying additional issues they felt bore heavily on the gender and social context of reproductive health. Although many of these have already been incorporated into the text, the workshop participants felt that some issues should be highlighted separately. One of these was the impact of male dominance on the health and well-being of women in general. Whereas the previous section of this chapter addressed this issue specifically in terms of its impact on reproductive decision making, many participants felt that the consequences of male domination were, in fact, much broader and far reaching.

One correlate of traditional male authority, for example, was the system of widow inheritance – a practice found mostly among non-Amhara and non-Tigre peoples in which a man maintains the right to inherit the wife of his deceased brother. This system imposes obvious restrictions on the reproductive decision making of women.

Another issue discussed during the workshop were cultural patterns that lead to preferences for children of one or the other sex. In a previous section, reference was made to the institution of bridewealth and its tendency to heighten the value of the girl child. In other parts of the country, however, it is the boy who enjoys preference. Workshop participants felt that regardless of which sex is preferred, institutionalized discrimination is a serious problem that must be addressed and remedied. One approach may be to encourage greater advocacy for gender equity and the protection of women's reproductive rights. This should be multisectoral in scope and entail the involvement of policy makers, service providers, and development workers as well as traditional leaders and religious groups. This would require a strengthening of IEC efforts, as well as more effective networking among stakeholders. Another approach would be to ensure more equitable participation of women in all decision-making bodies, including the household, community and regional authorities.

The third issue to emerge from the workshop was the need to apply the concept of gender in such a way that it does not simply become a euphemism for women's issues only. The present chapter, for example, has been structured around a series of practices generally referred to in the literature as "harmful traditional practices". But as one participant pointed out, "harmful traditional practices" in the Ethiopian context has come to be associated almost exclusively with those practices – FGM, abduction and early marriage – that unduly affect the lives of women. In the view of many participants, what the current literature sorely lacks is a systematic

examination of the cultural norms that potentially affect men's lives. These might include social pressures affecting male attitudes towards women, or cultural norms that influence the acceptance of certain health related behaviours (i.e. contraception). There was widespread consensus that further research was needed in this area.

Structural Framework and Mechanisms for Advocacy

In all regions visited by the assessment team, efforts were made to meet with groups whose activities focus specifically on women's health and economic well-being. These include Women's Affairs Bureaux in each of the regions as well as women's associations and a wide range of private and non-governmental associations. Activities undertaken by these groups range from combating harmful traditional practices, to sensitizing the community to reproductive health issues, to non-health related activities such as women's income generation.

While all such organizations have been active in promoting women's interests, their success has depended to a great extent on their ability to co-ordinate with other institutions - be they key decision making bodies, such as Regional Councils, or institutions at a more grassroots level such as community associations, school clubs, youth centres, and local committees. Visits to the field suggest that the record is quite uneven in this regard. In Amhara, Addis Ababa and Tigray, for example, the Women's Affairs Bureaux are fortunate in that they participate regularly in the quarterly meetings of the Regional Council - a forum which allows them to raise gender issues as well as to keep abreast of the activities of other sectoral bureaux. Also, in Tigray, a multisectoral technical committee exists within the Regional Office of Population where relevant agencies, including the Tigray Women's Association, participate in the development and implementation of population programmes.

Nevertheless, the assessment team also encountered regions where the Women's Affairs Bureaux have remained somewhat marginalized from regional decision-making processes. Furtheremore, even those bureaux with adequate representation at the regional level, are often constrained from maintaining an active involvement at the grassroots level, because they have no representation at the subregional (zonal, woreda or kebele) level or even within those sectoral bureaux relating to health and population. Representation among the latter, they argue, would help facilitate the integration of gender issues in projects and programmes as they are being designed by their respective bureaux.

Another issue commonly raised by many women's advocacy groups, particularly those in more rural areas, is the difficulty in getting women to participate in workshops, health education talks, or any other organized fora for the dissemination of information. Heavy workloads associated with women's triple responsibilities for reproduction, production and socialization, effectively limit their ability to participate in such activities outside the household. During the needs assessment, this situation was particularly evidenced in Gambela, where the Women's Affairs official at Itang woreda reported organizing awareness creation programmes on family planning, but found few local women able to attend, primarily due to the lack of free time.

Recommendations:

- *Mechanisms should be established for the inclusion of Women's Affairs Departments in the central Ministries, Women's Affairs Bureaux at the regional level, and women's NGOs.*
- *Networking among Regional Health Bureaux, Women's Affairs Bureaux and the Regional Offices of Population should be strengthened. Women's Affairs Bureaux should also be strengthened in capacity (human resources, logistic, training) to reach women at the grass roots level.*
- *Where possible, efforts should be made to help integrate reproductive health information into income generating programmes for women.*
- *Religious leaders and opinion leaders should be educated in the need to improve reproductive health; to strengthen advocacy for reproductive health; and to fight traditional practices that threaten the reproductive health of women.*

ADDRESSING THE REPRODUCTIVE HEALTH NEEDS OF YOUNG PEOPLE

Adolescents and young adults comprise one of the fastest growing segments of the population. As future parents, their health and well-being will largely determine the health and well-being of subsequent generations. Although young people have a capacity for innovative ideas and represent a critical reservoir of labour for national development, field visits by the assessment team revealed that their reproductive health needs are usually neglected. This is largely because of commonly held assumptions that, in comparison to children and older people, they are less vulnerable to life-threatening diseases. While it is doubtful this has ever been true, social, cultural and economic changes taking place in Ethiopia today have multiplied the risks facing young people. This chapter explores some of those changes and proposes strategies for addressing the reproductive health concerns that derive from them.

Societal Changes Facing Young People

Unemployment: Given the lack of reliable employment statistics and the size of Ethiopia's informal economy, it is impossible to quantify precisely the level of youth unemployment within the country. Yet in virtually every region visited by the assessment team, the shortage of jobs and the desperate search for those few that exist have given rise to a wide range of phenomena: migration to and between urban areas, lack of parental support or oversight; and forced idleness. All of these place young people at considerable risk of unwanted pregnancy, unsafe abortion and STDs including HIV/AIDS. Furthermore, their lack of financial resources means that even when young people do seek health care or address other reproductive health needs - they find themselves unable to do so, precisely because they cannot afford the costs.

Urban migration: While the search for employment has contributed significantly to increased levels of internal migration, so too has been the influx of young people into towns and cities to attend secondary schools, technical institutes and other educational facilities. In both cases, however, the consequences are the same: Young adults are increasingly being forced to construct new lives for themselves, often within totally unfamiliar surroundings. Unfortunately, the absence of moral and material support from family and friends has prompted many young people to adopt a wide range of "survival strategies" that have, in turn, had a devastating effect on their reproductive health. According to many educators and health care providers, these include a high level of sexual activity, including prostitution; delinquency; and forced idleness leading to alcoholism and drug abuse.

A common remark heard throughout the country is that prostitution is on the rise, particularly in the big towns and cities. The assessment team interviewed commercial sex workers in hotels and bars in Addis Ababa, Bahar Dar, Mekele, Gewane, Benishangul and Jimma. Most of the sex workers were between the ages of 18-30 and nearly all had migrated from either rural areas or other regional urban centres. Early marriage, unwanted pregnancy, unemployment, quitting school and family disruptions were identified as the principal reasons for

having chosen to leave their original towns or villages.

Lack of recreational places and facilities is another problem facing adolescents and young adults, particularly those out of school. Some young people seek out diversionary activities such as chewing *chat*, drinking alcohol and abusing drugs. A group discussion with young people in Bahar Dar gives a clear picture of the nature of their problems and concerns. They reported that their favourite "recreational places" are the local *chat* or *Tella* houses. Furthermore, the prices of the local drinks are so cheap that even small children can afford to buy them. *Tella* houses can also be centres for prostitution, thereby exposing young people even further to the hazards of early and unprotected sex.

Health Consequences of Social Change

In visits to health care facilities, schools and community development agencies, it was clear that young people are bearing the brunt of the social, economic and cultural changes taking place within modern Ethiopian society. In the process, they are suffering from unwanted pregnancies, contracting sexually transmitted diseases and dying from unsafe abortions.

The statistics and other research findings reported earlier often mask the magnitude of the problems and the impact they are having on the life of the community as a whole. In the view of the assessment team, nowhere has that impact been more underestimated than in the case of unsafe abortion. In region after region, the frequency of abortion among young people was nothing less than shocking, not just because of the enormity of the problem but because of the inability of health care facilities to provide adequate preventive and post-abortion services and because no part of the country has remained untouched by what providers and community leaders are increasingly calling a national "epidemic".

Complications due to unsafe abortion are a major cause of maternal mortality in urban centres such as Addis Ababa, where they account for up to 54% of all direct obstetric deaths (Yoseph, 1989). Moreover, the majority (67.2%) of those seeking treatment for incomplete abortions are under 24 years old. What is not so widely known is that the problem of unsafe abortion extends far beyond the country's major urban centres. For example, in the town of Gambela (20,000 population), an average of 3-4 incomplete abortions are treated each day at the regional hospital. This number exceeds not only the average number of hospital deliveries per day, but also the daily average of new family planning acceptors. Wherever the team went, the same pattern was evident. In Axum's St. Mary's Hospital, health officials reported seeing 15 incomplete abortions per month, many among girls as young as 12 years old. In Bahar Dar, health providers at Felege Hiwot Hospital reported 2 or 3 cases per day, typically associated with sepsis or uterine perforation, almost all being among school-age girls. Similar findings were encountered elsewhere in the country: for example Debre Tabor, Mekele, and even the Somali Region - an area that the assessment team had thought, for cultural and religious reasons, would not experience this problem.

A second major health threat affecting young people are reproductive tract infections, including HIV/AIDS. Again, national statistics provide some indication of the scope and magnitude of this major public health problem. But what these figures fail to convey is the degree to which the nation's young

people run a disproportionately high risk of not only contracting STDs, but of being excluded from appropriate curative and preventive services and information. As with unsafe abortion, the vulnerability of young people to STD and HIV transmission is recognized and emphasized by providers across the country.

Strategies to Address the Health Consequences of Social Change

The assessment team made a special effort during its visits to identify and meet with organizations that are addressing the social, economic and health needs of adolescents and young adults. These included youth development associations; government agencies such as the Women's Affairs and the Labour and Social Affairs Bureaux; non-governmental agencies such as FGAE and the Organization for Social Services for AIDS (OSSA); as well as many schools and community centres. It found that while there is indeed some exemplary work being done in this field, by and large the health and social services available to young people are scarce and inadequate. This section takes a closer look at some of the reasons why this is so, but also highlights a number of successes so that they, in turn, might serve as models for future efforts.

With few exceptions, health care providers and social sector professionals agree that the existing health care services do not adequately meet the needs of today's young people. Not only do they fail to encompass the kinds of services young people require most, but even those services that do exist are often provided through vertical programmes that leave many young people feeling out of place. One example of the latter is the universal practice of delivering family planning services and information exclusively through MCH/FP programmes. While there are sound reasons for this inclusion, the maternal and child health focus of such programmes often marginalize younger women whose age, marital status and parity typically set them apart from the majority of those seeking such services. In some areas, such as Debre Tabor, the health sector has recognized these structural barriers and has begun to target young people separately through ongoing IEC efforts and through the introduction of emergency contraception. These efforts, however, remain the exception rather than the rule. In general, it is still quite unusual to find public sector health care workers taking an active role in community extension services or in providing educational talks to schools or youth organizations on contraception and STD prevention.

Another major weakness of the service delivery system, particularly in the public sector, is the consistent lack of a youth-friendly approach towards service delivery, particularly in ensuring privacy and anonymity. Regardless of location, team members repeatedly found counselling sessions being carried out with minimal, if any, effort to maintain visual or auditory privacy. While space and other infrastructure-related factors may have played some role in this situation, it was also clear that many providers simply did not recognize privacy as a priority issue. Adequate privacy must always be an indispensable element of quality care. But in the case of youth services, its absence is especially critical, since "embarrassment", "shame" and "fear of rebuke" are among the most common reasons cited by them for refusing to seek either information or services.

Service Options for Young People

Despite the unfavourable environment for youth-centred health care services, a number of programmes were singled out by the assessment team as being noteworthy for their ability to reach young populations and to provide them with the kinds of services they require.

One such initiative includes youth centres operated by the Family Guidance Association of Ethiopia (FGAE) in the towns of Jimma, Dessie and Bahar Dar. Designed to provide a wide range of services under one roof, the programme offers family planning counselling and services as well as STD diagnosis and treatment. In Dessie, there is even an active community-based distribution (CBD) programme and a special counselling programme designed to encourage young men to bring in their partners for health care services. The programme also offers a broad range of recreational activities including library facilities, theatre and sports.

There were, however, other successful efforts to improve the health and well-being of young people. In Dire Dawa, the Ministry of Labour and Social Affairs (MOLSA) and Radda Barnen are operating a rehabilitation centre for the homeless, aged 18 years and younger. Begun five years ago, the programme now serves approximately 200 young people, offering vocational and other technical training, free health services, savings and credit schemes, educational services and a wide range of recreational activities. The programme also operates a safe home for 40 child prostitutes, providing them with temporary shelter, free health services and, in collaboration with FGAE, counselling on family planning and STD prevention and treatment.

In addition to organizations that provide direct medical or financial support, there are others that serve a primarily educational or awareness-raising role. One of the largest of these groups is the Tigray Youth Development Association (TYDA), a massive organization that includes over 153,000 members between the ages of 18 and 33. To address the reproductive health risks facing young people, the association has played a key role in establishing a number of well-known action committees. Perhaps the best known of these are the "Anti-AIDS Committees" which support health and sexual-education for young people, both in-school and out-of-school. Others include the Red Cross committees formed to train young people in first aid.

In addition to school-based activities, the TYDA is also involved in efforts to combat problems associated with unemployment. Like FGAE, it hopes to offer vocational training to young people and, with financial support from the Regional Council, to establish up to 18 youth recreational centres.

The role of organizations such as these cannot be over emphasized, particularly insofar as they raise the awareness of local authorities as to the need for youth centred services. As was noted previously, reproductive health can only become a priority issue if it has advocates and proponents at the regional level. Leaders and decision makers must lobby for funds, put the necessary reproductive health programmes into place, and ensure that they are implemented.

Recommendations:

- *The Ministry of Health should, in collaboration with the Ministry of Education, provide reproductive health information and services to school children; the focus of anti-AIDS clubs should be expanded to include reproductive health information; and, together with the Ministry of Labour and Social Affairs, pilot projects should be developed to provide reproductive health information and services to out-of-school teenagers.*
- *An evaluation should be undertaken to compare the operation and impact of different programmes to address the reproductive health needs of young people both in-school and out-of-school. Programmes with a proven track record at addressing those needs should be expanded, particularly into areas such as the Gambela, Harrar, Jijiga, Benishangul and Afar where few institutional mechanisms currently exist to do so. The evaluation should also explore the range of potential sponsoring institutions such as churches, schools, public health care facilities, and sports clubs.*
- *In developing strategies to address the reproductive health needs of young people. peer education and the integration of recreational, educational and family planning activities should be promoted.*
- *Greater efforts should be made to provide young people with continuing health education and information, including post-abortion care. The role of the mass media in promoting reproductive health should be developed further. Appropriate strategies for introducing emergency contraception should be investigated.*
- *The utilization of scarce financial and technical resources should be made more efficient through greater coordination and collaboration between governmental and non-governmental sectors.*

MANAGING THE DELIVERY OF REPRODUCTIVE HEALTH CARE SERVICES

Thus far, the present discussion has focused largely on the social, cultural and political context within which reproductive health services are delivered. This chapter and the one that follows focus on the quality and efficiency of the health system itself. The current chapter addresses the wide range of resources needed to deliver health care services and the relative efficiency with which these resources are managed. It evaluates the adequacy of systems to ensure that reproductive health supplies and commodities are readily available; whether the level of human resources is appropriate to meet the needs of those requiring health care services; and whether public sector service delivery activities not only operate coherently but also build on and complement reproductive health interventions by others working in the region. While this is a substantial task, the assessment team observed a number of gaps and weaknesses that directly relate to such management issues. This chapter summarizes those observations and suggests recommendations for resolving them through research or specific action.

Managing Human Resources

The seriousness of human resource shortages within the public sector is an issue upon which health care managers and providers are in agreement. Indeed, at present the ratio of physicians (1:40,000) and nurses (1:14,000) to the population at large are about one fourth and one third, respectively, of those recommended by WHO. Especially worrisome from a reproductive health perspective is the scarcity of midwives: only one per 53,000 people (Ethiopia, 1997c). Exacerbating this situation is the fact that health care professionals are generally concentrated in urban areas. The causes and consequences of these shortages in human resources are complex, in part because under the rubric of "shortages" are included such phenomena as high staff turnover, the exodus of skilled providers from the public to private sectors, and/or shortages of field-based staff with appropriate technical or sociocultural backgrounds. All of these issues were raised and discussed at length with the assessment team.

The decentralization of public sector health care services has created both opportunities and challenges in the effort to enhance the availability and quality of reproductive health services. One of the greatest of these challenges is to develop reproductive health programmes that reflect the social and cultural characteristics of the country's autonomous regions. As noted previously, the reproductive health risks facing any individual are very much tied to their cultural environment, since that environment often dictates such things as age at marriage, parity, birth practices and so on. Thus, communicating the risks associated with what most people perceive as a "normal part of life" requires familiarity with the local culture.

Decentralization of the public health care system has, for the first time, provided regions with the opportunity to define reproductive health priorities that reflect their own realities, and to translate them into interventions that are both appropriate and culturally

meaningful. However, what the team saw in a number of areas, particularly in Somali, Afar, Gambela and the SNNPR, were serious shortfalls of skilled local staff at the field level. In fact, in some of these areas, indigenous staff had actually been removed from the field and "promoted" to administrative positions, while those charged with service delivery were often outsiders with little or no knowledge of the local language or culture. This has proven unsatisfactory for all concerned. Local communities see health facilities as irrelevant, while providers see community members as unreachable.

More indigenous providers will be needed if the channels of communication between local communities and the health care system are to be strengthened. For them to be both effective communicators and active members of the community, their training must also include the skills necessary to bridge the gap between western medical culture and the culture in which they live.

A second issue is the increasing staff shortages resulting from the exodus of skilled health care staff from the public sector to NGOs or private clinics. Salaries within the public sector are undisputedly low, but it is also clear that salaries are only part of the problem. Many health workers are simply frustrated by what they see as the poor conditions of public sector service in general. They express concern about vague job descriptions which they say force them to take on extra work for which they are not qualified, equipped, or remunerated. Others highlight the lack of in-service training.

While job dissatisfaction in one form or another may be the immediate cause of many individual moves to the private sector, probably the most significant factor, at least at a national level, is the transformation of the health sector from what was once a socialist system to one in which providers are free to seek for-profit opportunities. For the immediate future, public sector health care managers can expect to continue competing with private providers in the search for qualified staff.

The third issue to be raised by health care managers and providers is the impact of high staff turnover on the availability of skills at the service delivery level. Typically, the problem of turnover manifests itself at two levels. At one level, its immediate consequence is a shortage of staff, particularly since the time required to fill vacant posts can be quite lengthy. But even more critical is the degree to which it detracts from the optimal use of available skills. As trained staff move on to other positions, their practical experience and technical expertise are lost, if not to the public sector as a whole, then at least to the particular service delivery unit in which their expertise was obtained. While exact figures on turnover are difficult to obtain, the problem seemed particularly acute, or at least expressed most openly, in Amhara, Afar and Gambela Regions.

Apart from dissatisfaction with working conditions in general, health care providers were unanimously critical of the lack of finite service year limits for staff working in hardship areas. With no fixed end-point, many staff simply keep their "eyes open" in hopes that new opportunities might arise. Another factor contributing to high turnover within the system is the fact that it represents one of the very few avenues for staff to broaden their own technical expertise. With limited opportunities for post-basic training or technical specialization, routine transfers from one specialty to another are widely seen as the most practical way for staff to enhance their own professional careers. Unfortunately, at

the service delivery level, this pattern limits levels of provider competence insofar as service delivery units end up being staffed by those who have not yet obtained the level of expertise necessary to move on.

Recommendations:

- *Efforts should be made to build local capacity to deliver quality reproductive health services in ways that reflect local needs and the sociocultural environment through which those needs are defined. Since building such capacity will take time, continued technical support from the centre will be critical to maintain delivery of services.*
- *Job descriptions should be revised to ensure that all personnel have appropriate training to meet their requirements.*
- *Efforts should be made to ensure that all health personnel can benefit from a clear career structure that enhances their knowledge and skills and acknowledges their status within the system.*

Health Care Supplies and Materials

Supplies and equipment:
Throughout Ethiopia, shortages of basic supplies and equipment are endemic. In visit after visit, assessment team members and health care personnel confirmed much of what had already been widely reported in studies such as the *Safe Motherhood Needs Assessment* (1996a) and the 1997 review of *Contraceptive Requirements and Logistics Management Needs* (Ethiopia, 1997a). Health facilities were lacking in basic maternity equipment, in equipment for delivery, as well as in basic consumable supplies such as syringes, needles and gloves. Providers also mentioned shortages of essential medicines such as antibiotics and reagents for STD testing.

One message the Safe Motherhood Assessment did not communicate, however, was the degree to which shortages derive not necessarily from the lack of supplies and equipment *per se* (indeed, in many parts of the country, regional level warehouses were well stocked), but from the lack of systems to ensure that existing stocks are distributed in response to routine reporting of health facility needs. One consequence of this absence was the randomness of stockouts and shortages. In some parts of the country, for example, contraceptive commodities could be found in surprising abundance, while in neighbouring towns, the shortages could be severe. This was found to be the case in Amhara, Tigray, Oromia and even in smaller regions such as Gambela. Another observation was the widespread lack of effective communication between health care facilities and the Regional Health Bureaux on logistics-related matters. Even in cases where the Bureau and health facilities were located in the same town, shortages occurred as a result of breakdowns in communication. In one Regional Hospital, for example, health care staff complained about not having had minipills for several months. It turned out that the Regional warehouse was well stocked with minipills and had been so for months.

In addition to poor communication, another constraint facing health care providers was inadequate management and procedures for re-supply. One example were restrictions on where and from whom commodities could be purchased. In a number of Regional Hospitals, administrators complained that even when the Central Medical Stores did not have the equipment they needed, they were not allowed to

purchase from other sources. In other instances, supply and equipment shortages were not attributable to the lack of resources (indeed, some budgets could not be fully spent), but rather to inadequate mechanisms for resupply.

While the immediate cause of many shortages can be directly traced to poor management and inadequate logistics systems, the consequences of these shortages can be felt throughout the health care system. In a number of areas visited by the assessment team, for example, the lack of STD treatment, the absence of certain contraceptive method options, and the inability to address complications resulting from incomplete abortion were directly attributable to shortages in equipment and supplies.

Another consequence of supply shortages is that they tend to restrict health care services to those with the means to procure supplies through pharmacies and other private sector vendors. The assessment team visited many such suppliers and found the private marketplace to be relatively well-stocked wherever they went. Drug vendors and pharmacies, for example, were well-stocked with antibiotics and also had a wide range of family planning methods, including socially marketed condoms and oral contraceptives. Obviously, there is a sector of the community with the means to access these items. But for many others, the need to resort to the private marketplace was viewed with considerable bitterness.

Recommendation:

- *The findings of the review of "Contraceptive Requirements and Logistics Management Needs" should be studied closely and its recommendations implemented to ensure the adequate and efficient provision of health care supplies and materials. Where necessary, further critical review and research should be conducted.*

Transport: Over 80% of Ethiopia's population is rural. Moreover, poor infrastructure and the difficult topography of many rural areas mean that if communities are to receive adequate health care coverage, then services must either be brought to them or they must be brought to the appropriate health care facilities. Neither option has proven particularly viable or successful, in large part because they both depend on the availability of one very scare commodity - adequate, reliable transport.

Throughout the country, shortages of adequate transport have had a major impact on both the quality and accessibility of existing services. In Gambela, where boats as well as land vehicles are needed to reach isolated communities, breakdowns have obstructed the delivery of services. In many parts of Afar, the absence of a functional cold chain has put an end to the activities of the Expanded Programme on Immunization (EPI), despite major outbreaks of measles and whooping cough. Meanwhile, in other areas such as Tigray and especially Oromia, the lack of transport has resulted in inadequate monitoring and supervision, the termination of basic outreach programmes and the lack of effective referral systems. At Adwa Hospital, health workers reported that the majority of patients with obstetric complications come in by stretcher, often over long distances.

The only long-term solution to these widespread transportation problems will be an increase in the resources available to meet basic transportation needs. This will mean more vehicles as well as more funds to ensure that existing vehicles are maintained and operated. In the meantime, however, managers and Regional Health

Bureaux will need to make better and more effective use of the limited transport facilities that do exist. Assessment team members were often told of scarce fuel and even scarcer vehicles being used to transport regional health officials around town, while outreach activities or even the delivery of essential medicines and supplies were suspended. In other cases, vehicles remained unrepaired despite repeated requests from subzonal managers that maintenance be carried out. Clearly, the implications of such indifference and poor management go far beyond their immediate impact on the quality of health care services. To those in rural areas, providers as well as clients, it is a sign that management is either unaware of, or unconcerned with problems at the grassroots level.

Recommendation:

- *Logistic support for transport should be improved at all levels. Although transport is ultimately a regional responsibility, the central level should continue to support the operational costs, procurement and disbursement of essential resources.*

Facilities: The 1996 *Safe Motherhood Needs Assessment* revealed serious deficiencies in the availability and adequacy of physical infrastructure for reproductive health care. Even at the hospital level, for example, barely half of the facilities visited had basic laboratory facilities or even adequate waiting and examination rooms. Fewer than half had toilet facilities and running water (Ethiopia 1996a).

The observations of the assessment team confirmed much of what had been reported earlier in the Safe Motherhood report. Health care facilities throughout the country remain in poor condition. Fortunately, a virtual "building boom" is taking place throughout the health sector. In region after region, hospitals, health centres and warehouses are under construction, many with the active support of local communities. In Gambela, for example, the team visited the nearly completed Regional Hospital as well as the new Regional Health Bureau Headquarters which includes offices and a central warehouse. The same was true in Amhara Region where the last four years have seen the construction of three new hospitals, 11 health centres and 135 health stations (Ethiopia, 1997b).

It remains to be seen, however, what impact this new construction will have on improving the quality of reproductive health services. Obviously, it will alleviate those deficiencies directly attributable to inadequate or non-existing facilities. However, it should not be seen as a panacea to all the problems identified in this and earlier chapters. In Dire Dawa, Harrar, Gambela, and Jimma, for example, the observed absences in auditory and visual privacy during counselling sessions were often less related to the amount of available space than to the failure of health care providers to recognize the importance of privacy in the first place. Even the poor physical condition of many facilities was found to be less a consequence of the actual infrastructure, than to the lack of motivation by local health care staff to maintain it. At one new health centre visited in Gambela, for example, team members encountered rooms littered with paper, drugs, equipment and even medical waste such as used syringes. Furthermore, even the most advanced facilities are useless if they cannot open because of staff shortages.

Recommendations:

- *An inventory of health care facilities, equipment and personnel needs should be undertaken as a critical first step to strengthen deficient health care infrastructure.*
- *Efforts to Involve the community in the support of health facilities should be strengthened.*

The vast majority of Ethiopia's population lives in rural areas where health care coverage is low and where existing public sector resources are being stretched to the limit. One of the greatest challenges facing the country's Regional Health Bureaux is determining how best to narrow the gap between existing service delivery facilities and the population whose access to them is so limited.

Primary responsibility for the delivery of health care services has traditionally rested with the public sector. In 1996, for example, over half of all health care services were provided through government-owned facilities. Over the same period, NGOs, traditional practitioners and rural drug vendors together made up about one third of all service provision (Ethiopia, 1996). The role of the private sector has also been significant in the area of family planning, where NGOs and the national social marketing programme have generated about a quarter of the total couple years of protection (CYP) (Ethiopia, 1997).

Although this assessment included visits to private health care providers and drug vendors, its primary focus was on the government and NGO sectors. This decision was based on the original mandate of the assessment and the fact that a thorough analysis of the private sector would, because of its far more diverse nature, have entailed a much more exhaustive field review than was possible in the time available to the team. However, there is a great need to evaluate private sector services and to explore their potential role including such "quasi-private" activities as the national social marketing programme.

The Public Sector

Within the public sector, narrowing the gap between existing service delivery facilities and the demand for them has entailed a number of strategies. One has been the recent construction of new health care facilities, particularly "health stations" which represent the lowest rung of the new health care system. Another strategy has been to establish extensive outreach services. The magnitude of such extension efforts was made clear to the assessment team on a visit to Itang Health Centre in Gambela Region. Although remote, the health centre supports eleven outreach sites for EPI, four of which are accessible only by boat. In addition, the woreda has four health stations, one located 14 hours away on foot and two accessible only by boat. All are staffed by community health agents.

The structure and operation of current outreach services clearly rest on the active involvement of traditional birth attendants, healers and other agents from the communities themselves. However, there is growing concern, particularly within the public sector, that this approach is not functioning adequately. There are often few incentives for most community-based agents to continue their often arduous activities. Typically, they are not paid and the limited financial resources of the communities they serve limit the feasibility of charging fees for the services they provide. While there is debate as to how best to provide adequate incentives, the community-based agents are ideally positioned to provide care to the majority of people who live beyond the immediate reach

of static health care facilities. For that reason, it is important that such agents be equipped with the knowledge, skills, and resources needed to do so.

In addition to extending the reach of public sector health care providers and facilities, health care managers have also found success by building on and complementing the interventions of other agencies operating in the same rural communities. In Amhara, Tigray, and Dire Dawa, for example, successful community-based distribution programmes for contraceptives are becoming entry points for other reproductive health services; employment-based health care programmes are gradually emerging; health training institutes are delivering health care services to rural communities; private health care providers and pharmacists are serving larger numbers of those with the means to pay for commodities and services; and lastly, there are dramatic increases in the level of collaboration between public sector and non-governmental health care agencies. The assessment team felt that these new linkages, outreach programmes and innovative service delivery mechanisms could help to alleviate the resource constraints described in this chapter. They will never, of course, replace a well-functioning, well-equipped public sector health care system. But their potential does indeed warrant closer study and evaluation, particularly if such efforts are to be replicated on a larger scale.

Community-based Activities

As noted previously, efforts are underway to introduce or expand the delivery of reproductive health care services and supplies through community-based distribution (CBD) programmes. However, visits to many of these areas suggest that despite some impressive results, the overall success record of community-based distribution remains quite mixed. In Gambela, for example, CBD activities have remained relatively dormant due to declining support on the part of the programme's original sponsors. Similarly, in Tigray, health officials claim that the lack of adequate incentives has severely constrained the expansion of community-based efforts in general, whether it be distributors, health agents or traditional birth attendants (TBAs).

Elsewhere in the country, however, community-based programmes have been quite successful. In Amhara Region, the German Technical Cooperation Agency (GTZ), has supported the training of some 5,000 agents and plans to train 5,000 more. Under this programme, each CBD agent serves 700 people, or about 100 households. Agents are trained for 5 days on basic primary health care, contraceptive methods and population issues. They each report directly to the clinic where they get their supplies.

FGAE has also been successful at establishing CBD programmes. In South Welo Zone, for example, a pilot activity has been set-up in two predominantly Muslim communities, Kombolcha and Haik. CBD agents are selected by the community and are supervised through site visits as well as a variety of other assessment techniques. Agents do not receive a salary, but are allowed to keep 60% of their income from contraceptive sales. In Kombolcha, FGAE also operates an urban outreach centre where CBD agents are active at integrating messages on family planning with HIV/AIDS prevention and education. GTZ has also expressed interest in expanding the range of services provided by community-based agents,

including acting as entry points for other reproductive health services, such as STD counselling.

Another community-based strategy was seen in Dire Dawa where the Health Department has recently trained 11 community health agents (CHA), six of whom have been deployed to the rural areas and the remaining five to the impoverished slums of Dire Dawa town. Each receives a salary of 150 Birr per month. In the rural village of Goro, the local health post is run by a CHA. In addition to treating minor medical problems, he also reports births, deaths and outbreaks of diseases. Basic drugs are supplied by UNICEF while oral contraceptives and condoms are provided by the Ministry of Health.

In Axum, efforts are being made to train TBAs more broadly to recognize signs and symptoms which may lead to problems in delivery. This is an approach which could very well be expanded to include basic antenatal care.

There is significant interest in expanding both the breadth and geographic scope of community-based programmes. The challenge is to assess the lessons from existing experiences so that best practices can be identified and replicated in a sustainable manner throughout the country.

Recommendations:

- *The operation and impact of the various approaches being used for CBD should be evaluated so that the conclusions, lessons learnt and best practices can be disseminated widely in other regions. Since CBD programmes may be the only way of increasing reproductive health care coverage in the foreseeable future, pilot studies should be developed to investigate the feasibility of broader use of CBD workers.*
- *Operations research should be undertaken to explore the potential for broadening the scope of reproductive health care services offered by community-based agents, including traditional birth attendants (TBAs).*
- *Successful community-based programmes should be expanded to make health information and services more accessible.*
- *An assessment should be undertaken to identify the most appropriate role for private sector participation in the delivery of reproductive health services.*

Non-Governmental Organizations

Across Ethiopia, the delivery of health care services is increasingly being supplemented by a broad range of private, non-governmental institutions. Many of these institutions are indigenous, others are international or at least affiliated with international bodies, and almost all are to some degree funded through bilateral and multilateral donor programmes.

While there is no region in the country where NGO activities represent the bulk of health care service delivery, they have played an important role in extending coverage to sectors of the population that might not otherwise have received adequate attention. Youth-centred activities, for example, are almost completely supported by NGOs as are most of the country's CBD programmes. NGOs are also constructing and running a limited number of hospitals and health posts, training field surgeons, and providing in-service training for health workers.

In meetings with the different health bureaux, regional officials acknowledged the key role played by

NGOs but there is also recognition by both sectors that greater coordination is needed if their relationship is to remain mutually beneficial. Many indigenous NGOs, for example, feel strongly that in order to meet the needs of specific target populations, they must have access to public sector support.

Recommendations:

- *Although the relationships between NGOs and health bureaux are good across most regions, areas of mutual support in reproductive health service delivery should be explored further.*
- *While acknowledging that NGOs cannot address the needs of all sectors of the population, the innovative approaches adopted by them should be evaluated and replicated where appropriate by the public sector.*

Improving the Quality of Reproductive Health Care Services

As noted in the Introduction, this assessment considered three broad questions. The first was to identify critical areas where the quality of reproductive health care services could be improved. The second was to determine which contraceptive methods could be introduced to appropriately expand choice. And the third was to understand and operationalize the key issues affecting the integration and management of reproductive health interventions.

In addressing these three issues, this report has analysed the reproductive health environment broadly, from the perspective of the prevailing technology base, user's needs, and the capability of the service-delivery system to provide quality services. For that reason, the discussion has not limited itself to detailing technical weaknesses or to summarizing shortfalls in the service delivery system. Instead, it has widened the discussion by looking at the broader and more fundamental question of how users, providers, and decision makers interpret the concept of reproductive health. It has examined what these groups view to be the most pressing reproductive health needs; and it has reviewed what resources and service delivery strategies currently exist to meet them. This and the following two chapters return to the three strategic questions in order to link the findings discussed so far with more specific observations on such issues as quality of care, contraceptive method mix and operationalizing reproductive health care.

Many of the observations described thus far have been raised and discussed in the literature. Shortages of equipment and supplies, lack of adequate provider training, and limited human resources, for example, are all themes that have in the past been singled out as weaknesses in the service delivery system. Where the current literature has often proven weak, however, is in looking beyond the identification of individual weaknesses at the health facility level in order to assess their significance relative to the delivery of reproductive health care services as a whole. It is too easy to single out problems in a particular clinical setting and recommend that they be resolved. However, in a resource poor environment, where all weaknesses cannot be immediately resolved, definitions of need must be established with reference to the standard of health care the service delivery system seeks to provide. The concept of quality of care provides such a point of reference because, like the concept of reproductive health itself, it takes as its starting point, not just the technical content of the services themselves but how those services address the needs of those who seek them.

The present assessment analysed the quality of services using a framework that defines quality in terms of elements clients themselves experience as being critical (Bruce 1990). Those elements addressed in this chapter include: range of services, information given to clients, technical competence of providers, and interpersonal relations. Developed nearly a decade ago to address the quality of family planning services, the framework has proven to be an extremely flexible tool, well suited to assessing the provision of reproductive health care services in general. This chapter, therefore, draws

on the assessment team's field-based observations to highlight those issues which, from a quality of care perspective, require strengthening and further support.

Range of Services

Within any service delivery system, the level and type of any particular health care facility will obviously determine the range of available services as well as the level of technical sophistication at which services can be provided. Not all facilities, for example, can be expected to offer all contraceptive methods nor perform all types of emergency obstetric care. Yet given the limited accessibility of the population to health care facilities in general, it is critical that all health facilities provide at least certain basic reproductive health services.

At present, the reproductive health services most widely available at all levels of the health care system are antenatal care and family planning. However, reproductive health services need to address far more than these two. It is clear that much remains to be done if Ethiopia's health care system is indeed to achieve its goal of providing "access to appropriate health-care services that will enable women to go safely through pregnancy and child birth and provide couples with the best chance of having a healthy infant." During its field visits, the assessment team identified at least four broad programmatic areas that it felt were severely underrepresented in the current range of reproductive health services. These included post-abortion care, STD detection and treatment, antenatal and postnatal care, and emergency obstetric care.

Post-abortion care: It was noted earlier that complications resulting from incomplete abortions account for a substantial proportion of obstetric admissions to most regional hospitals. Experience from other countries has shown that manual vacuum aspiration (MVA) offers an important alternative to sharp curettage. MVA uses a hand-held vacuum syringe and flexible plastic cannulas and has been found useful in primary and outpatient health care settings. Yet few hospitals offer, or have staff trained to offer, MVA. Even at health facilities with staff trained in MVA, the method is not necessarily available on a routine basis. In hospitals in Addis Ababa and Adwa, the team found that the MVA syringe and cannulas had been locked up while the gynaecologist was away.

The assessment team also observed that many women attending hospital because of the sequelae of unsafe abortion were not adequately informed about their condition or the treatment they were receiving. They rarely obtained counselling on family planning methods nor on how best to access contraceptive services.

STD diagnosis and treatment: Despite widespread recognition that levels of STDs and HIV/AIDS are high and are increasing nationwide, most health centres do not offer appropriate STD diagnosis and treatment. Few health providers are trained in the syndromic management of STDs and where services do exist they tend to be oriented towards what are often perceived as "high risk populations" such as men and sex workers. In some areas of the country, attempts have been made to integrate STD diagnosis and treatment with other reproductive health services such as post-abortion care, antenatal and postnatal care, but these remain the exception rather than the rule.

One of the more successful efforts to address the problem of STDs, including HIV/AIDS, was being undertaken in collaboration with the USAID-funded AIDSCAP Project. In the Tigray Region, three sites (Mekele, Maychew and Axum) received training,

drugs and IEC materials, and provided STD diagnosis and treatment as well as condoms to "multi-partner sexual control" (MPSC) groups and to local AIDS communicators.

In the Amhara Region, the AIDSCAP-supported programme established community and high school educational programmes on HIV/AIDS, and distributed condoms at some schools. At the service delivery level, AIDSCAP played a particularly critical role in training. At Bahir Dar Health Centre, for example, the STD clinic nurse (along with almost 1,000 others nationally) was trained in syndromic management. He, in turn, trained staff at other clinics in such areas as family planning and antenatal care, and provided backup support as well as antibiotics to these clinics. Education and condom provision has been organized for prostitutes. The Centre also contracted youth groups to assist community health workers in referring people for treatment or further consultation.

These examples, however, were few and far between. Furthermore, with the AIDSCAP project phasing out its activities, there is widespread concern throughout the health care community over the sustainability of ongoing STD and HIV/AIDS-related activities. The assessment team shared these concerns and strongly recommends that a review of all AIDSCAP-supported health centres be undertaken to determine the critical lessons relating to the sustainability of services; the transfer of expertise to family planning and antenatal care clinics; and to ascertain what is necessary to ensure that services are available more widely across the country.

Antenatal Care, Safe Delivery and Postnatal Care: As noted earlier, only an estimated 30% of pregnant women receive antenatal care; about 10% deliver at health care facilities; and only 3.5% receive postnatal care (Ethiopia, 1997c). The health facility based-Safe Motherhood Assessment carried out in 1996 revealed that most of the antenatal visits were done late in pregnancy. It also found severe deficiencies in the activities performed during the antenatal visits, particularly in the area of counselling and treatment of anaemia and malaria. The quality of care of normal deliveries was also found to be inadequate. TBAs were largely unable to recognize warning signs and did not refer women to health facilities appropriately. Not all hospitals and very few health centres provided essential care for obstetric complications. Health facilities suffered from chronic shortages of trained personnel and their personnel often received insufficient training and supervision. A minority of facilities had even the minimal equipment required for assisting mothers or neonates during and after routine delivery. For example, only 19% of health centres had a cloth or towel to dry the baby, and only 15% had material to wrap the newborn. None of the health stations had even these basic supplies.

During visits by the assessment team, it was evident that postnatal care services are offered by very few health facilities; and many providers were not even sure what services should be provided after delivery. One health worker attributed the low levels of postnatal care to traditional practices that prohibit mothers from leaving their homes within the first 45 days after delivery. Of the women who do attend for postnatal care, only a third report for a second visit. In the dissemination workshop it was suggested that home visits should be encouraged as part of postpartum care.

Emergency Obstetric Care: Emergency obstetric care was virtually non-existent outside Addis Ababa and the other major cities. Even in some of the Regional Hospitals, there was no

provision for blood transfusion; no one was trained in MVA; there was no anesthesia or even basic supplies such as gloves. Some Regional centres had no means for transporting women to the nearest referral hospital, despite heroic efforts by the hospital and community to bring them there. Access remains one of the most critical barriers to obtaining emergency obstetric care, and in the absence of a major investment in vehicles, particularly four-wheel-drive vehicles and their maintenance, it is hard to know how this problem can be overcome. Nevertheless, a significant effort must be made to improve the quality of essential obstetric care.

Recommendations:

- *A review of the activities of AIDSCAP-supported health centres should be undertaken to determine the critical lessons pertaining to sustainability of services; the transfer of expertise to family planning and antenatal care clinics; and the broader availability of services.*
- *Introduction of the syndromic management of STDs to a significantly larger number of health centres should take place and an appropriate supply of antibiotics should be ensured.*
- *Quality of care should be improved. Tools should be identified to assist health care providers and managers identify weaknesses and unmet needs in the service delivery system, and the appropriate strategies to overcome them.*
- *The quality of abortion and post-abortion care should be improved. Manual vacuum aspiration should be introduced into all regional and zonal hospitals and selected health centres. Post-abortion counselling and family planning services should be introduced in all facilities.*
- *Training in emergency obstetric care must be developed and provided to medical staff. Support should be given to provide wider coverage of such services. Appropriate procedures for each level should be identified and referral mechanisms should be strengthened.*
- *Results of the 1996 Safe Motherhood Needs Assessment should be reviewed and the policy on maternal and new born care should be finalized as part of a national reproductive health plan.*
- *Research should be undertaken to identify the reasons for low attendance at antenatal and postnatal clinics as well as for institutional deliveries. Interventions should then be developed to address them.*

Information

Just as important as the range of available services is the quality of information provided along with them. Adequate information increases access to services by making clients more aware of the options available to them. It also enables people to take greater responsibility for their own reproductive health by allowing them to make more informed decisions about their lives.

During the assessment, team members were able to observe and participate in activities where the dissemination of health-related information took place. These included individual counselling sessions as well as more open group discussions on reproductive health issues. The team frequently observed a reluctance by many providers to engage in open discussion with clients about the broader consequences of their actions. During the delivery of family planning services, for example, providers rarely referred to the side effects associated with the method being provided - even in the case of methods, such as injectables, where disruption of menstrual bleeding is known to be a major factor contributing to method discontinuation. Risk of STD transmission was also frequently ignored, even where the method being provided offered no protection against STDs.

Providers giving antenatal care services were often reluctant to offer general guidance and information in reproductive health. At one health centre in Addis Ababa, clients were observed being treated for hypertension and anemia, but with no explanation by the provider as to what these conditions were, what their implications for the pregnancy might be or, in the case of anemia, what actions the client should take in case of any unusual blood loss. Instead, the client was treated and simply dismissed. When asked by the team why further information was not offered, many providers appeared surprised at the question. Some even went so far as to say "if they ask, we tell them; if not, we don't".

Another example of inadequate provision of information was apparent during post-abortion counseling. In several regions visited by the team, interviews were carried out with women recovering from septic abortions. Patients often received little or no information on issues directly related to the treatment they received. Many post-abortion patients were not told how soon they could conceive again or what their contraceptive options might be.

The field visits showed providers to be heavily oriented towards curative interventions with little importance attached to providing information that could help their clients assume a greater responsibility for their own reproductive health and well-being. It is possible that many providers simply do not see "information sharing" as part of their job. This could, at least in part, explain the indifference shown by some providers at maintaining privacy during client sessions or the surprise of others at being asked to provide information without being asked. Alternatively, the reluctance to discuss broader reproductive health issues may simply reflect the inability of many providers to do so - either because they lack technical knowledge about the issues at hand or because they lack appropriate counselling skills. Many providers, for example, admitted feeling uncomfortable, even embarrassed, at raising the issue of STDs during family planning sessions unless they were specifically asked by clients.

Recommendations:

- *Existing IEC materials for both providers and the community should be reviewed and operations research undertaken to improve their content and dissemination.*
- *The experience of using mass media for the dissemination of key reproductive health messages should be reviewed.*
- *Training programmes for providers on client-provider relations and on reproductive health counselling should be developed.*

Technical Competence of Providers

In family planning, the issue of provider competence has traditionally focussed on the skills and knowledge required to provide contraceptive methods safely, especially those methods requiring some specialized clinical intervention. In the area of reproductive health, technical skills are also a central concern though obviously the range of skills, like the range of technologies, will be broader. The expectation that providers must implement a more comprehensive, holistic response to reproductive health means that the issue of technical competence is very much tied to a provider's knowledge about health issues beyond his or her own area of specialization.

During the visits to health care facilities, the assessment team encountered many dedicated, talented health care professionals, each carrying out his or her job tirelessly, often under arduous conditions, typically with limited technical support and almost always with minimal remuneration. It was also clear, however, that the knowledge and skills of many providers were simply inadequate to address the range of reproductive health needs demanded of them. The assessment team identified three factors that could account for this: inconsistent training, inadequate monitoring and supervision, and a lack of appropriate technical guidelines or manuals.

Training: While the training of providers is no guarantee of quality assurance, many weaknesses in provider competence can be attributed to poor or non-existent training. In the case of family planning for example, the assessment team regularly encountered providers who reported having to deliver services and advise clients without any previous training. This was particularly true at smaller health posts where fewer staff inevitably covered a broader range of needs, but it was also observed at larger facilities. Gaps in knowledge and skills were found in other areas of reproductive health care, particularly in the syndromic management of STDs, insertion of intra-uterine devices (IUDs), and manual vacuum aspiration, as well as in counselling, infection prevention, emergency obstetric and post-abortion care. Furthermore, as was pointed out by health officials in Bahir Dar, there were also shortages of skills in the planning and management of a decentralized health system.

Many of these shortfalls in skills and knowledge were symptomatic of more general problems in the current system for provider training. Both across and within Regions, the team found major variations in the length of time required for basic training of reproductive health providers as well as in the content of what they learned. Some were trained for two weeks, others for a month and still others for three months. The absence of a standard training curriculum contributed to disparities in knowledge and skills.

In addition to weaknesses in basic training, however, providers expressed concern at the lack of refresher, in-service or, on-the-job training. Indeed, as discussed earlier, the high level of turnover among health care staff may be directly related to the fact that it often represents the only means by which providers can actually broaden their expertise and technical knowledge.

Discussions with health care managers and administrators at the central and regional levels suggest that many of these problems have already been identified and that efforts are currently underway to resolve them within the framework of the national health reforms. In Amhara Region, for example, Health Bureau officials stated that the three regional training schools will soon increase their enrolment and that new national training curricula will be adopted.

Recommendations:

- *Training curricula should be reviewed to assess how training in reproductive health can be included for all categories of health personnel.*
- *Regular in-service training in reproductive health should take place. This ought to include, among other things, counselling, syndromic management of STDs, post-abortion care and IUD insertions.*
- *Training, updates and refresher courses are being conducted at different service delivery levels in the country. There is a need to resolve inconsistencies in these activities to ensure greater uniformity and an improved quality of reproductive health services.*
- *Key components of reproductive health should be included in the zonal planning process by providing orientation training in reproductive health to zonal planning teams.*

Inadequate monitoring and supervision: Assuring technical competence at the service delivery level typically requires a mix of monitoring techniques including routine supervisory visits, regular review meetings, and the systematic collection of service delivery and other health-related information. While all of these activities take place to some degree, the principal mechanism for assuring provider competence has tended to be supervisory visits by teams of health care officers. Regional teams are expected to supervise zones, the zones are expected to supervise woreda health activities and so on down the chain.

Most of the providers and administrators visited by the assessment team were well aware of public sector norms recommending that supervisory visits be carried out on a quarterly basis. And yet because of the resource limitations described above, particularly the lack of transport and skilled human resources, it is widely acknowledged that even one annual visit is probably more than most facilities can ever expect to receive. This is true not only for smaller, rural health care facilities, but even for relatively large urban-based centres. Indeed, one facility having reported no supervision visit in over 18 months was actually located in the same town as the Regional Board of Health.

Regional Health Bureaux have acknowledged the inadequacy of existing supervision systems and have begun to devise strategies to overcome the factors that affect them the most. In the SNNPR and in Tigray, for example, supervisory checklists have been developed so that teams can be

fielded even if their composition is not fully representative of the broad spectrum of health programmes. It is important that guidelines be developed and staff trained in facilitory supervision.

Recommendations:

- *Appropriate supervision and monitoring systems should be developed and applied at each level of the health system. These should include systems for the evaluation of quality of care, the identification of training needs, and the timely delivery of consumables and other commodities.*
- *A policy guideline on monitoring, evaluation and supervision should be developed by the Ministry of Health. The guideline should recommend the frequency of supervision at different levels, the need for written feedback to the facilities supervised and the supervision of community-based providers such as community health agents, traditional birth attendants, and community-based distributors.*

Reference materials: In 1996, the Ministry of Health published *Guidelines for Family Planning Services in Ethiopia* (Ethiopia, 1996c). Though limited in their scope, the guidelines nonetheless represented an important first step in efforts to ensure consistency and enhance the quality of reproductive health services in Ethiopia. Sadly, at the time of the assessment, few health centres had received copies and most providers were unaware of their existence.

Across Ethiopia, reproductive health services are being offered by providers who themselves have little, if any, on-site access to either reference materials or guidelines. This is true, both in the case of the Family Planning Guidelines and for an earlier publication, *Reproductive Health: A Family Planning Training Manual for Health Professionals in Ethiopia* (Ethiopia, 1994b), both of which could serve as important reference guides. The absence of materials is not a geographically limited problem: It is as likely to occur at major health facilities in Adwa, Mekele, or Dessie as it is in smaller rural facilities. Occasionally, the team found providers who still relied on handwritten notes from their initial basic training. For those providers who received no formal training, however, the situation is serious indeed.

Recommendation:

- *Existing guidelines for providers (such as the Family Planning Guidelines and any STD diagnosis and management guidelines) should be reviewed and updated as well as put into the context of reproductive health.*

Interpersonal Relations

A key component of quality is the relationship between the clientele and the health care facility as a whole. This relationship establishes the general tone or manner of interaction during individual service delivery sessions. It may reflect the way in which services are presented to clients, or the way in which facilities adapt their style of management to the needs of the community in general. In short, the concept of interpersonal relations sets the tone for the overall relationship between a health care facility and the community it serves.

During the assessment, team members explored the issue of interpersonal relations through interviews with providers and clients of reproductive health services, through group discussions with community members, and through observations at service

delivery points. While it is beyond the scope of this chapter to undertake an exhaustive analysis of provider/client relationships across the health care sector as a whole, the team made a number of critical observations.

Access to health services in most parts of Ethiopia is limited by distance; with the vast majority of the country's population living at least 10 kilometres from the nearest health facility. It was, therefore, easy for team members to empathize with the frustration and even anger expressed by many community members when they recounted instances of having traveled tens of kilometres to seek medical help, only to find the facility shut, or the provider away without any indication as to when he or she would return. Clearly, situations such as these will always arise, whether they are due to emergencies being attended by the providers, to human resource shortages, or to unforeseen circumstances. For service delivery facilities, it is critical nevertheless to appreciate and respect that seeking medical help often represents a significant sacrifice for the client, both in time and resources.

Another factor which influences interpersonal relations is attention to client privacy and confidentiality. The team found that while clients generally have little privacy, in some instances quite elaborate mechanisms have been established to ensure the confidentiality of STD testing results. At Gambela Hospital, for example, blood specimens and the results of the STD tests were locked away and only the laboratory technician had access to them. But in the same hospital, interviews were being conducted with post-abortion and family planning clients, as well as with young people, in settings so exposed that people in adjacent rooms could overhear the conversations. In one Addis Ababa clinic, the lack of curtains made it possible for bystanders to see Norplant and even IUD insertions being performed.

The team found a widespread perception, particularly among young people, that public sector health centres are unfriendly and unwelcoming. The consequences of this perception have been discussed previously but such perceptions can have a profound impact on the utilization of services by anyone who feels they may be judged harshly, for whatever reasons, by health care staff. This includes post-abortion clients, STD clients, or any other group who might feel threatened or judged. Provider attitudes significantly influence how clients view services and whether or not they should use them.

Despite the fact that many facilities were seen to maintain meticulous client records, and to actively encourage clients to return for resupply of contraceptive methods or for STD treatment, providers expressed concern that human resource shortages within the public sector virtually preclude any possibility of health care staff following-up or visiting the clients themselves.

Recommendation:

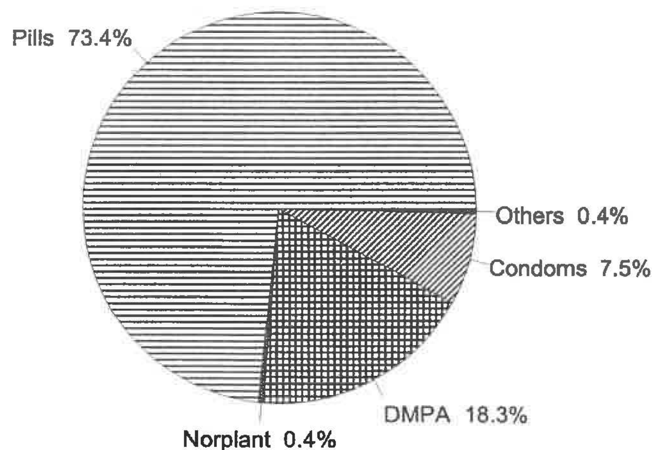
- *Interpersonal relations and the need for privacy and confidentiality in should be included in all health care training activities.*

EXPANDING CONTRACEPTIVE CHOICE

The range of modern contraceptive methods theoretically available to clients in Ethiopia is broad. According to the review *Contraceptive Requirements and Logistics Management Needs* (Ethiopia, 1997a), over six brands of oral contraceptives are available (Microgynon, Neogynon, Lo-Feminal, Marvelon 28, Exluton, and Microlut), in addition to injectable contraceptives (Depo-Provera, Noristerat), condoms, the IUD, sterilization, foaming tablets (Neo Sampoon), and even Norplant in selected urban areas. Despite this apparent broad method availability, however, there is neither a high contraceptive prevalence nor a broad method mix. As shown in Figure 4, over 90% of current family planning clients use either oral contraceptives or the injectable Depo Provera.

Various explanations have been given to explain why utilization of the full range of methods is not greater. Some focus on factors that hinder the supply of methods through the service delivery system while others emphasize factors that influence client demand. Few efforts, however, have taken a closer look at the actual range of methods itself to determine whether it is, in fact, truly appropriate within the Ethiopian context. In other words, rather than assuming that more methods invariably lead to greater contraceptive choice, what is needed is some determination as to what would constitute an appropriate range of contraceptive methods given users' needs, the existing capacity of the public sector health care system and available methods. By adopting the WHO strategic "user/system/

FIGURE 4
Contraceptive Method Use (Ethiopia, 1997c)



technology" framework described earlier, this assessment has attempted to address this issue by posing the following three questions: Is there a need to explore the introduction of a new contraceptive technology in Ethiopia? Are there existing methods for which better utilization should be explored? Is there reason to discontinue already available methods?

Of the methods currently available through the public sector, several appear to have the potential for increased utilization: injectables, condoms, surgical sterilization and, possibly, Norplant and the IUD. With respect to the introduction of new contraceptive technologies, the assessment identified emergency contraception as potentially playing a critical role in limiting unwanted pregnancies and reducing the need for unsafe abortion. It is, however, important to recognize that although the following recommendations for contraceptive introduction reflect findings at the field level, there is a critical need to prioritize the availability of these methods in terms of cost, organizational capacity and operational feasibility. Moreover, it must be stressed that other than condoms, no method offers protection against STDs/HIV.

It is important to acknowledge that in addressing the issue of contraceptive choice, one broad category of family planning methods is absent from the present discussion. That includes *natural methods* such as exclusive breastfeeding, sexual abstinence, the "rhythm method", withdrawal, as well as a wide range of *traditional methods* for which effectiveness and even safety have yet to be established. Research from studies such as the 1990 *National Family and Fertility Survey Report* (Ethiopia, 1993) have shown that both groups of methods constitute important components of Ethiopia's overall method mix, especially in rural areas. Furthermore, some of these methods, such as exclusive breastfeeding, have been shown to have a demonstrable impact on the health and well-being of both the mother and child. The omission of natural and traditional methods from this discussion should in no way be interpreted as diminishing their role in expanding contraceptive choice. It is recommended that further research be undertaken to improve the quality of natural family planning through expanding and improving existing counselling services and dissemination of appropriate information.

Injectable Contraceptives

While injectable users represent less than a quarter of the total number of women who use the pill, providers, programme managers, and even users, indicate that injectables constitute an important component of the method mix. They offer anonymity since they may be administered outside the home, and beyond the watchful eye of anyone opposed to their use. They do, however, have side-effects, particularly disruption of menstrual bleeding, which requires adequate counselling.

While it is difficult, given the nature of the assessment, to quantify the current unmet need for injectable contraceptives, there are a number of factors that do seem to constrain their wider use. Supply shortages have had a major impact, not just on the availability of the method, but possibly even on the demand for it. Experience from other countries, for example, suggest that one of the most important factors influencing client selection of a contraceptive method is its perceived long-term availability. Visits to health care providers in Tigray, Amhara, and parts of Oromia, have shown that stockouts of injectables are common. Injectable users, if they wish to continue with the method, must either choose an alternative during the

interim or seek out the occasional supplies of injectables that become available in the marketplace.

Another issue relating to the use of injectable contraceptives are the fears and rumours associated with its use, particularly concerns surrounding menstrual irregularities and their longer-term impact. Thorough, accurate counselling is critical to the use of injectable contraceptives as they do disrupt bleeding patterns and induce weight gain. Since counselling skills were observed to be weak, training in this area must be addressed if injectable contraceptives are to be used more widely. Moreover, it is critical that where injectable contraceptives are provided, adequate attention be paid to good injection practices.

Recommendation:

- *Users' perceptions of the use of injectable contraceptives should be evaluated.*
- *The introduction of injectables at all levels of the system should be expanded subject to the availability of provider training on counselling and safe injection practices.*

Condoms

While barrier methods currently offer the only protection against STDs, condom users still constitute less than 8% of all family planning users in Ethiopia. Although theories abound as to why the condom remains so underutilized, one potentially important factor has been the tendency to associate condom use with STD protection only.

Based on interviews with clients and providers, the exclusive association between the condom and STD protection can be attributed to a number of factors. The first has been the tendency for advocacy efforts to target those believed to be at greatest risk of STDs, such as the young, commercial sex workers, and those living in cities or along major trade routes. Youth associations, for example, routinely direct their reproductive health interventions towards reducing STD transmission, either through abstinence or the promotion of "safe sex". Public sector interventions have similarly focused STD interventions on "high risk" groups such as commercial sex workers.

While interventions directed towards certain "high risk" groups are important, the approach can also have a number of negative consequences. It can, for example, lead to a false sense of security on the part of those who do not fall within the "high risk" groups, thus disregarding the fact that the overall risk for STDs and HIV, at least in urban areas, is substantial. Furthermore interventions promoting condoms for the prevention of STDs may fail to emphasize the fact that condoms also prevent pregnancy.

A second factor contributing to the exclusive association between the condom and STD protection are institutional divisions between public sector programmes that effectively drive a wedge between the distribution of condoms for STD protection and family planning use. At the central level there has been little coordination between the divisions of Family Health and HIV/AIDS over condom use. This is reflected at the Regional level, where the divisions not only report condom use separately but seem to have very different views on the utility of the method itself. At one Regional Health Bureau, for example, health care managers were quite open in questioning the utility of condoms for family planning, claiming that they only "bring down our calculations of CYP".

Finally, the third factor limiting wider condom use has been supply shortages of the method itself. While the magnitude of such shortages was difficult to gauge, the team was often told of disruptions in condom distribution activities attributable to stockouts at major storage points, particularly within the context of community-based programmes. Considerable evidence in the literature supports this view (Mehret et al, 1996).

Although the observations presented above may help to explain why current condom use is low, further information is needed in this area. In the case of the female condom, expanding utilization presents still other challenges. For one thing, it is a method with which few women or even providers are familiar. Another important issue associated with the female condom is that of cost.

Recommendations:

- *Research should be undertaken to understand the reasons for non-use of condoms. It should review the experience of social marketing and community-based distribution programmes to determine what groups are currently using condoms, for what reasons, etc.*
- *Insofar as condoms offer the only reliable protection against transmission of STDs, including HIV/AIDS, efforts should be made to increase their utilization, including, if feasible, that of the female condom.*
- *A pilot study of the female condom should be undertaken within the context of broad method choice. The study should explore such issues as cost, acceptability, and unmet need – with the latter focusing specifically on the method's unique niche within the overall method mix.*

Norplant

Norplant contraceptive implants have been available in Ethiopia since 1994, when delivery of the method was initiated at five health care facilities in Addis Ababa. Within months, Norplant services were expanded to include six additional sites. This expansion was followed by a series of orientation workshops designed to familiarize providers with the method and to establish the framework for a formal referral system. By the end of 1996, the Ministry of Health reported a total of 3,300 insertions, and slightly less than 200 removals. In 1997, the Ministry of Health expanded availability of the method beyond Addis Ababa into Amhara, Oromia, Tigray and SNNPR. Today, Norplant services are available in more than 24 health facilities nationwide.

During visits to the field, the assessment team visited a number of these service delivery points, observed the quality of Norplant services available, and obtained from providers their impressions and concerns surrounding the method itself. While Norplant implants have become popular within the country, the team also saw that its recent expansion had brought with it many logistical and other operational constraints. One such constraint were periodic stockouts of the method itself.

Of greater concern to the assessment team, however, was the ability of existing training programmes to transfer the knowledge and skills required to offer Norplant services with appropriate quality of care. One provider at Bahir Dar, for example, reported having performed 52 insertions in the past 3 months but had still not been trained in removal techniques. Similar concerns were expressed elsewhere. One provider at

Axum had performed only two insertions and one removal during his in-service training.

Another concern was the lack of adequate mechanisms for client follow-up, specifically systems for contacting Norplant users for implant removal after five years. One provider in Bahir Dar was extremely conscientious about telling clients to come back after five years. However, when questioned, she freely admitted having no idea whether the clients would ever do so or how they could be contacted when the time came.

Clearly, there is a need to review certain key elements within the current service delivery programme for Norplant (e.g. supplies, training, follow-up, counselling) to determine whether the weaknesses viewed by the team are representative of Norplant provision in general and, if so, how best they might be overcome.

Recommendations:

- *An assessment of the introduction to date of Norplant implants should be undertaken.*
- *The introduction of Norplant implants should be undertaken in a phased and controlled manner; training should be provided through "centres of excellence" such as Black Lion Hospital and FGAE; and all services should be supported with appropriate logistics back-up. Training must comprise an adequate number of insertions, removals and counselling to ensure appropriate follow-up and tracing.*

IUD

Given the strong bias towards hormonal methods within Ethiopia's overall contraceptive method mix, the IUD could meet the needs of certain women for whom hormonal methods are not appropriate. Yet, in urban areas, it is used by only 3% of married women. In rural areas usage is virtually non-existent (Ethiopia, 1993).

Though providers in the field often remark that there is little demand for the IUD, visits undertaken during the assessment suggest that perhaps one of the most critical factors contributing to the lack of demand is the inability of service providers to offer the method with adequate quality. Providers often cannot perform pelvic exams, health centres are unable to undertake STD diagnosis and management, and in many cases, they lack adequate equipment to insert them.

Given the current prevalence of STDs in Ethiopia, the geographic isolation of the population as a whole, and the supply and logistics problems facing health care facilities in general, there are no easy answers to these quality of care issues. The design of appropriate service delivery models will need to weigh such factors as the feasibility of on-site diagnosis of STDs; the potential for referral (for STD diagnosis and treatment and IUD insertion); and/or the health implications of combined STD diagnosis and treatment regimens. All of these factors must be assessed relative to their potential costs and the likely demand for IUD services in general. Even at health care facilities that currently offer

quality insertions, the IUD rarely makes up a sizable proportion of the overall method mix. At the FGAE clinic in Dessie, for example, IUD users represented only 4 per cent of the centre's family planning clients, a figure only slightly above the national average for the method.

While it is doubtful the IUD will ever represent a major proportion of the overall contraceptive method mix, provision with appropriate quality of care could provide women with an effective alternative to hormonal contraception.

Recommendations:

- *The potential role of the IUD within the national family planning programme should be explored further in conjunction with appropriate STD diagnosis and treatment.*
- *Practical models for the delivery of quality IUD services should be identified, particularly in rural areas where the capacity for adequate STD diagnosis and treatment is problematic. Efforts should focus on the appropriate use of existing human resources, equipment and infrastructure.*

Surgical Contraception

Sterilization, particularly tubal ligation, makes up between 0.4% and 2.5% of Ethiopia's contraceptive method mix (Ethiopia, 1997a; Ethiopia, 1997c). However, based on discussions with both providers and clients, this low utilization does not reflect any lack of demand, but rather the limited supply of sterilization services within the public sector health care system as a whole. Three factors appear to be critical in accounting for this. The first is the shortage of staff trained to perform minilaparotomy. With very few exceptions, the availability of sterilization in public sector hospitals has depended on linkages with FGAE, particularly their regional offices where the majority of trained providers are located. In Awasa Hospital, for example, all sterilization services were provided by staff from the local FGAE office. In other parts of the country such as Bahir Dar and Dessie, public sector facilities depended on FGAE for training, for the supply of certain medical supplies, and even, in some cases, for the provision of administrative materials such as consent forms.

The second reason cited for the limited supply of sterilization services is the greater priority given to curative or emergency obstetric services, many of which draw on the same infrastructure, equipment and supplies.

Finally, the third factor is the lack of motivation and commitment on the part of medical staff themselves. In a resource-poor environment, the provision of sterilization services implies staff commitment, not just to obtain the necessary training, but to recognize and respect the rights of those women who wish to obtain it. Unfortunately, such commitment is often lacking. At a number of health care facilities, for example, sterilization services were perceived as a luxury; in some cases they were described as "time consuming" relative to non-permanent methods, and in others "wasteful" in that they stood to drain supplies and equipment potentially required for more "critical services".

Surgical contraception could play a critical role in meeting the needs of the millions of Ethiopian women who no longer wish to have more children. For this role to be realized, however, greater efforts are required to increase the numbers of trained staff, as well as expand the availability of materials

and equipment required to perform services with appropriate quality of care.

The other component of surgical contraception, namely male sterilization or vasectomy, was not directly observed by the assessment team, largely because its availability is even more limited than that of tubal ligation. But this should not be seen as an indication that demand for such services is non-existent. The fact is, research on male knowledge and attitudes about vasectomy is extremely limited in this country. FGAE and Marie Stopes are currently offering vasectomies and, according to them, demand for the method exists. Given the expertise of these organizations in providing male sterilization, participants at the reproductive health needs assessment dissemination workshop recommended that all training in male sterilization, including that offered at Addis Ababa University, be better coordinated with them.

Recommendations:

- *Efforts should be made to educate medical staff on the importance of providing sterilization as a contraceptive option. Training of staff should be expanded and arrangements made in conjunction with FGAE to provide sterilization services throughout the country.*
- *A pilot study should be undertaken on the provision of vasectomy.*

Emergency Contraception

During visits to communities and health centres, the assessment team frequently encountered women who claimed they did not want to be pregnant, who appeared reasonably well informed about modern contraception and who had access to either public or private health care facilities but who still had not adopted a regular family planning method. Some of these women attributed their decision to the irregularity of their sexual relations, others to the cost of the contraceptive methods themselves. Whatever the rationale, for many of these women, the outcome of their decision was evident either in unwanted pregnancies or in the health consequences of having recently undergone an abortion.

There is no doubt that assisting women to achieve their reproductive intentions will best be accomplished by encouraging the adoption of routine family planning methods. It is also clear, however, that short of this, mechanisms must be in place to assist women who, either because of method failure or unprotected sex, are at risk of an unwanted pregnancy and wish to do something about it.

Emergency contraception, could play a critical role in limiting unwanted pregnancies, reducing the need for unsafe abortion, and, ultimately, in lowering rates of maternal morbidity and mortality. It could also give providers an additional tool for rape management. While there are different forms of emergency contraception, the most commonly used involves taking a number of high-dose oral contraceptive pills within 72 hours of unprotected sex followed by additional number 12 hours later. The actual number of pills will vary depending on their hormonal composition. The pills themselves may be taken from a pack of high-dose pills or from those specially packaged for emergency contraception.

The use of oral contraceptives for emergency purposes has been advised by health care providers for decades. Although the method is both safe and effective at preventing pregnancy, it should not, by any means, be considered a "family planning miracle". The efficacy of pills taken after

unprotected sex, for example, is not as great as that of pills taken on a daily basis. And because the dose of pills required for emergency contraception is higher than one would normally take in a single day, women using emergency contraception are more likely to experience side effects such as nausea and vomiting. Despite the shortcomings of this method, however, for women who experience unprotected sex – whether due to rape, condom breakage, method misuse or any other number of reasons – emergency contraception remains the only safe way to avoid an unwanted pregnancy or abortion. For these women, therefore, the choice is not between emergency contraception or some other more "effective" method; it is between emergency contraception and nothing at all.

Despite its potential for addressing the reproductive needs of so many women, emergency contraception still remains unknown to most providers. Consequently, the assessment team recommends that a pilot study be undertaken to explore the service delivery implications and reproductive health impact of introducing emergency contraception services. One group that clearly stands to benefit from this method is younger women who, as noted earlier, have traditionally been reluctant to adopt more routine family planning methods. In addition to unwanted pregnancies, one frequently overlooked advantage of this method is that it can encourage use of regular family planning methods (Ahmed et al. 1998).

Recommendations:

- *A pilot study should be undertaken on the provision of emergency contraception as one of a broad range of methods available at all service delivery points.*

Given the magnitude and range of Ethiopia's reproductive health needs, it is clear that any resolution of those needs will require the involvement and active participation of many players. The health sector will obviously have a pivotal role to play in this process, but as discussed in the chapters on gender and youth, the reproductive health environment is as much influenced by events and decisions within the educational, religious and legal sectors, as it is by the provision of health care services *per se*. Implementing the research agenda and action steps proposed in this report, therefore, will therefore require a multisectoral approach – one that draws on the support and involvement of society as a whole.

The Dissemination Workshop

A central element of the WHO Strategy is the participation of a broad range of stakeholders at key decision points in the assessment process. Prior to the field visits, for example, a seminar was convened in the town of Debre Zeit to allow stakeholders from across the country to identify issues deemed most critical for the assessment process. During the fieldwork itself, providers, decision makers, and community members were asked to provide insight into the current reproductive health environment, and to suggest how best to overcome existing problems. Finally, in August 1998, a national dissemination workshop was convened. Held in Nazareth, the event brought together over 75 stakeholders from all eleven Regions of the country.

Of the workshop's key objectives, one of the most critical was the identification of strategies for translating the report's recommendations into action. Rather than stopping at the production of a final publishable document, the workshop became the principal forum through which the third objective of this assessment could be realized: operationalizing the broader concept of reproductive health.

To guide participants, five broad questions were developed. Each question required that the assessment's findings be reviewed in terms of their legal and policy implications (both within and outside the health sector); their resource requirements (human, physical, and financial); their operational consequences (for training, supervision, etc.); their informational prerequisites; and their implications for applied research. Most of the preliminary results of these discussions have already been incorporated into this report. It was agreed that this exercise would be continued under the workplan of the Ministry of Health.

Gaps and Imbalances

The assessment undertook a broad view of reproductive health needs putting them in a societal context and looking at them from the perspective of the user as well as that of the service delivery system. As with any assessment, this one also had its limitations. The assessment focussed primarily on issues concerning reproduction and sexually transmitted diseases. In the area of family planning, traditional practices to control fertility, such as extended breast feeding, abstinence and natural family planning methods were not

evaluated. As traditional methods of fertility control are commonly used, further exploration of this issue should be undertaken. Concerning safe motherhood, the assessment relied partly on the 1996 Safe Motherhood Needs Assessment. Neither the Safe Motherhood Assessment nor this assessment focussed on the health and care of the new-born.

Although the assessment addressed sociocultural practices that are harmful to women, it did not include many important noninfectious problems of the female and male reproductive system, such as vesico-vaginal fistulas, uterine prolapse, urethral strictures/fistulas, varicocele or malignancies. As was pointed out in the chapter on the Gender and Social Context of Reproductive Health, there is a need to explore men's reproductive health needs and perceptions. Such issues would include male attitudes towards the desired number and sex of children, family planning information and services, and issues relating to sexually transmitted diseases. While there was a focus on the reproductive health of adolescents, that of older people was not addressed.

With regard to health service provision channels, the assessment focussed mainly on the public sector. At a time when the role of the private sector is increasing, this may be seen as a limitation, and was raised as such by participants in the dissemination workshop. Because the private sector encompasses a very diverse field in terms of the range of services offered, a fuller assessment of the private sector services, including both the non-profit and the for-profit sectors, is warranted. This should focus on quality of care, as well as the level of fees charged and populations served. In addition, it is important to explore how best to ensure that the standards, guidelines and monitoring tools developed for the public sector are applied to the private sector.

The Way Forward

Reproductive Health as a Priority

The issues behind making reproductive health a priority and the need to raise awareness of and increase information on reproductive health are discussed earlier. The chapter "Reproductive Health as a Priority" emphasized the need to ensure that relevant governmental and non-governmental organizations at national, regional, zonal and woreda levels are made aware of and understand the importance of the concept of reproductive health and the need to incorporate it into all health services and social strategies.

The federal government should begin to develop a national reproductive health plan which provides strategies and guidelines for implementation. This plan must, in the context of the overall national health plan, take into account the multisectoral nature of reproductive health through the involvement of other key ministries such as Labour and Social Affairs, Education and Planning.

The collection of reliable information through the development of management information systems is essential as is the government's role in advocacy and training.

Recommendations:

- *National and regional exercises should be undertaken to reach consensus on the appropriate scope of reproductive health, to identify needs and priorities, and to develop strategies for the implementation of priority interventions.*

- *There is a need for improving the knowledge and awareness of health providers, managers and policy makers of the national policies governing the provision of reproductive health.*

- *Management information systems should be developed to respond to reproductive health planning, management, supervision, and monitoring needs. Those regions which do not have basic reproductive health planning information should be assisted in generating such information.*

- *Health care decision makers at all levels need to be informed about reproductive health and be trained to plan reproductive health strategies.*

- *There should be more collaboration and networking at all levels of the health system to provide better information on reproductive health and to ensure continuing commitment by all concerned.*

The Challenge of Operationalizing a Reproductive Health Approach

With the advent of a more holistic definition of reproductive health, the need to remain focused on client needs becomes especially critical since these needs can often be overlooked in the quest "to operationalize" the new concept. The concept of reproductive health, for example, holds that the physical, mental and social aspects of the reproductive system are bound together. But it does not necessarily follow that in order to address all those aspects effectively, all health services themselves must be bound together; and that with the abandonment of vertical programmes must come the abandonment of services focussed on specific health issues.

The major challenge facing most regions in the country is to provide access to quality health services. Enormous infrastructure projects are underway and there are plans to build zonal hospitals and hundreds of health stations. This will, to some extent, allow certain components of reproductive health to be better serviced. As this report indicates, addressing many of the essential components of reproductive health remains problematic. In fact, many of them are so great that it will take major economic and social changes to address them. However, some of the critical issues to be addressed when operationalizing reproductive health services are discussed below.

A major reason for maternal death during delivery is the lack of access to a trained health worker, either because there is no health facility to attend or because it is too far away. While an increased number of health facilities can improve this situation, they will only do so if there is a greater emphasis on training providers in emergency obstetric care. Moreover, it is essential that TBAs be trained to identify potential obstetric complications as early as possible so that women can be transported to a health facility. Transport, however, also represents a problem for which there are no easy solutions other than massive investment in vehicles and maintenance facilities.

This report addresses the need to diagnose and manage STDs, not just as an independent service but as part of family planning and antenatal services. Historically, the public sector has tended to separate STD diagnosis and management from other reproductive health services, as far down as the woreda level. While this separation may be traced to administrative divisions between

different vertical programmes, its consequences are evident in the degree to which access to STD diagnosis and treatment is differentiated by gender, age and parity. For those seeking existing MCH/FP services, for example, the division obviously creates barriers since it requires clients to go elsewhere for attention. It forces them to undergo separate registration procedures, and because of separate data collection activities, it hinders the linkage of information that could be useful for addressing other reproductive health issues. By the same token, however, services must also be provided where they will be best accessed. For example, if STD diagnosis and management is only available with family planning and antenatal services, it leaves men and young people with little recourse but to accessing services there, something they are typically unwilling to do. Thus, a systematic look at the different ways in which STD diagnosis and treatment are offered is necessary so that the needs of those who seek such services can be better met.

The report also addresses at length the issues surrounding the reproductive health of young people. It outlines several approaches to reaching young people. Few young people, whether in-school or out-of-school, have access to information which would allow them to address their reproductive health needs and access services should they require them. Again, this requires a coordinated effort among the Ministries of Health, Education and Labour and Social Affairs.

Improving reproductive health, however, involves far more than increasing access to health facilities. It is significantly influenced by personal behaviour and the attitudes and practices of the community. This report touches upon many of the social practices that affect the lives and reproductive health of many women, either positively or adversely. These issues can only be addressed by increasing community involvement. Communities must be helped to identify and address their reproductive health problems and needs, including the effects of certain traditional practices on the health of women. This awareness creation is not easy and can only be undertaken across sectors and again requires joint action at Ministerial levels.

Action to be Taken by the Ministry of Health

As a result of the conclusions and recommendations arising from the needs assessment and their endorsement at the dissemination workshop, the Ministry of Health was charged with the following actions:

1) to coordinate the development of a national reproductive health strategy and to identify gaps in the national policies on health, population, women and drugs that would affect implementation of such a strategy;

2) to begin dissemination of the findings of the needs assessment and begin discussion of the concept of reproductive health at the regional level;

3) to initiate the development of a national research agenda based upon the recommendations of the needs assessment and the priority areas agreed to within the Health Sector Development Programme.

4) to reactivate the National Reproductive Health Task Force and assist it to implement the recommendations of the needs assessment. The Task Force should comprise representatives of all relevant Ministries, in particular, Health, Labour and Social Affairs, Education, Ministry of Economic Development and Cooperation (MEDAC), and Planning. It should also include those national, governmental and non-governmental organizations that can provide intersectoral support (whether advocacy, financial, legal or service provision) to reproductive health; and

5) to begin implementation of activities in reproductive health through the UNFPA sub-country programme, while involving other multilateral and bilateral donors in funding many of the activities required to address the recommendations contained in the present needs assessment.

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