



AFRICAN POPULATION AND HEALTH RESEARCH CENTER

The Packard Foundation's Ethiopia Population Sub-program

**The Packard Foundation's
Ethiopia Population Sub-program:
An Evaluation Report for the Period 1998-2007**

**Blessing Mberu, Jean Christophe Fotso, Alex Ezeh,
Hildah Essendi, Chimaraoke Izugbara and Latifat Ibisomi**

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Promoting the well-being of Africans through policy-relevant research on population and health

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List of Acronyms

ACIPH	Addis Continental Institute of Public Health
ACSI	Amhara Credit and Saving Institution
ADA	Amhara Development Association
AIDS	Acquired Immunodeficiency Syndrome
APHRC	African Population and Health Research Center
ARH	Adolescent Reproductive Health
ARI	Acute Respiratory Infection
ASFR	Age Specific Fertility Rate
ASRH	Adolescent Sexual Reproductive Health
BCC	Behavior Change Communication
CAC	Comprehensive Abortion Care
CAFS	Center for African Family Studies
CBO	Community Based Organization
CBRH	Community Based Reproductive Health
CBRHA	Community Based Reproductive Health Assistant
CBRHP	Community Based Reproductive Health Program
CHA	Community Health Agents
CIA	Central Intelligence Agency
COPEs	Client Oriented Provider Efficient Service
CORHA	Consortium of Reproductive Health Associations in Ethiopia
CPR	Contraceptive Prevalence Rate
CPY	Contraception Person Years
CRDA	Christian Relief Development Association
CS	Case Study
CSA	Central Statistical Authority
DFID	Department for International Development
DR	Desk Review
DSW	The German Foundation for World Population (Deutsche Stiftung Weltbevölkerung)
DTRC	Demographic Training and Research Center
EDHS	Ethiopia Demographic and Health Survey
ENMA	Ethiopian Nurse Midwives Association
EmOc	Emergency Obstetric Care
EOC-DICAC	Ethiopia Orthodox Church- Development and Inter-Church AID Commission
EPHA	Ethiopian Public Health Association
EPR	Environment and Policy Review
ESOG	Ethiopian Society of Obstetricians and Gynecologists
ETB	Ethiopian Birr
FGAE	Family Guidance Association of Ethiopia
FGD	Focus Group Discussion
FHI	Family Health International
FP	Family Planning
GBV	Gender Based Violence
GO	Government Organization
GPSDO	Guraghe People's Self-Help Development Organization
HAPCO	HIV/AIDS Prevention and Control Organization
HBC	Home Based Care
HEEC	Health Extension and Education Center
HEW	Health Extension Worker
HIV	Human Immunodeficiency Virus
HSDP	Health Sector Development Program
HTP	Harmful Traditional Practices
ICOMP	International Council on Management of Population Programmes
IDI	In-depth Interview
IEC	Information Education and Communication
IGA	Income Generating Activities
IIE	Institute of International Education

INSYGHT	Initiative to Save the Young Generation's Health Today
IPPF	International Planned Parenthood Federation
IPO	Implementing Partner Organization
IUD	Intra-Uterine Device
IUCD	Intra-Uterine Contraceptive Device
KII	Key Informant Interview
LAPM	Long Acting and Permanent Methods
LDM	Leadership Development Mechanism
LTPM	Long-term and Permanent Contraceptive methods
MAPP	Medical Association of Physicians in the Private Sector
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MIS	Management Information System
ML/LA	Mini Laparotomy under Local Anesthesia
MOEAED	Ministry of Education and Economic Development
MOH	Ministry of Health
MSIE	Marie Stopes International Ethiopia
NGO	Non-governmental Organization
NOP	National office of Population
OB/GYN	Obstetrician and Gynecologist
OCSSCO	Oromiya Credit and Saving Share Company
ODA	Oromiya Development Association
OE	Organizational Effectiveness
OICE	Opportunities Industrializations Center Ethiopia
OJT	On-the-Job Training
OVC	Orphaned and Vulnerable Child
PAC	Post-Abortion Care
PACNet	Post Abortion Care Network
PASDEP	Plan for Accelerated and Sustained Development to End Poverty
PHI	Public Health Institute
PLP	Population Leadership Program
PLWHA	Person Living with HIV/AIDS
PMC	Population Media Center
PNA	Performance Needs Assessment
PNC	Postnatal Care
PPH	Post-partum Hemorrhage
PRB	Population Reference Bureau
PRSP	Poverty Reduction Strategy Program
PSFI	Private Sector Franchise Initiative
RH	Reproductive Health
RHR	Reproductive Health Rights
REST	Relief Society of Tigray
RNE	Royal Norwegian Embassy
RTI	Respiratory Tract Infections
SDA	Secondary Data Analysis
SDPRP	Sustainable Development and Poverty Reduction Program
SNNPR	Southern Nations Nationalities People's Republic
SRH	Sexual and Reproductive Health
SRHR	Sexual Reproductive Health Rights
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
TGE	Transitional Government of Ethiopia
TOT	Training of Trainers
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
UNESCO	United Nations Education, Social and Cultural Organization.
UNFPA	United Nations Population Fund

USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
VLP	Visionary Leadership Program
VSC	Voluntary Surgical Contraception
VVF	Vesicovaginal fistula
WIC	Walta Information Center
YFS	Youth Friendly Service
Y2Y	Youth to Youth

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Foreword

The African Population and Health Research Center (APHRC) is an international research institute committed to conducting high quality and policy-relevant research on population, education and health issues facing sub-Saharan Africa. The Center brings together African scholars to take the lead in developing and implementing priority research programs and enhancing the use of research findings for policy formulation and program improvement in the region. APHRC's mission is to promote the well-being of Africans through policy-relevant research on key population, education and health issues affecting the continent. The Center seeks to contribute to science, especially knowledge that can inform better understanding of population, education and health issues in sub-Saharan Africa through the development and implementation of projects and programs, and the publication of its research in leading peer-reviewed journals in the fields of population, health, education and development. The Center's research efforts are organized into four thematic areas of work, namely urbanization and well-being, population and reproductive health, health challenges and systems, and education.

Executive Summary

Ethiopia is the second most populous country in Africa with an estimated 77 million people, whose median age is 18 years, and 43 percent of whom are below 14 years of age. With a population growth rate of 2.5 percent, Ethiopia is one of the fastest growing populations in the world and will exceed 150 million people by 2040 (UN 2007). Following the recognition that the country's population and reproductive health indicators were neither optimistic nor consistent with national aspirations for food security, universal primary education, increased access to health services, extended employment opportunities and overall economic development goals, the Ethiopian Government adopted a population policy in 1993, to harmonize the country's population growth rate with its national economic development agenda. In furtherance of these goals, the government established the National Office of Population (NOP) with the responsibility of coordinating institutions and ministries involved in population activities and launched the Health Sector Development Program (HSDP) and the Poverty Reduction Strategy Program (PRSP).

The Population Program of the David and Lucile Packard Foundation invests in pioneering organizations and individuals that strive to give women and their families the ability to decide the number of children to have and when to have them, and to receive proper medical attention when they do. For 40 years, the Foundation has focused on tackling major reproductive health challenges in some of the least developed countries in the world and in the United States. Identified as having an unmet need for family planning and reproductive health information and services, Ethiopia is one of the five countries of the developing world, where the Foundation's country-level grant making is concentrated. The other four countries are India, Nigeria, Pakistan, and the Philippines. The Ethiopian Population Sub-program was established in 1998 to increase access to quality family planning and reproductive health services, especially among young people. The Foundation is among the major international organizations that provided technical and funding support for the population, family planning and reproductive health (FP&RH) programs of the Ethiopian Government. From 1998 through 2007, the Ethiopia sub-program awarded 80 grants worth about US\$67 million. This report is part of the current review of the sub-program's overall strategy to assess the effectiveness of grants and investments in achieving program objectives.

The sub-program's grant-making areas in Ethiopia fall under three broad strategies:

1. Expanding family planning and reproductive health (FP&RH) service delivery
2. Improving adolescent sexual and reproductive health (ASRH)
3. Creating an enabling environment for family planning and reproductive health.

On expanding family planning and reproductive health service delivery, grant awards were made in seven key project areas: Expanding FP/RH through Community-Based Programs, Expanding Access to FP through Private Sector Franchise Initiatives (PSFI), Improving Access to Long-Term and Permanent Contraceptive Methods (LTPM), Expanding Access to Family Planning Through Social Marketing, Reducing Maternal Morbidity & Mortality and Preventing Unsafe Abortion, Empowerment of Women through Linking FP/RH/Population Services with Micro-Credit, And HIV/AIDS Prevention and Integration with Reproductive Health.

Under the improving adolescent sexual and reproductive health (ASRH) strategy, grant awards were made in two project areas: Improving Adolescent Sexual and Reproductive Health (ASRH) and Improving Adolescent Livelihoods Through Life Skills and Vocational Training And Access to Micro Credit. On the strategy for creating an enabling environment for family planning and reproductive health, grant awards were made in three project areas: Developing Reproductive Health Leaders, Advocating for Reproductive Health and Rights (RHR), and Building Organizational and Institutional Capacity.

The evaluation utilized a mix of methods to answer both the overall question of the impact of the sub-program on the broad demographic and health goals of the Ethiopian Government and the more specific questions on the success of particular strategies, along with the related management, coordination, collaboration, and leveraging activities carried out by the Foundation staff and country representatives. The methods used include desk reviews of relevant reports and documents and secondary analyses of nationally representative data from the 2000 and 2005 Ethiopian Demographic and Health Surveys. To answer some more specific questions focusing on perceptions of stakeholders on the sub-program and its key successes and weaknesses, primary data were collected using Key Informant Interviews (KII) and In-Depth Interviews (IDIs) of key stakeholders including the Foundation's officials and grantees, Ethiopian Government officials, staff of development partner organizations, NGOs and CBOs in the field of population and RH. Environment and policy reviews (EPR), and critical and in-depth analyses of specific strategies or projects through case studies also yielded additional evaluative information.

Contributions of the Packard Foundation's Funded Projects to National and Regional Population and Reproductive Health Indicators

The key objective of this section of the evaluation was to determine the contributions of the Packard Foundation's Ethiopia Sub-program to national population/reproductive health indicators between 1998 and 2007. The specific task was to identify the changes that have occurred over the past decade in Ethiopia's population growth rate, fertility levels, contraceptive prevalence, maternal and child health, and related population, demographic and reproductive health indicators, including ASRH outcomes and the key achievements of the Packard Foundation and its grantees in these areas.

Triangulated data from quantitative and qualitative sources confirm modest but positive changes in national and regional population and reproductive health indicators across the country and in the particular regions of Amhara and Oromiya, where the Foundation's funded projects were primarily implemented. Several data sources show that the country's TFR dropped from 6.4 in 1990 to 5.1 in 2007, with large fertility differentials across regions. Data on ideal number of children confirm an overall reduction in family size aspirations nationwide, including for Packard and non-Packard areas in Amhara and Oromiya regions (as shown in Figure 2.5). However, we find a more substantial reduction in areas where the ideal number of children was more than four at the beginning of the observation period. Further evidence of positive change towards smaller family size norms can be located in massive reductions in the number of women giving non-numeric responses to the question on ideal family size, from about 70 percent during the 1999 baseline survey in Amhara to 15 percent in the 2005 EDHS. This outcome at least suggests that the conditions for change in fertility behavior are in the horizon, as women who gave non-numeric responses are generally associated with high fertility aspirations.

The Foundation made substantial investment towards expanding access to family planning and reproductive health information and service delivery through funding a variety of projects in the Amhara and Oromiya regions since 1999. The evaluation shows a modest but positive change in knowledge, ever and current use of contraceptives between 2000 and 2005 in both focus program regions and across the country (see Figures 2.7 to 2.9). One key dimension of our finding is the evidence that current use of all and modern contraceptives is gendered with men being more likely to be current users than women in all regions, except in the Amhara zones where Packard projects were located. The level of unmet need for family planning declined nationally by about 30 percent between 2000 and 2005. However, the results varied widely across regions and between Packard and non-Packard program areas, with Oromiya experiencing a 10 percent increase in unmet need over the same period (see Figure 2.11). Despite substantial investments and a 74 percent increase in CPR nationally between 2000 and 2005, CPR has remained generally low in Ethiopia including Packard and non-Packard zones of Amhara and Oromiya regions.

Focus on the SRH of Ethiopian Youths

One of the three core areas of the Foundation's work in Ethiopia focused on youths aged 10-24. The ASRH strategy had about 28 grants and constituted about 19.4 percent of all funds expended by the Foundation's Ethiopia Population Sub-program in the last 10 years. While most grantee projects have youth components, these particular grants were to groups wholly devoted to ASRH activities. We identified changes over time in ASRH indicators particularly in regions served by the Sub-program focusing specifically on age at first marriage and first sex, youth pregnancy and motherhood, youth's knowledge, ever and current use of contraceptives, and HIV/AIDS knowledge and prevention.

On changes in age at first marriage, national data sources have identified positive changes with the proportion of women married by age 15 declining from 38 percent among women age 45-49 to 13 percent among women age 15-19 in 2005 (CSA and ORC Macro, 2005). In Amhara zones where the Foundation's grantees concentrated their program activities over the last 10 years, available data show that the mean age at first marriage increased by 2.2 percent in Packard zones relative to 1.5 percent in non-Packard zones. In Oromiya region, there was a 7.9 percent increase in Packard zones against a 0.7 percent increase in non-Packard zones. In Addis Ababa, there was a 4.8 percent increase in mean age at first marriage between 2000 and 2005. The importance of increases in mean age at first marriage in Packard zones and Addis Ababa becomes even more critical against an average decrease of 1.0 percent in other regions of the country. Our in-depth case studies identified concrete achievements of the Foundation's grantees in terms of not only rescuing girls from early marriages but also in the provision of funds for the support of the education of bright but poor girls who are unable to afford schooling, a condition that makes them prone to early marriages.

A significant dimension of national and regional differentials in demographic indicators relates to the age at first birth for women of childbearing age. Generally, childbearing begins early in Ethiopia but available national level data suggest a recent rise in age at first birth in the country (EDHS 2005), and our examination of this indicator, summarized in Figure 2.4, confirms a higher but marginal increase in Packard zones relative to non-Packard zones in

both Amhara and Oromiya regions. In terms of changes in other youth-related regional and national indicators, our findings demonstrate that the overall goals of the youth intervention projects were largely met in terms of knowledge of ASRH issues and interpersonal communication regarding HIV/AIDS, family planning and other ARSH matters with both parents and sexual partners significantly improved. The use of youth-friendly SRH services, such as VCT, family planning, counseling services, etc also improved significantly. Age at sexual debut also increased, especially among males, and the number of sexual partners and incidence of casual sex decreased significantly.

The Foundation's Specific Strategies and Resulting Outcomes

We examined the extent to which the Foundation successfully fulfilled each of its strategic objectives, focusing on the 12 project areas under the three main strategies of the Sub-program. On expanding family planning and reproductive health service delivery, evidence from our reviews and analyses of data indicate that the seven project areas under this strategy accounted for about 40 percent of the Foundation's Ethiopia Sub-program funded projects and received about 54 percent of funds dispensed over the ten-year period (1998-2007). Considering the overall strategy goal, we found impressive achievements in FP service provision in general, especially through CBRH projects and social marketing of injectables. There was some indication of increased willingness to pay for contraceptives, suggesting growing demand for services. Significant advances were made in the area of capacity building for health personnel and infrastructure, particularly through the *Biruh Tesfa* network of private clinics. Almost every project had an IEC component, which successfully increased knowledge of FP, RH and HIV/AIDS but also created concerns about duplication.

Networking with various categories of organizations added value to all the projects under this strategy, which was most apparent in the successful advocacy around the Ethiopian government revision of the Penal Code relating to abortion. Most projects were successful in leveraging funds for their future sustainability. However, less marked achievements were made in the area of delivering LTPM, ANC, PNC and abortion-related services. Women's empowerment through linking micro-credit to FP failed to fully overcome prevailing gender disadvantages or to integrate micro-credit with family planning service delivery.

Under the second strategy of the sub-program, the Foundation supported two strands of projects since 2000; the first was aimed at developing adolescent-focused SRH services and the second focused on integrating skills and employment promotion services with SRH services. There were 28 projects funded under the ASRH strategy, constituting about 19.4 percent of all funds expended by the Ethiopian sub-program. The first group of projects focused on the provision of youth-friendly information, education and counseling services, by supporting and strengthening youth self-help initiatives (clubs), creating and strengthening a network of youth clubs, and promoting young people's development and protection among in- and out-of-school youths in selected rural and urban areas, including Addis Ababa. The second project under this strategy addressed unemployment among the youth and its implications for sexual risk-taking behavior and the reproductive health of adolescents.

Looking at the strategy as a whole, we found substantial achievements in the area of promoting reproductive services to young people. However, similar achievements were not recorded in the skills and employment promotions. The training activities were not always well linked to local employment opportunities, and there were limited opportunities for trainees to access micro-credit in order to start their own businesses. Looking into the future, there may be need to expand projects that have been shown to enhance the participation of women and girls, such as tailoring and embroidery, and employment promotion interventions. Leveraging activities for sustainability may be fundamental for this strategy moving forward.

The third strategy on creating an enabling environment for expanding and improving FP and RH services focused on developing reproductive health leaders, supporting advocacy on reproductive health and rights, and building institutional and local capacities to generate knowledge and provide services. The Foundation made about 37 grants worth about US\$ 12 million and constituting about 23 percent of the Foundation's total grant during the period under review. Using data from key informant interviews and desk reviews of pertinent policy documents and reports in the field of family planning and reproductive health and rights, the evaluation examined national and regional changes in population and RH environment that have occurred in Ethiopia, the level and patterns of institutionalization of RH in the national health program, and perceptions of Packard Foundation's work, including its networking and advocacy in Ethiopia.

In terms of substantial achievements of the Sub-program in this area, we found considerable progress in building cadres of FP and RH leaders who were able to engage with Ethiopian Government officials, other policy makers and people. One challenge that has not completely been addressed, despite efforts in this regard, was the difficulty in reaching women leaders. Advocacy activities played a tangible role in changes to government policy on RH generally.

Of particular importance was the role of the Foundation's grantees in educating stakeholders and government officials that culminated in the review of the Penal Code and expansion of the abortion law in the country. There was evidence of success in building the capacity of local NGOs, service providers, individual researchers, and universities. However, there was less success with linking research and local RH information needs. There was evidence of successful efforts to leverage funds for sustainability of projects under this strategy. There was, however, manifest concern expressed in the key informant interviews (KIIs) about lack of coordination of activities in this strategy.

Lessons, Recommendations and the way Forward

Under this section, our report summarizes the key strengths, successes as well as weaknesses of the sub-program, highlighting the opportunities and challenges for the sub-program moving forward. The strengths and successes of the sub-program were located in the Foundation's pioneering of FP/RH issues in Ethiopia; considerable achievements in building institutional and local capacities to generate knowledge through research; the sustainability of most projects through leveraging of funds; strong and successful networking and advocacy with substantial records of achievements particularly in creating an enabling political and legal environment for FP/RH programming; the comprehensive IEC campaigns that characterized the funded project activities; and the collegial and flexible management approach of the Foundation's staff.

Despite the significant strengths and successes of the sub-program, a number of weaknesses were identified, and these include weak coordination and supervision of grantee activities; the problem of multiplicity of activities and duplication of efforts; the Foundation's inadequate staffing level to effectively support grantees and their field operations; weaknesses in translating built capacity into outputs and service delivery; failure to adequately address gender disparity particularly in projects targeted at women; and the limited geographic focus of the sub-program.

On opportunities for the sub-program moving forward, one key recommendation is the need for a clear delineation of program boundaries and definition of measures of success as integral parts of the project proposal reviews and award of grants.

A key recommendation of the evaluation was the need to translate successes recorded in the area of IEC and capacity building to service delivery. This position is reinforced by the existing positive policy environment and the networks already established by the Foundation with grantees, development partners, the media, and research organizations across the country. The need to reinforce activities around coordination of grantee activities is identified as critical for the program moving forward. This will help the sub-program to ensure greater accountability and reduce duplication. Related to this is the need for coordination with other development partners to enhance impact.

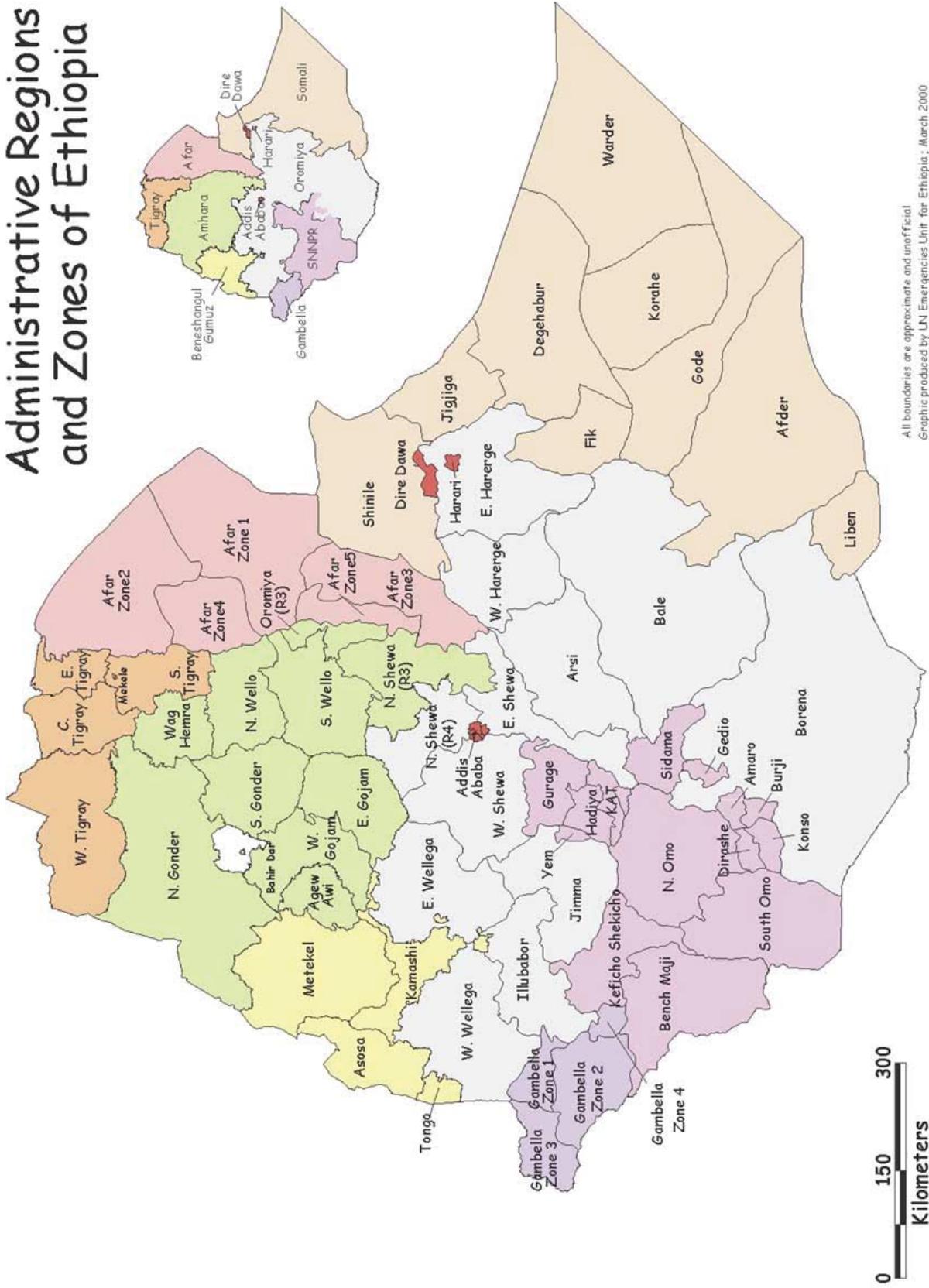
The entire program needs an organic monitoring and evaluation component at vital points in time: base-line, mid-term and endlines. With each program component having defined measurable success indicators that go beyond outputs and service statistics to outcome and impact, the monitoring and evaluation of project activities should focus on measuring these outcomes at defined intervals.

A general consensus among grantees and stakeholders is the need to expand the Ethiopian Packard office to create more capacity to support field operations of grantees. If field supervision of on-going projects will be effectively undertaken and if expansion to other regions will be implemented, then expanding the staffing capacity at the country office is a necessity. The need for the Foundation to expand activities beyond population and reproductive health to include other related areas such as the challenges associated with the environment was highlighted.

Finally, in the area of youth and women empowerment, funding to diversify the vocational skills training program was found critical for the next steps of the sub-program. Additional investments will be needed to assist trained beneficiaries in finding jobs and/or identifying sources and enhanced access to micro-finance for those who would like to start their own businesses. Particular skills training in areas such as tailoring and embroidery to benefit women and young girls was identified as something that could enhance their participation, and the overall goal of the sub-program.

Figure 1.1: Map of Ethiopia showing all the Regional States

Administrative Regions and Zones of Ethiopia



Chapter 1: Introduction

1.1 Ethiopia's Population and Economy

Ethiopia, with a total land area of 1.1 million square kilometers, and an estimated population of 77 million people is the second most populous country in Africa. The median age of the population is 18 years; 43 percent of the population is below 14 years of age; 54 percent is between 15 and 64; and about 3 percent are aged 65 years and above (CIA, 2008). More recent estimates indicate a population growth rate of 2.5 percent (Africa Population Data Sheet, 2008), making it one of the fastest growing populations in the world. The 2006 revision of UN population estimates suggests that Ethiopia's population will double between 2005 and 2040. By this time, the country will also be among the 10 most populous countries in the world with a total population of more than 150 million people (UN 2007). Only 16 per cent of Ethiopia's population reside in urban areas (Africa Population Data Sheet, 2008; MOEAED, 2006), making it the third least urbanized African country.

Ethiopia is ethnically heterogeneous, with about 80 distinct ethnic groups and the country's democratic government is a federation of ethnic regional states. The country's religious profile shows that Orthodox Christians comprise half the population, Muslims about a third, and Protestants about 10 percent (CSA, 1998), the rest being indigenous religion worshippers, atheists and agnostics, among others. Agriculture is the mainstay of the economy, accounting for almost half of its gross domestic product (GDP), 60 percent of all exports, and 80 percent of total employment. However, as a result of frequent droughts and poor cultivation practices, the country's earnings from the sector have continued to dwindle. Consequently, the nation's gross domestic product has only been increasing by an average of 1.5 percent annually between 1990 and 2005 and 78 percent of the population is estimated to live on less than US\$2 per day (Africa Population Data Sheet, 2008; CIA, 2008).

1.2. Population and Reproductive Health (RH) Indicators

Ethiopia has a total fertility rate of 5.4 and maternal mortality ratio of 673/100,000 births (CSA and ORC Macro, 2005). There is evidence that these are generally the result of poor health and nutritional status, high burden of communicable diseases, high workload, early marriage, high fertility, and inadequate access to and under-utilization of health services. Unsafe abortion and low status of women in the society are also other key factors underlying the high maternal mortality burden in the country. Infant and child mortality rates are estimated at 77/1000 and 123/1000 respectively. Under-five mortality averages 140/1000 implying that one in every seven children born in Ethiopia does not survive to their fifth birthday (CSA and ORC Macro, 2005; CIA, 2008; MOEAED, 2006).

HIV/AIDS is a key challenge in Ethiopia with current adult HIV prevalence at 4.4 percent. About 1.5 million people live with HIV/AIDS, and 120,000 HIV/AIDS deaths were reported for 2003. By 2005, AIDS deaths (adults and children) ranged from 38,000 to 130,000 annually while AIDS orphans totaled between 280,000 and 870,000 (UNAIDS 2006). The country's health sector is bedeviled with a dire shortage of health services and workers. There are also inadequate sanitation, inefficient procurement systems, and weak monitoring and evaluation systems (World Food Program, 2006).

Evidence from the 2005 Ethiopia Demographic and Health Survey (EDHS) shows high knowledge of contraception (88 percent among currently married women and 93 percent among currently married men), but ever and current use were relatively low. Currently, only 24 percent of currently married women and 19 percent of currently married men have ever used any family planning (FP). In 2005, only 15 percent of married women reported current use of any method of contraception. The 2005 EDHS also shows that only 25 percent of mothers who had a live birth in the five years preceding the survey received antenatal care from health professionals. Unwanted pregnancy and unmet need for family planning continue to be very critical issues in the country.

1.3. Population and Reproductive Health Policies and Programs

The Ethiopian government adopted a population policy in 1993, following the recognition that the country's population and reproductive health indicators were neither optimistic nor consistent with national aspirations for food security, universal primary education, increased access to health services, extended employment opportunities and overall economic development goals. The overall objective of the policy was to harmonize the country's population growth rate with the nation's economic development agenda. A key goal of the policy was to achieve a TFR of four children per woman by expanding family planning programs.

The policy specifically sought to achieve a contraceptive prevalence rate (CPR) of 44 percent by 2015 (TGE, 1993). In furtherance of these goals, the government established the National Office of Population (NOP) with the responsibility of coordinating institutions and ministries involved in population activities. The NOP also was to advise government on policy and program development in the broad field of population. Other key policy responses of the Ethiopian government to the challenges of population growth and the nation's economic development aspirations include the Health Sector Development Program (HSDP) and the Poverty Reduction Strategy Program (PRSP).

1.4. The Packard Foundation Population Sub-program in Ethiopia

1.4.1. Background to the Program

The Packard Foundation (also referred to as the Foundation) Population Program was established in 1998 with the goal of slowing the rate of growth of the world's population and expanding reproductive health options among the world's poor. The Program invests in pioneering organizations and individuals that focus on giving women and their families the ability to decide how many children to have, when to have them, and to receive proper medical attention when they do. The Ethiopia Sub-program is among the five programs in which the Foundation has made its most substantial investments. Other programs were located in India, Nigeria, Pakistan and the Philippines.

The Foundation is among the major international organizations that provide technical and funding support for the population, FP and RH programs of the Ethiopian government. From 1998 through 2007, the Ethiopia Sub-program awarded some 80 grants totaling about US\$67 million. The current review of the sub-program's overall strategy aims to assess the effectiveness of grants and investments in achieving the program's stated objectives, outlined below.

1.4.2 Grant Making Areas

The sub-program's grant-making areas are under three broad strategies: Expanding family planning (FP) and reproductive health (RH) service delivery; improving adolescent sexual and reproductive health (ASRH); and creating enabling environment for family planning and reproductive health. Under the three key strategies, grant awards were made to 12 specific program areas. On the strategy of expanding family planning and reproductive health service delivery, grant awards were made in seven key project areas:

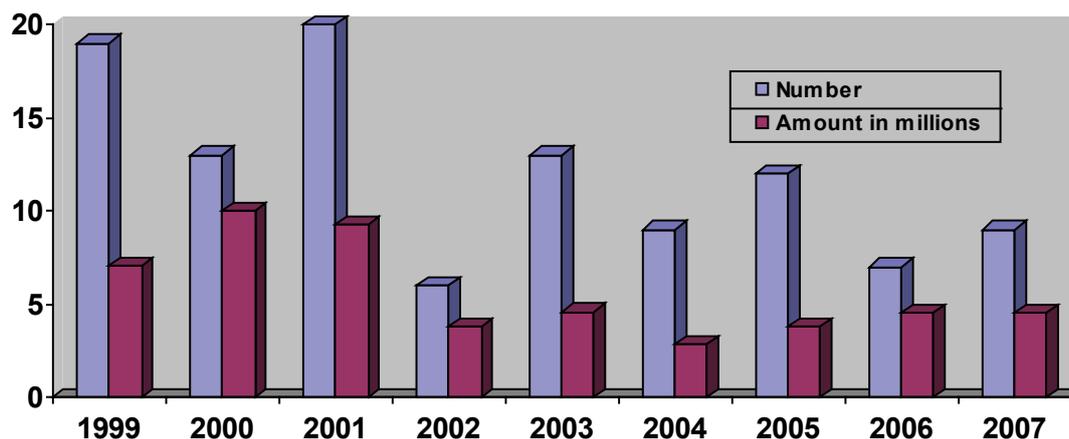
1. Expanding FP/RH through community-based programs,
2. Expanding access to FP through Private Sector Franchise Initiatives (PSFI),
3. Improving access to long-term and permanent contraceptive methods (LTPM),
4. Expanding access to family planning through social marketing,
5. Reducing maternal morbidity & mortality, and preventing unsafe abortion,
6. Empowerment of women through linking FP/RH/population services with micro-credit,
7. HIV/AIDS prevention and integration with reproductive health.

Under the improving adolescent sexual and reproductive health (ASRH) strategy, grant awards were made in two project areas: Improving Adolescent Sexual and Reproductive Health (ASRH) and Improving Adolescent Livelihoods through Life Skills and Vocational Training and Access to Micro Credit.

On the strategy for creating an enabling environment for family planning and reproductive health, grant awards were made in three project areas: Developing Reproductive Health Leaders, Advocating for Reproductive Health And Rights (RHR), and Building Organizational and Institutional Capacity.

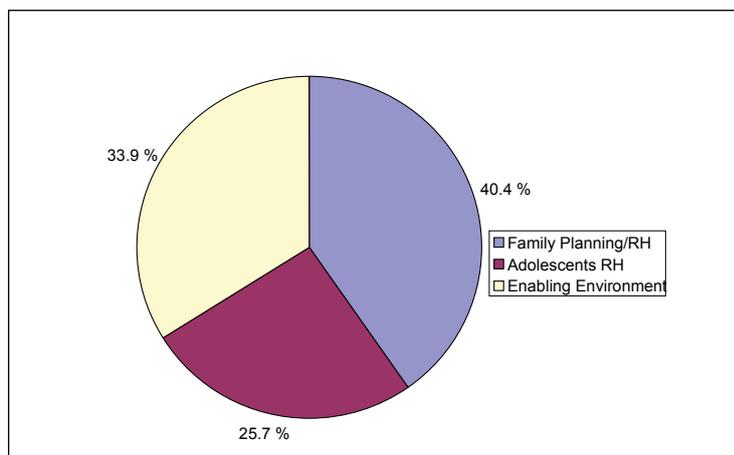
A distribution of grants awarded over the ten-year period is summarized in Figure 1.2. The number and value of grant awards over the period vary across the years with the lowest number of awards made in 2002 and the lowest total financial value of awards in 2004. However, from 2004 onwards, there has been a sustained upswing in the financial value of grant awards.

Figure 1.2: Number and Amounts of grants by year of award



On the number and value of grant awards under the three Packard Ethiopia strategies, Figures 1.3 and 1.4 show that programs focusing on expanding family planning and reproductive health service delivery received the largest share of awards in terms of number and monetary value. Projects under the strategy received 40 percent of the number of the awards and close to 54 percent of all grant values. Programs to create enabling environment for family planning and reproductive health (developing reproductive health leaders, advocating for reproductive health and rights and building organizational and institutional capacity) attracted 34 percent of the grants but only 23 percent of the grant money. Programs under the adolescent sexual and reproductive health strategy received one in four of grant awards but less than a fifth of the value of all the grants awarded.

Figure 1.3 Number of grants by strategies



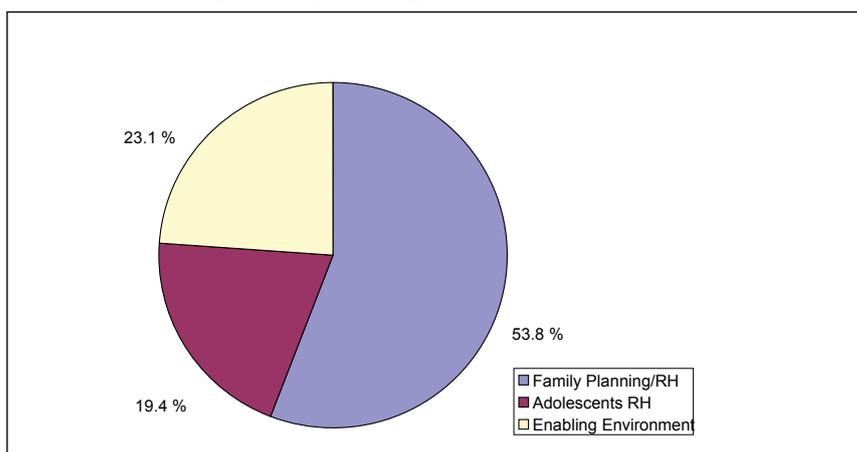
Whereas several grantee programs addressed ASRH issues directly or indirectly, the focus here is on major grants and grantee organizations that were primarily focused on ASRH. It is important to note that several¹ grant awards totaling about US\$2,638,731 that cut across more than one strategy were not included in the above classifications.

1.5. The Evaluation of the Ten-Year Ethiopia Sub-program (1998-2007)

1.5.1. Objectives and Expected Outcomes of the Evaluation

In this evaluation, we sought to assess the overall success of the Ethiopia sub-program in achieving its goals and its contribution to achieving the national population/reproductive health goals as well as the success of particular elements of the sub-program's strategies. The assessment covered all of Packard Foundation's population-related grant-making in Ethiopia from 1998 through 2007, along with the related management, coordination, collaboration, and leveraging activities carried out by the Foundation staff and country representatives. Although the success of the sub-program strategies depends heavily on the success of the projects carried out by the grantees, the evaluation focused on the overall sub-program and sub-strategies, and referred to individual grantees' projects only to substantiate and illustrate key achievements or lack thereof. The evaluation sought to answer the following specific questions:

Figure 1.4 Amount of grants by strategies



A. Contribution to National/Regional Population and RH Sector

1. What changes have occurred over the past decade in Ethiopia’s population and reproductive health and rights environment, including in the areas of health service delivery, policy, and civil society, and to what extent did the Packard Foundation and its grantees’ achievements contribute to bringing about these changes?
2. How did the Packard-funded programs contribute to the national Health Service Development Program (HSDP) and the Poverty Reduction Strategy Program (PRSP)?
3. How did the sub-program contribute to the institutionalization of reproductive health in the national health program?
4. How are the Packard Foundation’s work, networking and advocacy perceived by the federal and regional governments, key stakeholders in the population and reproductive health sector and other development partners in Ethiopia?
5. What changes have occurred over the past decade in Ethiopia’s population growth rate, fertility, contraceptive prevalence, maternal mortality, and related population, demographic and reproductive health indicators, and what are the key achievements of the Packard Foundation and its grantees in these areas?

B. Assessment of Specific Strategies

6. How successfully has each of the Ethiopia sub-program strategies been implemented, and what outcomes have resulted at the local, regional and national levels?
7. What are some of the unexpected/unplanned consequences (both positive and negative) of the program on the other key vertical health programs (e.g. maternal, neonatal and child health) and the health system (e.g. work force)?
8. How successful has the program been in leveraging resources for population and reproductive health and how do the grantees perceive the Foundation in this regard?
9. Besides financial support, what other support services are provided by the program to its grantees; what is the quality of this support; and what can be done to strengthen it?
10. How was the program managed (HQ staff, in-country advisors, and consultants) and what are the strengths and drawbacks of the management structure and style? What can be done to improve it?

C. Lessons, Recommendations and Way Forward

11. What are the key strengths/successes and weaknesses/failures of the sub-program; what explains the weaknesses and failures; and what lessons can be learned from both the strengths/successes and the weaknesses/failures?
12. Given Ethiopia’s current reproductive health situation (including its demographic/health challenges, the policy environment, the state of the healthcare system, and the funding landscape), the experiences of the Packard Foundation’s Ethiopia Sub-program, and the emerging directions of the overall population program strategy, what are the opportunities and challenges for the sub-program moving forward?

1.5.2 Technical Approach to the Evaluation

The evaluation utilized the following mix of methods to answer both the overall question of the impact of the sub-program on the broad demographic and health goals and the more specific questions on the success of particular strategies:

- **Desk Reviews (DR):** A number of the questions raised in this evaluation were addressed through reviews of reports and documents including project baseline survey reports, grantees’ proposals, project narrative and financial reports,

external evaluation reports, the Packard Foundation-sponsored baseline surveys, mid-term and end-line project evaluations and reports, and general publications related to Ethiopia's population, FP and RH.

- **Secondary Data Analysis (SDA):** The evaluation made use of existing nationally representative data from the 2000 and 2005 Ethiopian Demographic and Health Surveys to examine the changes in Ethiopia's demographic and RH indicators and the achievements of the Packard Foundation and its grantees in these areas. Data from the 1999 and 2000 baseline surveys of zones in Amhara and Oromiya regions where Packard interventions are focused were also used.

- **Primary Data Collection and Analysis:** To answer some key questions in the evaluation, primary data collection was undertaken. Predominantly qualitative data were gathered through Key Informant Interviews (KII) and In-Depth Interviews (IDIs) with key stakeholders including Packard grantees, Ethiopian government officials, development partners, NGOs and CBOs in the field of population and RH².

- **Environment and Policy Review (EPR):** We reviewed various policy documents and examined changes in Ethiopia's policy environment in population and reproductive health and rights over the period under review. The reviews under this subsection specifically focused on national reproductive health and adolescent reproductive health strategy documents, health and population policy documents, the health sector development program and the poverty reduction and sustainable development programs.

- **Case Studies (CS):** This approach involved critical and in-depth analysis of specific strategies or projects to identify their key achievements and challenges. In particular, illustration and documentation of key achievements relating to the Foundation's goal of developing RH leaders and leveraging of funds were undertaken. Experiences of individuals who directly benefited from the Packard Foundation's program activities were also examined and reported, focusing on marriage cancellation and supporting girl-child education.

Appendix 1 provides a summary of the methods used to address each of the 12 specific evaluation questions enumerated above.

1.5.3 Primary Data Collection and Analysis

The project team designed data collection instruments in English for in-depth and key informant interviews. This process went through several iterations until the final instruments were arrived at. After designing the instruments and before the actual interviews were conducted, these instruments were pre-tested and accordingly amended. The instruments were designed for specific grantees, development partners, government and Packard officials, to address their specific connections to the Packard Population Sub-program in Ethiopia over the period under review. The specific instruments designed for specific groups are available on request.

Based on the amount and frequency of grants received from the Foundation, the type of project, a total of 30 people were selected for interview. This selection was done in May, 2008. The interviewees were stratified into four broad stakeholder categories: Government institutions and agencies, Packard Foundation Ethiopia Sub-program officials, development partners working in the field of population and reproductive health in Ethiopia, and project grantees. The list of stakeholders under each sub-category is presented in Appendix 2. Before conducting the interviews, the Packard Foundation wrote to all the identified interviewees informing them of the intended evaluation and sought their agreement to participate. This was followed by phone calls to confirm receipt of this information and availability of the respondents. Letters were also written by the Foundation introducing the evaluators to the interviewees.

Most of the interviews were conducted with Packard Foundation's grantees, government officials, development partners and Packard Ethiopia officials over a five-week period, from June 9th to July 11th 2008. These interviews took place in Addis Ababa, Oromiya and Amhara regions where interviewees were located. An interview with one of the grantees, Center of African Family Studies, headquartered in Nairobi, Kenya, was conducted with two of its top officials in Nairobi. Interviews with Brown University, Providence, RI, USA (a grantee) and Packard officials at the Foundation's headquarters in California relied on mail questionnaires. One more interview with a key government official in the Ministry of Health was conducted later in Addis Ababa.

Given the cultural sensitivity in Ethiopia and to allow grantees to speak more freely, the interviews were not tape-recorded; they were conducted in English or Amharic, depending on the interviewees' preference. Overall, 24 interview sessions were successfully conducted: five key informant interviews with five government departments and two development partners, two sessions for Packard officials in Ethiopia and California, respectively, and 15 in-depth interviews with grantees. Two of the successful interviews were long-distance written interviews. Attempts

to conduct other interviews with some selected federal government officials were unsuccessful. Further efforts were made to undertake these interviews but they were not successful. Many potential interviewees were said to be very busy with on-going strategic planning processes in the government, while others were too new in their positions and did not know much about the Foundation's Ethiopia Sub-program. The interviews conducted, however, combined with other sources of data enabled the collection and analysis of valuable data that have informed this report. In-depth interview data were analyzed based on themes central to the evaluation.

1.5.4 Secondary Data Analysis

The 2000 and 2005 Ethiopia Demographic and Health Survey (EDHS) data sets were used in this evaluation. The 2000 EDHS was the first survey of its kind in the country to provide data on population and health that are comparable to data collected in other developing countries. The EDHS provides national and regional demographic and health information from a representative sample of women and men in the age groups 15-49 and 15-59, respectively. The primary purpose of the EDHS is to furnish policymakers and planners with detailed information on fertility, family planning, infant, child, adult and maternal mortality, maternal and child health, nutrition and knowledge of HIV/AIDS and other sexually transmitted infections. The key variables of interest from the 2000 and 2005 EDHS include total fertility rates; desired number of children; age at first sex, marriage and birth; knowledge, ever use and current use of contraceptives; antenatal and delivery care, child immunization as well as HIV/AIDS. The evaluation also has a special focus on adolescent reproductive health issues including teenage motherhood and pregnancy.

1.5.5 Desk Review

A total of 52 grantees' reports and documents were used in this review. These include annual, mid-term, progress, summary and final reports. Other reports utilized include:

1. The list of grants' history.
2. A 1999 baseline survey report on Packard project zones in Amhara region.
3. A 2000 baseline survey report on Packard project zones in Oromiya region.
4. Two evaluation reports on grantees' activities.
5. Five grantees' proposals to the Foundation.
6. The report on the family planning and reproductive health collaboration and coordination meeting held in 2000.
7. The report of the bi-annual grantees and partners meeting of 2007.
8. One concept paper on Packard-LDM in 2000.
9. Reports on activity plans.
10. Background paper on the David and Lucile Packard Foundation's Program in Ethiopia.
11. The 2007 David and Lucile Packard Report on *Six Years of International Grant-making in Reproductive Health Book*.
12. The 2008 David and Lucile Packard and Macro International Report on *Trends in Youth Reproductive Health in Ethiopia, 2000 and 2005*

The grantees' reports and other documents were sorted by the sub-strategy they related to. Each of the reports is then reviewed vis-à-vis the 12 questions that the evaluation seeks to answer. After going through the reports and documents, the identified issues were collated by the question they respond to and merged with the findings of the other evaluation instruments.

1.5.6 Challenges Faced by the Evaluation Project Team

The evaluators faced a number of challenges, most of which were concerned with data collection, desk review and secondary data analysis. More critically, the planned and needed collaboration with an in-country partner failed to deliver as expected beyond the initial collaborations at data collection. These challenges are detailed below.

Primary Data Collection: One of the limitations faced during primary data collection was the inability to interview most government officials selected. Out of the nine government officials selected from the Ministries of Health, and Finance and Economy, only five ultimately made themselves available for interview. The distance between Nairobi and Addis Ababa created further hurdles for APHRC staff in securing interviews. Due to cultural sensitivity in Ethiopia, and to allow grantees to speak more freely, the interviews were not tape-recorded; they were conducted in English and Amharic depending on the interviewees' preference. This approach involved a time-consuming process of producing, translating and back-translating long sets of hand-written notes, which added to the time required for data analysis.

Desk Review: One limitation faced during the desk review was the lack of electronic copies of most of the reviewed documents. This proved to be a challenge in sharing the documents among the various individuals that worked on the evaluation. Further, the project reports accessed for the evaluation did not have a uniform reporting format and reports did not cover the entire period under review.

Secondary Data Analysis: While the evaluation team was able to use the censuses and some baseline evaluation reports to assess levels of fertility indicators before 2000, there was no quantitative data to evaluate the performance of the Packard-funded projects in the last two years (2005-2007). In addition to the weaknesses of national level surveys in capturing local specific situations, which we had to contend with, our conclusion is further limited by lack of data in this latter period, which as our desk reviews indicated, witnessed significant increase in activities expected to have elevated impact on key indicators of interest for the evaluation. Differences in the sample composition of EDHS 2000 and 2005 of women undermined the comparability of TFR, CPR and some other indicators between the two surveys (see Section 1.5.7, below). Moreover, the evaluation faced a major challenge of comparing indicators from different surveys, which are generally difficult, if not impossible, following differences in sampling frameworks and changes in population composition over a period of time.

Poor Collaboration: The evaluation project was designed to be a collaborative effort between APHRC in Nairobi, Kenya, and an Ethiopian in-country partner. The collaboration worked well during the conceptualization of the project and data collection, but failed to deliver needed support at critical points of implementation of the project, including desk reviews, scheduling and conducting of outstanding interviews, further analysis of existing secondary data and writing of report. Consequently, the APHRC team reassigned all tasks to its team members, which altered the original timelines for the completion of the evaluation.

1.5.7 Limitations of the Study

1. **Study Design:** Some of the questions, especially around the contribution of the Sub-program in FP/RH achievements in Ethiopia could only be realistically addressed through a carefully designed household survey of Packard Foundation program areas and a potentially comparable non-program area. Although this was mentioned to Packard Foundation colleagues, it was ruled out of consideration because of cost and time constraints. The agreed design of using qualitative methods was only appropriate for assessing issues around perceptions relating to the Foundation's program.
2. **Impact Assessment:** Although this was a desired outcome of this evaluation, the lack of appropriate datasets and comparison groups make this an impossible task. First, although Packard Foundation's program in Amhara and Oromiya started in 1998, the baselines for these regions were conducted in 1999 and 2000 in Oromiya and Amhara regions, respectively. Again, the first DHS in Ethiopia took place in 2000 meaning that most of the initial impacts of the program may have been missed by these available datasets. Similarly, the latest survey with comparable data was the 2005 EDHS. This data set missed the last two years covered by the evaluation when many of the funded programs (based on reviews of grantee reports) were reaching maturation in terms of impact and expansion.
3. **Comparison Group:** Perhaps the most significant limitation of the impact assessment is the lack of appropriate comparison groups. The Packard Foundation program areas changed over time. New areas were added while some existing *Woredas* were dropped as other funders entered into the areas. In addition, other donors were also active in other regions outside Amhara and Oromiya, often with larger resources than those being invested by the Foundation in its program areas. Therefore, benchmarking changes in FP/RH indicators in the Packard Foundation program areas and building a case for impact assessment were impossible. Even though we were able to identify Packard Foundation areas in the two EDHS, these were not necessarily the same areas making it impossible to compare changes in indicators over time. For instance, while only 71 percent of the women lived in rural areas in the Packard Foundation areas in the 2000 EDHS, 91 percent did so by 2005. Compared to the country as a whole, the proportion living in urban areas actually remained 16.7 percent over the same period. In addition, FP and RH indicators differed significantly between urban and rural areas.
4. **Timeframe:** We underestimated the amount of time and the complex nature of the evaluation. While this is partly due to the lack of expected support from our Ethiopian partner, it was also due in part to the need (in the absence of appropriate secondary data sets) to thoroughly examine all available documents to gain a better appreciation of the work done and the challenges faced by grantees. This process was central to fully addressing some of the evaluation questions.

- 5. Scope of the Evaluation:** There was possibly a miscommunication between APHRC and the Packard Foundation colleagues on the scope of the evaluation. Both the initial discussions and terms of reference identified Packard programs in Ethiopia within three clusters and 12 strategies. The terms of reference requested for an evaluation of each strategy which APHRC took to mean each of the 12 strategies. In a recent discussion with a Packard staff, it was clarified that the strategies meant were the three clusters and that the 12 program areas were really not strategies but rather activities to achieve the three strategies. APHRC had to restructure the report accordingly.

Despite these limitations, the evaluation team applied the most appropriate and robust designs to achieve a proper assessment of the impact the Foundation has had in Ethiopia over the first 10 years of its program in the country. The use of EDHS data (despite their limitations and the lack of appropriate comparisons), shows the Foundation's program was effective in increasing awareness and knowledge of FP/RH issues, but less so in increasing contraceptive use and reducing fertility levels. The qualitative data provided strong and consistent evidence of the program's impact in pioneering FP/RH work in Ethiopia, contributions to changing the national policy and legal environment, creating RH leaders, and supporting grantees in leveraging funding from other donors for program sustainability.

1.5.8 Structure of the Evaluation Report

The following four chapters present the results of the ten-year evaluation. Chapter 2 presents the contributions of the Packard Foundation to national and regional changes in population and reproductive health environments and rights, the institutionalization of RH in the national health program, and the perception of the Foundation's work, network and advocacy in Ethiopia. This chapter also examines the changes in Ethiopia's national and regional population and reproductive health indicators and the contributions of the Packard Foundation towards them. Chapter 3 presents the evaluation of each of the 12 project areas under the three key sub-strategies and their success in achieving program objectives. Chapter 4 presents other achievements of Packard-funded grantees and the Foundation's support beyond cash grants. Finally, the concluding Chapter 5 summarizes the strengths and successes, weaknesses and failures, as well as the opportunities and challenges for the sub-program moving forward.

Endnotes

¹ Such awards include four grants of US\$ 176,564; US\$20,500; US\$200,000; and US\$125,000 specifically for Addis Ababa in 1999, 2003 and 2006 for projects across all three strategies: expanding access to FP through Private Sector Franchise Initiatives, expanding access to family planning through social marketing, improving adolescent sexual and reproductive health and advocating for reproductive health and rights. Another is the three sets of grants for US\$500, 000; US\$466,667 and US\$650,000 for SNNPR in 2004, 2006 and 2007 for three projects across two strategies: Expanding FP/RH through community-based programs (CBRH), improving adolescent sexual and reproductive health (ASRH); and improving adolescent livelihoods through life skills and vocational training and access to micro credit. Also there was a grant of US\$500,000 for Tigray in 2004 excluded for the same reasons. Further the amount of grant 2001-20397 to the Consortium of Family Planning NGOs in Ethiopia was not listed. In all, the record represents over 80 percent of all grants reported to have been expended by Packard Ethiopia between 1998 and 2007. For the purpose of this analysis single grant entries from Packard records awarded for Amhara and Oromiya regions were split and entered separately for each region. There were about 28 such joint grants over the period and if we account for such double entry, we will be having a total of about 81 grants.

² The six different questionnaire instruments developed and used for data collection from Ethiopia government officials, Packard development partners, Packard Officials in Addis Ababa and California, Grantees in Ethiopia, Brown University Providence and CAFS in Nairobi Kenya were not included in this report for space reasons, but are available on request.

Chapter 2: The Contribution of Packard Foundation to the National and Regional Population and Reproductive Health Sector

The key objective of this chapter is to determine the contributions of the Packard Ethiopia Sub-program to the national population/reproductive health situation between 1998 and 2007. The specific focus is on identifying the contributions made by the Foundation to the changes in Ethiopia's population and reproductive health and rights environment, poverty alleviation and health service development programs. We examine stakeholders' perceptions of Packard Foundation's work, networking and advocacy in Ethiopia. Finally we review the changes that have occurred over the past decade in Ethiopia's population growth rate, fertility levels, contraceptive prevalence, maternal and child health, and related population, demographic and reproductive health indicators, and identify the key achievements of the Packard Foundation and its grantees in these areas.

2.1 The Packard Foundation and Ethiopia's Population and Reproductive Health Rights Environment

2.1.1 Background

Social and political environments are key to successful work on population and health issues. Without a positive social context, efforts to deliver effectual social policy interventions may not achieve their projected impacts (Izugbara, 2004). In recognition of this, the Packard Foundation is committed to creating and fostering an environment that promotes population and reproductive health rights in Ethiopia. This commitment is critical given the changes in Ethiopia's historical socio-political environment, following the coming to power of a new government committed to addressing the country's population problems in 1991 (Tareke, 2004). Unlike the socialist government before it, which was pro-natalist and hostile to promoting reproductive and health rights (Office of the National Committee for Central Planning, 1989), the new government recognized the adverse implications of rapid population growth and formulated in 1993, the Ethiopian National Population Policy. It further demonstrated its commitment to sustainable population growth, by adopting the Program of Action of the International Conference on Population and Development (ICPD) in 1994, which emphasized a broader approach to reproductive health by expanding access to education and health services while making family planning readily available.

To succeed, the population programs of the new government needed adequate funding, favorable and workable policies, and popular support but the prospects for progress in reproductive health and family planning in Ethiopia were particularly low. This was exacerbated by political conflict, widespread illiteracy, and erratic food distribution that characterized the large, rapidly growing population in one of the world's poorest nations. Women, on average, married at age 16, and gave birth to six children. Despite a massive demand for contraceptives, the percentage of married women using any form of birth controls whatsoever did not exceed eight percent in the years before 1993. Against the backdrop of this daunting challenge, the David and Lucille Packard Foundation became one of the earliest and most consistent allies of the new Ethiopian government in its efforts to meet the huge national demand for family planning services, tackle the country's population problems, and foster sustainable development.

Since 1999, the Foundation has been at the vanguard of funding agencies supporting population, FP and sexual and reproductive health and rights (SRHR) activities and advocacy in Ethiopia. Advocacy-related programs supported by the Foundation targeted a number of critical issues including, but not limited to, the following:

- Creation of public awareness about the policies and strategies concerning population and RH/FP, reproductive rights among policy-makers, funding agencies, the news media, health care providers, women's organizations, and religious and community leaders

- The creation of a supportive environment to expand and promote reproductive health and rights in Ethiopia through advocacy and leadership development to bring reproductive health issues to the center of the development process in the country
- Empowerment of Ethiopian women through enhancing advocacy efforts of women's rights organizations
- Media advocacy on RH/FP, environmental protection, HIV/AIDS, gender, and adolescent sexual reproductive health through entertainment and education programs to address population and HIV/AIDS issues, panel discussions and publishing and distributing advocacy materials, among others.

As part of the present evaluation, we sought to tease out the extent to which the Foundation has contributed to fostering changes in Ethiopia's population and reproductive health rights environment and to precisely determine the nature of these contributions. We focus on three key areas namely: national and regional changes in population and RH environment that have occurred in Ethiopia, the level and patterns of institutionalization of RH in the national health program in the country, and perceptions of Packard Foundation's work, including its networking and advocacy in Ethiopia. Our primary interest is to understand whether or not Packard's funded activities in the country have contributed to changes in these areas.

Judging by the available data, the Packard Foundation made a total of 37 grants aimed at fostering positive changes in Ethiopia's Population and Reproductive Health Rights environment. The Foundation's grants in the sub-field (totaled about US\$12 million) formed nearly a quarter (23 percent) of its total grant during the period under review. Seven of these grants specifically sought to foster identifiable changes at both national and regional levels in population and RH environment, 20 were aimed at poverty alleviation and health development programs, and 10 targeted the institutionalization of RH in the national health program in the country.

2.1.2 National and Regional Changes in Population and RH Environment

A number of key changes have occurred in Ethiopia's population and reproductive health and rights environment over the past decade. Indeed, only in a few African countries has progress in population and RH environment been as transformative and noticeable. Besides evidence of a rapid and steady growth since the turn of the millennium in the number of NGOs, government agencies, and private bodies providing reproductive health programs to youth, women, and men in Ethiopia, millions of Ethiopians have received education about reproductive health and contraception, and the use of modern contraceptive methods has increased. According to the YouthNet (2004), this is evidence of a national environment that is increasingly growing favorable to population and reproductive health and rights-related work. Policy makers and civil society organizations in Ethiopia have also become much more informed about population problems and are actively involved in strategies to solve them. Currently, reproductive health is a national priority and the government continues to follow up on the commitment it made in 1994 to enlarge access to reproductive health services, including contraceptives and safe abortion. The government has not relented on its commitment to the prevention of unintended pregnancies, the reduction of the high attrition rate of females in the educational system, the provision of career counseling in secondary schools and universities, the establishment of youth reproductive health counseling centers, and the prevention of STIs and HIV. In tandem with these, the government adopted the 1993 population policy (still in effect today), passed into law the Family Bill (raising the minimum age of marriage, among other supportive articles), and revised the Penal Code, decriminalizing the advertisement and sale of contraceptives.

With political support for reproductive health rights (RHR) on the increase, advocacy, sectoral guidance and policy formulation, inter-agency coordination, leadership development, and school-based programs have all become commonplace. Unlike in previous times, the principal government ministries and offices that currently provide reproductive health and rights education or services include the Ministry of Health (MOH); the National Office of Population; the Ministry of Youth, Sports, and Culture; the HIV AIDS Program and Control Office; and the Ministry of Education. The MOH has been pursuing various adolescent reproductive health initiatives under its Family Health Department. A National Reproductive Health Task Force charged with the responsibility of coordinating activities related to the RHR program has also been established. The contribution of a group of conscientious local and international organizations with financial support from the Packard Foundation cannot be overemphasized. Together, they have helped foster identifiable national and regional changes in population and RH environment in Ethiopia, raising the profile of family planning and reproductive health and rights in the once-closed country and helping millions of Ethiopians to live healthier lives, as shown below.

With the support of the Packard Foundation, the Consortium of Reproductive Health Associations (CORHA), a coalition of 70 NGOs, collaborated in 2003 with the National Office of Population to raise awareness among the nation's law-makers and policy-makers on population issues. The two groups led a four-day field trip for 33 members of parliament, who visited reproductive health programs in Amhara, Oromiya, and Ethiopia's southern regions, and met with service providers, local officials, community leaders, and women who proudly told them their health was

no longer weakened by nonstop pregnancies. The lawmakers were surprised to learn the depth of the country's need for reproductive health services, and were impressed by the strong support for family planning among local religious leaders. Back in Addis Ababa, CORHA organized a two-day workshop on population and reproductive health, in which 400 parliamentarians participated. Upon its conclusion, the chairperson of the Finance and Budget Standing Committee declared, "We now have an adequate understanding of population and reproductive health issues. Therefore, I can say that you have a strong champion in parliament." Participants subsequently passed resolutions supporting broader access to reproductive health, including safe abortions.

A second example is the National Office of Population (NOP), Ethiopia's flagship agency for population and RHR issues which has been in the forefront of activities to ensure an environment promotive of reproductive health and rights work. The NOP is an active participant in the Packard Foundation-supported youth reproductive health programs and has benefited immensely from the Foundation's capacity-building efforts.

Following collaboration with the Packard Foundation's-funded organizations, the NOP has coordinated the implementation activities relating to the National Youth Policy and the "National Population Information, Education and Communication and Advocacy Strategy (YouthNet, 2004). Both policy documents have been key to fostering in-country RHR leadership as well as an environment conducive to work on RHR matters. The Foundation's Ethiopia Sub-program, through its grantees, particularly Ipas, was also instrumental in expediting the process of developing guidance and implementation of the new abortion law ratified by the House of Representatives in Ethiopia. Ipas, relying on Packard's grants, formed an ad-hoc committee to draft a working document for the guidelines on the abortion bill. In 2004, the Ethiopian Parliament passed the bill into law, marking the birth of one of Africa's most progressive piece of abortion laws. The new penal code expanded the conditions for legal abortion, adding rape, incest, fetal abnormality and a woman's physical or mental disabilities. Parliament also approved abortion for minors who are physically or otherwise incapable of caring for a child. By expanding opportunities for safe abortion, the law is expected to reduce maternal mortality in Ethiopia.

The Foundation's lead role in changing the population and RH environment in Ethiopia is also confirmed by qualitative data elicited from a range of key RHR stakeholders including government representatives, development partners and the Packard Foundation grantees in Ethiopia. These informants were asked to describe key changes that have occurred in Ethiopia's population and reproductive health and rights environment and the extent to which the Foundation has contributed to them. Interviews focused particularly on changes in health service delivery, policy and civil society in the last ten years. Data gathered from these interviews suggest a consensus among stakeholders in Ethiopia that the RHR landscape has improved considerably. The identified changes were in three specific areas: policy and service delivery, public awareness, and activism and advocacy. Interview data suggested that concrete policy changes related to population and reproductive health have occurred and that the government was also increasingly more open to ideas, information, and advice from civil society. This has reportedly resulted in the drafting of various progressive policies and strategies with RH/FP components as well as improvements in extant ones.

The new national youth policy and strategy, new family penal code, new abortion law, and the inclusion of population issues in strategic government policy documents like the Health Sector Development Program (HSDP) and the Plan for Accelerated and Sustainable Development to End Poverty (PASDEP) were frequently mentioned as examples of this positive development. Data also suggested that there has been increased commitment among leaders, decision makers and the government to prioritize population and reproductive health issues. The spokesperson of one government department noted: "On policy, there are now health policies and strategies in place which have the RH/FP component included."

Interviewees from a variety of backgrounds (governmental and non-governmental organizations, and international agencies) frequently reported that reproductive health policy-making and delivery of services have been scaled up nationwide and called attention to the formulation of several new and workable policies that have spiraled into more openness, more action, and more interest over matters of reproductive and sexual health in the country. Interviewees also reported striking improvements in the area of population and contraceptive services offered in Ethiopia, particularly noting the increased availability of various methods of family planning, including long-term methods.

The Ethiopian government's efforts to prioritize reproductive health were also widely acknowledged. Budgetary allocations to the health sector have been increased and more health inputs and resources, including contraceptives are currently more available and accessible. Interview respondents from governmental agencies informed our team that the emerging trend was for the Ethiopian government to seek alternative (national) sources of funds for its health programs and policies. Juxtaposed against a longstanding tradition of wholly relying on donor support for such programs, the current tradition of seeking alternative funds for programs was generally viewed as a positive

development that will guarantee long-term sustainability of programs. Driving this point home, an official from one of the national agencies pointed out that government's recent interest in broadening the funding base of its population and reproductive health programs would help to ensure the survival of these health projects in the long-term.

Respondents also generally reported that the health promotion activities of government and civil society have not only led to greater awareness about health issues, including HIV/AIDS and contraceptives, but also to more keenness on the part of Ethiopians to seek and utilize formal health services. Greater mass awareness of the availability of different methods of contraception was also viewed as responsible for the increased use of contraception in Ethiopia. More health facilities have also been constructed by both the government and the private sector and with the help of the CBRHAs, and the HEWs, formal care services were reportedly more accessible to Ethiopians. The rapid rise in HIV-related knowledge among Ethiopians was also mentioned as an indicator of the success of government's persistent and aggressive health campaigns. Underscoring these changes, a high ranking female government official maintained that:

There is now expanded service delivery to people at the local levels. For example, we now have the CBRHAs and the Health Extension workers who go door-to-door providing RH/FP services, including counseling and referrals for fistula and abortion cases.

The emerging positive socio-political context has also reportedly led to a vibrant and strengthened civil society sector in Ethiopia. Increasingly, civil society organizations in Ethiopia are showing a capacity for sustained and fruitful engagement with government on matters of policy. The Ethiopian Women Lawyers Association and Legal Advocates supported by Pathfinder, an anchor grantee of the Foundation, influenced the government's decision to affirm 18 as the legal age of marriage and to explicitly outlaw female circumcision, rape, forced marriage, other rights violations and harmful practices. They were also able to press government to permit CBRHAs to talk with parents on the need to keep their girls in school, delay girls' marriage until they are educated, and stop the custom of circumcision. Unpublished records of grantees' activities show that by 2004, Packard grantees had reached more than six million youth with reproductive health information, with 250,000 young people receiving family planning services.

Grantees fostered national awareness and interest in reproductive health through a range of aggressive advocacy work. The Population Media Center dramatized the subject with popular radio serials airing to audiences of millions. Pathfinder International trained community-based agents who reached tens of thousands of people with contraceptive services. Deutsche Stiftung Weltbevölkerung (DSW) provided almost two million young people with reproductive health information. Heralding future progress, reproductive health is now firmly established as a government priority, with many of the lawmakers informed and keen to act (Packard Foundation, 2007). More development partners are also committing resources to reproductive health programming. A spokeswoman of a key civil society organization in Ethiopia articulated the important role of Packard in their successes thus:

In RH there are lots of players. But there is tremendous change in civil societies who are involved in RH activities. More NGOs are being established. In 2001, it was only the Packard Foundation that was funding RH programs. But now there are about 6-7 donors on RH.

While it not possible to independently evaluate these claims, there is sufficient evidence from the EDHS and other surveys that there has been a substantial rise in levels of awareness regarding HIV, contraceptives, and reproductive and sexual health generally. While respondents were clearly very cautious to attribute all changes in the Ethiopian population and reproductive health environment to the Foundation, they were all unequivocal in stating that the Foundation has contributed in fundamental ways to fostering these changes. The Foundation's major contributions as articulated by the respondents were in the areas of funding population and reproductive health programs and policies, facilitating advocacy and policy engagement, recruiting and training of community health workers to supplement government services at the grassroots level, and directly educating government officials and policy makers on population and reproductive health matters.

Interviewees also frequently spoke of how the efforts of funders, particularly the Packard Foundation, had created an opportunity for population, health, and environmental issues to be incorporated into the country's poverty reduction strategies. Narratives frequently articulated the Foundation's lead role in supporting the democratization and decentralization of policy-making, which made it possible for decisions to occur at sub-national levels, where local authorities are more willing to confront the local population and the environmental problems they face. The Foundation was particularly acknowledged for supporting a growing number of civil society organizations engaged in poverty reduction activities that connect population and environmental issues and for opening the way for other large donor inputs aiming to facilitate the country's realization of the Millennium Development Goals.

Also highlighted was the Foundation's pioneering role in raising concern about population and reproductive health issues in Ethiopia, in supporting efforts for changes in policies, and in funding key population and reproductive

health meetings or seminars like the Bahir Dar conference, which culminated in the formulation of the youth policy. According to our informants, the Foundation was also key to the formulation of both the abortion and post-abortion care policies as program areas in the HSDP document and in facilitating the government's capacity to prioritize and streamline policies that link reproductive health, development, and the environment. One government policy-maker noted that:

At a point Packard staff had to speak in the Ethiopian Parliament on population growth and its effect on development, following which the government began to mainstream population matters into development planning. One respondent who worked in one of the key ministries noted that 'Until this speech at the floor of the parliament, the government's response to population issues was not encouraging. But after the speech, the Ethiopian government began to take the issue seriously. Even now the Ministry of Health is budgeting for contraceptives. It was not common to (designate) a fund for contraceptives. It was generally believed that contraceptives can be obtained from UNFPA and USAID at any time. Even when I was working for the regional health bureau, I was not willing to allocate budget for contraceptives.

A similar sentiment was expressed by the director of a grantee organization: "Following Packard's lead... the government and decision makers were able to understand what reproductive health is and its relationship to development and the environment. Previously there seemed to be a disconnect between RH, development and the environment but their advocacy made a change in the attitude of policy makers."

Several other informants spoke of how the Foundation's efforts were key to changing the training landscape on reproductive health matters in Ethiopia. One representative of a grantee organization specifically noted that the Packard Foundation started work in Ethiopia at a time when some regions were building their health systems but with very little human resources and capacity. The respondent further maintained that the Packard Foundation led efforts to fill this gap by recruiting and training community health agents. She notes:

Following the example of Packard, the Ethiopian government successfully replicated the training which has produced about 30,000 health extension officers on a permanent basis among underserved populations in rural parts of the country.

2. 2 The Packard Foundation, Poverty Alleviation, and Health Development in Ethiopia

A key mission of the Packard Foundation in Ethiopia is to contribute to poverty mitigation, health services development and provision, and accelerated and sustainable development. In this specific area of work, the Packard Foundation made a total of 20 grants, amounting to US\$3,839,383. We reviewed the Packard Foundation's contributions to poverty alleviation and health services in Ethiopia by focusing on the Health Sector Development Program (HSDP) and the Plan for Accelerated and Sustainable Development to End Poverty (PASDEP).

2.2.1 The Health Sector Development Program (HSDP)

The 20-year Health Sector Development Program (HSDP) was initiated by the Government of Ethiopia in 1997. This health sector strategy - consisting of four five-year programs - recognizes the time-bound character of the MDGs, which aim to improve health service delivery, capacity building and the development of preventive health care and equal access to health services. The HSDP is, above all, an attempt to move services out from facilities to the household and village levels and to bridge gaps in access to health services between rural and urban areas and between the poor and rich.

The Foundation played a key role in the development and implementation of the HSDP. Evaluation data indicate that the Packard Foundation was one of the few funding organizations that were actively consulted by policy-makers during the development of this policy document. The Foundation reportedly provided materials, equipment, and capacity-building training to those working on the document. Although only a few of the Foundation's grantees participated in the development of the policy documents, many of them have been involved in its implementation in the course of their programmatic activities. A government official highlighted the role of the Packard Foundation in developing the HDSP thus:

In the development of the HSDP, the bureau has been closely working with the Ministry of Health and we participated in every development at the regional level. In coming up with the HSDP, a committee was formed, which was tasked with looking at health documents from other countries and then adopt some of the practices. The Packard Foundation was represented in this committee. Also together, we studied the HSDPs and the targets indicated and came up with a plan of action whether a long-term plan or short-term plan so that the targets can be implemented at the regional level.

A key development partner to the Ethiopian government elaborated on the same point:

Our organization as well as the Packard Foundation attended the HSDP review meeting and here we tried to make sure that FP is on the list. Packard on its side, besides supporting the whole process by funding, brought a lot of technical experts to review the HSDP document and we on our part commented on the HSDP II document and it was found that RH issue was not covered. Now they have included it.

With support from the David and Lucile Packard Foundation, several organizations have also implemented a series of projects, that have tremendously benefited and leveraged the HSDP, extensively advancing Ethiopia's health programming efforts. Between April 2003 and June 2006, the Pathfinder, for instance, received grants from the Foundation that enabled it to launch an innovative Private Sector Franchise Initiative in Ethiopia, known as *Biruh Tesfa* (meaning "Bright Future" in Amharic). Aiming to promote public and private sector partnership in the provision of affordable and sustainable access to family planning and other reproductive health services in the country, the initiative has dramatically shifted the perception of private health care, which has historically been viewed in Ethiopia with suspicion. Pathfinder also created a standard for quality of care which private sector providers must meet in order to become *Biruh Tesfa* certified, bolstering their public acceptance and image. Through the Franchise Initiative, providers receive training and are certified to offer a broad range of services in the areas of reproductive health and HIV/AIDS. By demonstrating that the private sector can contribute to the overall national reproductive health and family planning effort, *Biruh Tesfa* has received a vote of confidence from an overwhelming number of the private clinics and the Ethiopian government at the federal, regional, and zonal levels.

The Foundation also funded the Pathfinder and the Oromiya Development Association (ODA) to partner with other local non-government organizations to bring quality FP/RH to poor and hard-to-reach communities. Currently, 47 such organizations are implementing RH/FP programs directly. The Packard grantees have also had remarkable success at the community level. The ever-expanding corps of nearly 8,000 community volunteers, CBRHAs, and HEWs travel throughout their districts, each serving approximately 120-140 clients, and distributing condoms and pills. They are trained by grantees in basic reproductive health, such as the DSW, Ipas, ESOG (Ethiopian Society of Obstetricians & Gynecologists), EPHA (Ethiopian Public Health Association), ODA, and Pathfinder International. They promote child immunization and exclusive breastfeeding, as well as pre- and post-natal care, make referrals to health facilities for safe delivery and clinical family planning, including long-term and permanent methods, and teach people to recognize when a woman is in danger from childbirth complications or from unsafe abortion and how to seek professional help. These CBRHAs are also HIV/AIDS prevention educators for millions of Ethiopian women not targeted by AIDS-prevention programs, but who remain vulnerable. Many CBRHAs work with sex workers, promoting the message that no sex is safe without condoms. Many of them provide care and support for dozens of children orphaned by AIDS in their districts. While an exhaustive list of all the key contributions of the Foundation's grantees in supporting the HSDP is not possible here, our review of key related reports leaves no one in doubt of the achievements in the area of health program development in Ethiopia over the period of the evaluation.

2.2.2 Plan for Accelerated and Sustainable Development to End Poverty (PASDEP)

The PASDEP is a five-year (2005/06-2009/10) tactical framework that builds on the strategic Ethiopian Sustainable Development and Poverty Reduction Program (SDPRP) but also embodies some bold new directions including a major focus on growth with particular emphasis on commercialization of agriculture, private sector development, and the scaling up of resources to achieve the MDGs. PASDEP is recognized as one of the few Poverty Reduction Strategy Programs (PRSPs) to be based on an MDG needs assessment. The realization of the MDGs requires interventions in seven key sectors (i.e. agriculture and rural development, education, health, water and sanitation, road, urban development, private sector and trade issues) as well as three cross cutting areas (i.e., gender, HIV/AIDS and population). The Ethiopian PASDEP is synchronized and aligned with the longer term MDG time frame and has eight pillars, namely building all-inclusive implementation capacity; a massive push to accelerate growth; creating the balance between economic development and population growth; unleashing the potentials of Ethiopia's women; strengthening the infrastructure backbone of the country; strengthening human resource development; managing risk and volatility; and, creating employment opportunities (UNESCO, 2007).

The PASDEP is a comprehensive policy, which encompasses sectors that were not adequately articulated in the SDPRP such as tourism, small and medium-enterprise development and job creation, urban development and construction, among others. With the PASDEP, the poverty reduction effort of the Government of Ethiopia assumed a longer-term focus oriented towards the MDGs. In other words, it established a concrete basis for human rights, articulating a policy and institutional innovation in agriculture and rural development, rural-urban linkages, pastoral development, spatial dimensions of the growth strategy and the right of every person in the country to health, education, shelter and security, as pledged in the Universal Declaration of Human Rights and the UN Millennium Declaration.

As with the HSDP, the Foundation played a key role in the development and implementation of the PASDEP. It provided materials, equipment, and capacity-building assistance to those who worked on the document. The Foundation has funded projects focusing specifically on poverty alleviation and the economic empowerment of the most vulnerable Ethiopians. The main thrust of the Foundation's work in this area has been the provision of micro-credit to very poor people, especially women. By linking micro-credit activities with family planning programs, it is anticipated that women's receptiveness to family planning and contraceptives will improve.

The Foundation supported two projects that linked FP/RH with micro-credit in Oromiya and Amhara regions since 2003. The projects seek to empower rural women to make independent decisions through access to integrated credit facilities and family planning services. In Oromiya, the Oromia Credit and Saving Share Company (OCSSCO) in close collaboration with the Oromia Development Association (ODA) has been implementing the project in selected communities. Likewise, the Amhara Credit and Saving Association (ASCA) implemented a similar project in collaboration with the Amhara Development Association (ADA).

Other organizations that have received funds from the Foundation to implement poverty alleviation interventions include the Opportunities Industrialization Center Ethiopia (OICE), the Relief Society of Tigray, and the LEM Ethiopia - Development Society of Ethiopia. Grantee records show that these projects have provided thousands of women with micro-credit loans and training in small-scale business management, paving the way for their economic contributions to family and community that will transform their status.

Further, between April 2003 and June 2006, Pathfinder implemented the Empowerment of Ethiopian Women project with support from the Foundation. The funding has also leveraged and advanced extensive Pathfinder programming supported by USAID. Focused on removing obstacles to women’s basic rights—both social and economic—the project was carried out in the Amhara and Oromiya Regions as well as the capital city of Addis Ababa. In 2005, the Foundation awarded Pathfinder a second related grant for the Women and Girls Empowerment Project, designed to continue the effort, but expanding the focus to adolescent girls in recognition of a need for early intervention. This second project worked to increase awareness and education among girls and women about RH/FP and personal rights, as well as to emphasize education, life skills, and leadership development. It also promoted female education through scholarships, role models and mentoring. This multi-pronged project helped to keep girls in school, raised a network of successful Ethiopian women (who visit rural schools as mentors inspiring role models of another possible way of life), and trained several poor women in vocational and business management skills, providing them seed money to establish small-scale businesses. Available statistics from Pathfinder (see Table 2.1) show that the Women and Girls Empowering Project was successful in meeting its objectives.

Further details on grantees’ project-specific contributions under the women empowerment strategy, particularly by the Oromiya Credit and Saving Share Company (OCSSCO) in close collaboration with the Oromiya Development Association (ODA) and the Amhara Credit and Saving Association (ASCA) in association with ADA are further discussed in Chapter 3, Section 3.1.6 under the subheading: Empowerment of Women through Linking FP/RH/ Population Services with Micro-Credit.

2.3. Institutionalization of RH in the National Health Program

Institutionalization is key to sustainability of reproductive health programming and to addressing the consequences of the rapid population growth that Ethiopia faces. Akande (2007) writes that a major reason programs do not succeed in the developing world is their lack of embeddedness and institutionalization within sustainable programmatic frameworks. Against this backdrop, the Packard Foundation is committed to ensuring the institutionalization and mainstreaming of RH in national health programs and policies. This strategy holds great promise, since it is the only way to guarantee the long-term sustainability of current efforts and programs.

There is evidence that the Foundation has made an important contribution in the area of institutionalization and mainstreaming of RH. As earlier noted, through Ipas, the Foundation was key to expediting the implementation of the new abortion law. The legalization of abortion in 2004 in Ethiopia marked a watershed in the country. It laid

Table 2.1 The Impact of the Women and Girls Empowering Projects

Activity	Number of individuals
Women trained in small business management and given micro-credit loans	2,400
Girls helped to evade early marriage (in two provinces in 2004 alone)	12,950
Girls receiving scholarships to stay in school	122
Girls clubs formed	156
Girls trained as peer educators	1,500
Women mentors and role models recruited?	48

Source: The Pathfinder (2005)

a strong institutional basis for subsequent work on population and reproductive health-related issues in a hitherto conservative society. Also, through its grantees, the Foundation has consistently supported an integrated approach to health care delivery, especially to reproductive health and family planning information and services to traditionally underserved areas. This approach is built on the tripod of service provision, capacity building and the promotion of stakeholder buy-in and support of programs.

For instance, relying on funds from the Foundation, grantees (such as the ODA and Pathfinder) have trained thousands of Community-Based Reproductive Health Agents (CBRHAs) who reach clients in their communities through home visits, disseminating information at social and religious gatherings, and offering referrals to participating health facilities. The Ethiopian Health Ministry is also increasingly involving these CBRHAs to provide key social and reproductive health services, including condom distribution, awareness creation, and policy formulation (EHSP, 2005). The involvement of this cadre of providers in the formulation and implementation of national policies has long-term positive implications for work around RH in Ethiopia. Evidence from Brown University has shown that these efforts led to increased capacity of the Ethiopian public health sector to successfully disseminate knowledge of HIV preventive behaviors to youths through clinics and health centers (In-depth interview transcript, 2008). As a result, sexual risk taking among youths in small towns and rural areas remains infrequent, and consequently HIV prevalence levels in these areas are relatively low.

The Foundation has also been at the forefront of supporting local capacity building. This is exemplified by the role of grantees in the revision and development of national training curricula and manuals to foster high standards of practice in reproductive health and service delivery, and the training of a critical mass of reproductive health service providers at the national, regional, and community levels. It is also demonstrated in the expansion and availability of high quality family planning methods, especially long-acting contraceptives such as Norplant and IUCD. These activities are key to the institutionalization and sustainability of reproductive health programs in Ethiopia. Grantees such as the Pathfinder received funds to implement interventions that build the capacity of public, private, non-profit, and faith-based organizations in health service delivery and management. Other grantees (such as the Family Guidance Association of Ethiopia, the Christian Relief Development Association and the Relief Society of Tigray) continue to work with those groups, which are dominant forces in people's lives, to ensure buy-in at all critical levels. These include government institutions, among them the Ethiopian Ministries of Health and Justice, the National Office of Population, and officials at the regional, zonal, *woreda* (district), and *kebele* (village) levels; local NGOs; and Christian and Muslim faith-based organizations.

As part of efforts to institutionalize RH, the Foundation committed funds to upgrading research and training capacity in population and reproductive health at the highest levels. Besides funding the development of local public universities' capacity to conduct research on RH and population issues, the Foundation also provided scholarships to Ethiopian nationals to study in overseas universities. Currently, 19 faculty members from Jimma, Gondar, and Addis Ababa Universities have participated in training workshops organized by Brown University. Workshop participants have projects in the Amhara and Oromiya regions. They received training in demographic methods for the collection and analysis of fertility and contraceptive use data. Five of the participants from Jimma University are currently working closely with Brown University and on their own on issues of adolescent reproductive health. During the time of Brown University's involvement with the Public Health Faculty at Jimma University, the quantity and quality of reproductive health research being produced at Jimma was reported to have increased substantially.

Brown University's partners at Jimma University have successfully conducted several large-scale surveys in Jimma Zone and nationally, and have been exceptionally productive in publishing policy relevant research for both stakeholders and scientific audiences. With support from the Packard Foundation, Brown University has been able to make reproductive health a key part of faculty research agendas and graduate training at Jimma University. Prior to their involvement with the faculty in the Department of Population and Family Studies, none of the faculty members were conducting research in the area of fertility and adolescent reproductive health. The availability of a critical mass of local researchers interested in fertility and reproductive health is a veritable way to keep RH issues permanently on the national agenda. As these ongoing local data collection projects involving local researchers gain ground, it is expected that they will furnish evidence to inform reproductive and health service delivery programs in the country.

The Foundation's grantees working together with the government have aided the development of national strategies to address various reproductive health policies and services, including post-abortion care, the Youth Policy, the Marriage Law, and major government policies such as the HSDP and the PRSP/PASDEP. The success of these efforts has led to a more proactive and reflexive civil society working to deepen the institutionalization of RH issues in the country. For instance, encouraged by past successes, ESOG, a Packard grantee has successfully influenced the integration of

reproductive health in the medical, nursing and allied training curricula. This is expected to enable students in these fields to become aware of reproductive health issues before they start to practice. Some educational institutions were reported to have started implementing the curriculum.

Interviews with informants in relevant government departments show that a conscious effort has been made to include RH issues in all government strategic plans in some program areas. Government key informants consistently reported they were prepared to promulgate more laws if need be to intensify work on RH, develop more strategies to expand access to family planning methods and maternal and child health services, and deepen the acceptability of population and RH programs among different groups in the country. The Foundation has enhanced the level of sensitization in Ethiopia, with the rapidly expanding base of committed local consultants, a teeming population of people who are increasingly aware of the importance of reproductive health matters, a government committed to promoting family planning, and community health. This point was very aptly made by the following respondent: “Increasingly, Packard’s work in Ethiopia is creating the required significant technical expertise for us to be able to do things by ourselves. I foresee future tremendous improvements in many areas... and we will have greater coverage of health services in the community. The future generally looks brighter.”

2.4 Perception of the Packard Foundation’s Work, Networking and Advocacy

How is Packard Foundation’s work in Ethiopia perceived? What do associates and partners of the Foundation consider as its strengths and weaknesses? Answers to these questions have the potential to broaden understanding of the issues surrounding the Foundation’s work in Ethiopia and gauge the acceptability of its activities and efforts. We generated data on perceptions of the Foundation’s work through key informant interviews, targeting staff of Ethiopia’s federal and regional governments, local and international development partners, civil society, and other critical stakeholders. Interviews specifically sought information on the views and opinions about the Packard Foundation in Ethiopia. Key informants were also requested to describe from their experiences ways in which the Foundation could become more effective in the country.

Judging by the available interview data, the Packard Foundation’s activities in Ethiopia are generally viewed positively among policymakers, activists, and development and reproductive health workers. Local and international respondents from wide-ranging backgrounds acknowledged the Foundation as one of the earliest donor organizations to begin work on population and reproductive health in Ethiopia, saying that the Foundation filled a donor ‘commitment gap’ in this area. As noted above, before the Foundation began working in Ethiopia, very few people recognized the enormity of population problems in the country or had a clearly thought-through agenda for addressing them. The Foundation was reported as strategic in fostering political and grassroots understanding of population issues in the country as well as in sustaining popular interest and zeal in addressing the impact of high population growth rates on livelihoods in Ethiopia. Respondents thus frequently described the Foundation in such terms as ‘vanguard’, ‘trailblazer’, and ‘pioneer’ of population and SRH and rights work in Ethiopia.

Respondents widely acknowledged the foundation as a key capacity-building and leadership development organization in the country. There were regular assertions among the bulk of government officials interviewed that the Foundation is held in very high esteem by the government of Ethiopia. As a result, the Ethiopian government regularly invites the Foundation to contribute to its key policy documents. One respondent noted that the Ethiopian government’s regular invitation to the Foundation to input into its policies and programs results from a recognition of the importance and effectiveness of the Foundation’s work. In his words, ‘They know how useful Packard is to Ethiopia.’ Another government official also noted that ‘The present government is particularly grateful to the Foundation for its contribution on population and RH in this region.’ This also came out very clearly in one Government official’s comments that the country has remained on target with its major policies and programs due to the support of organizations like the Packard Foundation. Another government representative commented that: “This government body is particularly grateful to the Foundation for its contribution on population and RH in this region.” (KII Government).

The Foundation also enjoys high-level respect and recognition among Ethiopian NGOs. Responses from the leadership of key NGOs in Ethiopia suggest that they consider the Foundation to be a frontline ally in the struggle for sustainable development in Ethiopia. One respondent argued that the Foundation easily qualifies as the ‘most dependable ally of NGOs working in population and RH issues in Ethiopia. If you have a good idea on how to foster positive change regarding RH in Ethiopia, the people to seek support from would be Packard’. The Foundation was also reportedly staffed with friendly and approachable personnel who hardly interfered in the work of grantees.

The common opinion of informants was that the Foundation’s work in Ethiopia has been primarily successful. Indicators of success frequently mentioned by interviewees included positive changes in the RH climate in the country, high-level political support for RH and population programs, rising contraceptive use rates, growing levels of HIV-

related knowledge, and declining fertility levels. The amount of money that the Foundation has committed towards population and reproductive health in Ethiopia was also reported to be remarkable. The investment in activities relating to capacity building opportunities for grantees, particularly leadership training, was seen as particularly substantial. An example given was the contracting of the Center for African Family Studies (CAFS) to train the two associations, ODA and ADA, on management information systems (MIS).

The Foundation's success was primarily attributed to its strategic approach. Before embarking on interventions, the Foundation reportedly makes conscientious efforts to properly understand the issues, the political and policy contexts, and the capacity of its implementing organizations in the country. The spokesperson of one grantee organization summarized the situation when she noted:

When we first started collaborating with the Packard Foundation they tried to understand the existing environment within the country. They tried to see into bureaucratic situations, policy and political environments. They also tried to see and understand the capacity of the implementing organizations and build the capacities through commissioned agents. For us they have commissioned Center for African Family Studies (CAFS) to give support on capacity building. What I want to say is they assess the organization's strength and weaknesses and they always try to fill the gaps.

Several other interviewees noted that the Foundation's reliance on strategic local and reputable international organizations to implement its programs has also contributed to its success. This approach reportedly permits the Foundation to work with grassroots as well as international organizations that are able to deliver results.

Also noteworthy is that respondents considered the Foundation to be very respectful of local governance structures and values. The understanding which the Foundation shows for government's administrative systems in Ethiopia was identified as key to its ability to effectively navigate the policy and political environment to impact positively on population and reproductive health issues. The multi-pronged nature of the Foundation's approach, which involved direct work on population matters such as funding the provision of contraceptives, supporting family planning campaigns, as well as work on matters such as women empowerment, leadership development, provision of training opportunities, were viewed as an innovative problem-solving design that has yielded both short and long-term gains.

There is also evidence from the interviews that the Foundation is seen as effective in raising awareness among policy makers and network members. The Foundation reportedly prefers to work effectively with like-minded organizations including local and international NGOs, the government and other major development partners such as UNFPA and USAID in seeking to achieve its goals. This networking occurs through the Foundation's well-coordinated annual partners' meetings, where all grantees and other stakeholders in population and reproductive health attend and engage in information exchange, experience sharing and discussions on work progress, challenges, and existing opportunities. The Foundation's capacity to create and sustain dynamic networks of stakeholders in population and reproductive health fields was frequently credited with having reduced the duplication of efforts, and enabling more effective collaboration. Networking has also promoted the leveraging of resources from other major donors. One interviewee describes the Foundation's coordinating role as follows: "Ipas and EngenderHealth train government employees on long term contraceptive methods using our clinics. We communicate with other stakeholders so that we will not duplicate efforts. That way we are jointly able to do more. We also share information on resources to support the work that each of us does. Packard has been key in bringing all of us together."

The Foundation's advocacy activities in Ethiopia were also acknowledged by the respondents, the bulk of whom ranked the Foundation among the most important population and sexual and reproductive health and rights advocacy organizations in the country. The Foundation's longstanding advocacy work particularly on the SR health rights of women and young people was recognized and positively spoken of by respondents. This work was reportedly influential in drawing policy-makers' attention to the needs of women and young people, which has led to important policy changes in the Ethiopian SRH and rights landscape. There were also reports that Foundation's activities have institutionalized advocacy and education as mechanisms for fostering changes in policy in Ethiopia. The Foundation's reliance on empirical evidence in its advocacy and education activities has contributed to the effectiveness these activities.

The very high esteem in which the Foundation is held in Ethiopia, and the general positive perception surrounding its work notwithstanding, reservations were expressed concerning its work in the country. A common negative perception among the respondents was that the Foundation favored foreign organizations in the disbursement of larger grants. Data gathered from the leadership of many local organizations indicated that although they often did (or felt that they did) the same type and quality of work as the international organizations, they always received smaller and often insufficient grants for their work. This was not only considered unfair, but also discouraging. We interrogated this perception further, by examining the Foundation's grant award data and its veracity was not substantiated.

Additionally, the Foundation was reported to be weak in follow up, feedback, and monitoring, with the effect that the field performance of grantees is not sufficiently scrutinized. Some respondents reported knowledge of organizations that have received funds from the Foundation without putting them to good and proper use. The Foundation's apparent lack of effective monitoring reportedly allows corruption and lack of accountability among grantees.

Related to these views, the Foundation's staffing level of about three program officers in the Ethiopian country office was seen as low and inadequate to promote sustained engagement with government, communities, and grantees. Clarifying this point, one respondent noted that: "At their Addis Ababa office, you find only two or three people... These people (Packard Staff) do not have enough time for all the activities. Sometimes there is nobody there to attend to you. They are too few and they are overstretched."

This point was further reasserted by another grantee thus: "Packard staff members are too few and are not able to address grantees' issues adequately and in a timely fashion... I think they have to increase their staff number." Respondents argued that a larger workforce is key to the long-term sustainability of the Foundation's efforts. The Foundation's focus on a few regions in the country was viewed by some respondents as ill-considered. The problems associated with high population growth, lack of access to contraceptives, and the scourge of HIV/AIDS were reported to be pervasive in Ethiopia. These were not region-specific issues and therefore required a comprehensive, not a piecemeal response. The view of many respondents was therefore that the Foundation's regional focus makes it difficult for its efforts to deliver the desired level of impact.

2.5. Changes in National and Regional Population and Reproductive Health Indicators

The key objective of this section of the evaluation is to determine the contributions of the Foundation's Ethiopia Sub-program to the national population/reproductive health indicators between 1998 and 2007. The specific task is to identify the changes that have occurred over the past decade in Ethiopia's population growth rate, fertility levels, contraceptive prevalence, maternal and child health, and related population, demographic and reproductive health indicators, and the key achievements of the Packard Foundation and its grantees in these areas.

To achieve these objectives, we triangulate data from the national census and Central Statistical Authority reports, the 2000 and 2005 Ethiopian Demographic and Health Surveys, and the 1999 and 2000 baseline surveys in Amhara and Oromiya regions, respectively. We also utilized published materials from several sources including some from the Packard Foundation, others from a commissioned evaluation and others from the Foundation's grantees and development partners. Finally, we use responses from our IDIs and KIIs in linking the activities of specific grantees to these changes in national population and reproductive health indicators.

2.5.1 Total Fertility Rates

DHS and census data show that the total fertility rate (TFR) in the country steadily dropped from 6.4 in 1990 to 5.9 in 2000 and to 5.4 in 2005 (CSA, Ethiopia & ORC Macro, 2001; 2006). The most recent estimate indicates a further decline to 5.1 in 2007 (CIA, 2007). The changes over the period are summarized in Figure 2.1.

To estimate the role of the Foundation and its grantees in this decline in TFR, we analyzed differentials in fertility levels in Packard and non-Packard zones of Oromiya and Amhara using data from the 2000 and 2005 EDHS. Baseline survey reports in Packard zones of Amhara in 1999 and Packard zones of Oromiya in 2000 were also analyzed. Evidence from our analysis as summarized in Figure 2.2 reveals contrasting results between Oromiya and Amhara. Between 2000 and 2005 Amhara recorded an overall decline of 0.7 child resulting from a sharp drop (5.8-5.1 child) in non-Packard zones and a slight increase (4.8 -5.0 child) in Packard areas. In Oromiya by contrast, TFR slightly declined in Packard areas (5.5-5.4 child) and slightly increased in non-Packard zone (6.2-6.3 child), for an overall drop of 0.2 child between the same period. Further, fertility went down by 0.4 (from 1.8 to 1.4) in the Addis Ababa region, and increased by 0.1 child (from 5.4 to 5.5) in the other regions as a whole. Looking back at the 1999 baseline survey report in Packard zones of Amhara, the recorded TFR was 5.9. For the 2000 baseline survey report in Packard zones of Oromiya region, the recorded TFR was 5.7.

Despite these trends, the points that are clearly manifest are:

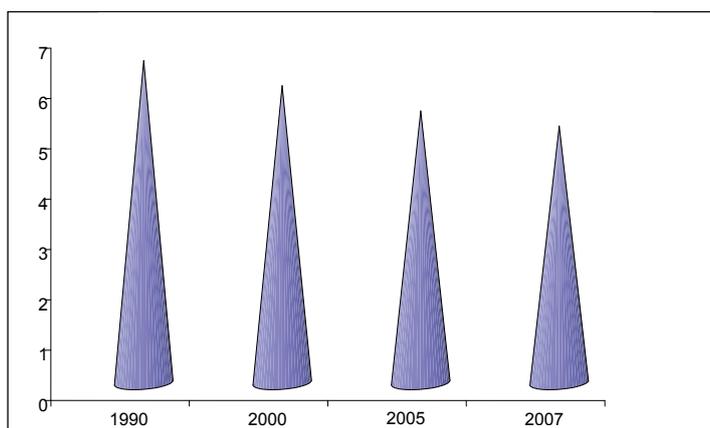
1. There are absolute fertility differentials across regions of the country ranging from near pre-transition high fertility in all regions including Amhara and Oromiya to below replacement fertility for Addis Ababa in 2000 and 2005.
2. A look at the magnitude of fertility reduction in regions where there were decline shows that while there was a 24 percent reduction in fertility in Addis Ababa, there were less than 1 percent and 12 percent declines in Packard and non Packard Oromiya zones, respectively. This outcome suggests that the marginal national fertility reduction over the period is driven primarily by events in Addis Ababa.

Taking into account the challenges of comparing indicators from different surveys following differences in sampling frameworks, these observations raise key challenges for the Packard program in Amhara and Oromiya regions in terms of impacts that will affect national level indicators. Further, the fertility decline observed in Addis Ababa has been linked to a complexity of factors including late marriage, high levels of poverty, youth unemployment and lack of housing in the city (Sibanda, et al 2003). The above findings underscore the limitations of FP and RH programs alone in achieving fertility reductions.

However, the weakness of national sample surveys in capturing local area changes places limits on any certain conclusion here. This is even more so considering the lack of data beyond 2005 when the impact of the programs for indicators like TFR would have matured and become more visible in such national surveys. The marginal increase in TFR observed for Packard Amhara may be related to changes in the composition of the zones under focus between 2000 and 2005. In 2000, Packard zones in Amhara were 70 percent rural, but in 2005, Packard zones were 90 percent rural. Consequently, the fertility differentials between urban and rural areas may have contributed to the observed outcome.

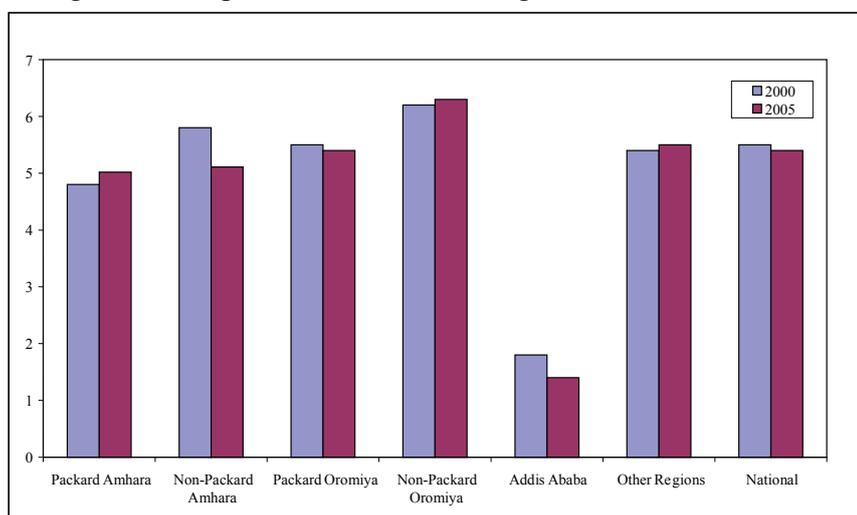
Our KII with the Foundation’s officials in Ethiopia suggested that changes in rural composition of Packard project areas may be related to the fact that the Foundation’s projects were primarily rural-based and programs often moved to other rural areas in attempts to extend projects to remote places without similar programs. It is also important to note that zones and regions designated non-Packard may have had population and reproductive health programs funded by other donors. In fact, interviews with key informants in the field in Ethiopia suggested that in some cases, non-Packard areas might have more programs and better-funded projects by other donors and stakeholders like USAID and Pathfinder International. Taking cognizance of these backdrops, the subsequent sections examine changes in selected proximate determinants of fertility in the general population and among the youth in particular. The variables of interest are: age at first sex; age at first marriage, ideal family size, knowledge and use of contraceptives, unmet need for FP, unplanned pregnancies, teenage motherhood, and HIV/AIDS knowledge and prevention.

Figure 2.1 National Trends in Ethiopia’s TER 1990-2007



Source: CSA, 1994; CSA/ORC-MACRO 2000 AND 2005; CIA, 2007

Figure 2.2 Changes in Ethiopian TER for women aged 16-49, 2000-2006



2.5.2 Age at First Marriage

Marriage marks the point in a woman's life when childbearing becomes socially acceptable in Ethiopia. Age at first marriage has a major effect on childbearing because women who marry early have on average a longer period of exposure to pregnancy and a greater number of lifetime births (EDHS, 2005). Early marriage has been identified among the most prevalent harmful traditional practices (HTPs) in Ethiopia (Birhan Research and Development Consultancy/David and Lucile Packard Foundation, 2001). The median age at first marriage among women age 25-49 is 16.1 years, with 66 percent married by age 18. Beyond the potential for breeding large families, early marriage is associated with high risk pregnancies and complications during delivery, which may lead to high maternal morbidity and mortality. In particular, many women who had early pregnancy and childbirth before physical (biological) maturity end up with fistula complications, with its associated stigmatization. The children of very young mothers also have lower chances of surviving to adulthood compared to other children. The fight against HTPs, including the female genital cut and early marriage, has received encouraging support through legislation on minimum age of marriage at 18 years for both sexes. The Regional Government and NGOs have been leading these efforts.

The Packard Foundation invested substantial resources in Ethiopia towards reducing maternal morbidity and mortality, and preventing unsafe abortion, through preventing early marriage, and by implication early childbirth, as well as other HTPs. Investments in Community Based Reproductive Health Programs (CBRHPs) in Amhara and Oromiya regions have particularly focused on these challenges. Further, female education generally tends to increase age at marriage, explaining the Ethiopian National Education Policy's interest in increasing female enrolment in education at all levels. Again, these national aspirations are consistent with the Packard Foundation's strategy of improving adolescents' livelihood through providing life skills and vocational training, to which the Foundation has made substantial investments. National data have shown noticeable success in these efforts, with the proportion of women married by age 15 declining from 38 percent among those aged 45-49 to 13 percent among those aged 15-19 (CSA and ORC Macro, 2005).

The particular impact of the Packard Foundation-funded program in this regard, can be gauged by examining changes in mean age at first marriage in the zones where the Foundation's grantees have concentrated their activities in Amhara and Oromiya regions in the last ten years against non-Packard zones in the same regions and other regions combined (see Figure 2.3). Case study reports of young women who have been rescued from early marriage and supported by the Foundation's funded programs to continue their education in the two regions are also presented.

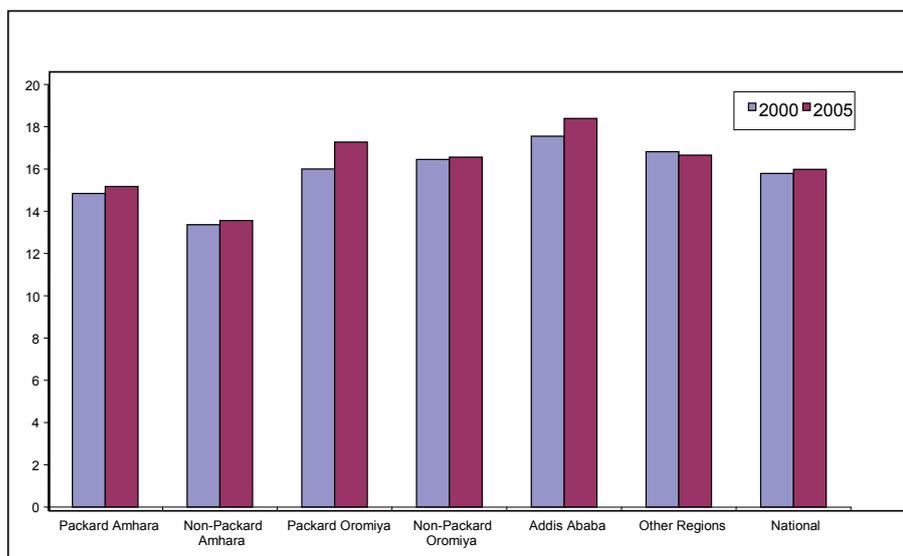
Available data show that age at first marriage slightly increased in Packard and Non-Packard zones in Amhara and Oromiya regions. Surprisingly, the percentage change was higher in Packard than non-Packard zones in both regions. In Amhara, the mean age at first marriage increased by 2.2 percent in Packard zones and 1.5 percent in non-Packard zones. This increase is however not statistically significant. In Oromiya, there was a significant change with a 7.9 percent increase in Packard zones against a 0.7 percent increase in non-Packard zones ($p < .05$). In Addis Ababa, there was a 4.8 percent increase in mean age at first marriage between, 2000 and 2005. The importance of increases in mean age at first marriage in Packard zones and Addis Ababa becomes even more important against the 1.0 percent decrease in other regions of the country.

For further investigation of the roles of the Foundation in addressing the challenges of HTPs, case study in-depth interviews were held with four young Ethiopian women; two had been rescued from early marriages and the other two were young women whose education was being sponsored through the Packard Foundation-funded organizations working at the grassroots levels to improve adolescent sexual reproductive health and women's health. The funded organizations are the Family Guidance Association of Ethiopia (FGAE) and the Amhara Women Association. Other government agencies such as the Ethiopia Police were also involved in fighting HTPs. These organizations have played significant roles in the improvement of adolescent sexual and reproductive health through the prevention of Harmful Traditional Practices like withdrawal of the girl-child from school for early marriages. Concrete achievements were recorded in rescuing girls from early marriages and the provision of funds for education support for bright but poor girls.

Girls benefiting from educational support were particularly appreciative of the change it has made in their lives. One of them maintained:

They selected me because my family is poor. My family had tried to get me married to a man when I was a grade four student...It was when I was under such condition that the Amhara Women Association and Packard came to my village, selected me and gave me the chance for education. Then I came to Bahir Dar to attend school. All my expenses are covered by Packard through Amhara Women Association.

Figure 2.3: Changes in Age at first marriage among Ethiopian women aged 15-49, 2000 and 2005.



Source: EDHS, 2000 and 2005

Another observed:

I am 14 years old and a grade six student... My family asked me to stop my education from grade four and manage the house... Then when I found myself in a difficult situation I told the case to my teacher who is living in our village. The man who asked my parents to get me married was a priest and was about 30 or more years old. Therefore, through my teacher I wrote a letter to the district's women counseling committee about my case. Then they tried to talk to my parents but they refused. Then the issue was taken to the district police and the police gave them warning that if they don't cancel the marriage they will be fined 5000 Eth. Birr or sentenced to five years imprisonment. When they are given this warning they became afraid of the measure and then they let me to go to school.

Asked about their opinions regarding this support, the girls were grateful for it and requested for extension up to the final grade. One of the girls suggested that the opportunity be extended to other girls, noting that girls needed education to overcome their vulnerability to early marriage, HIV/AIDS, and to dependence on men.

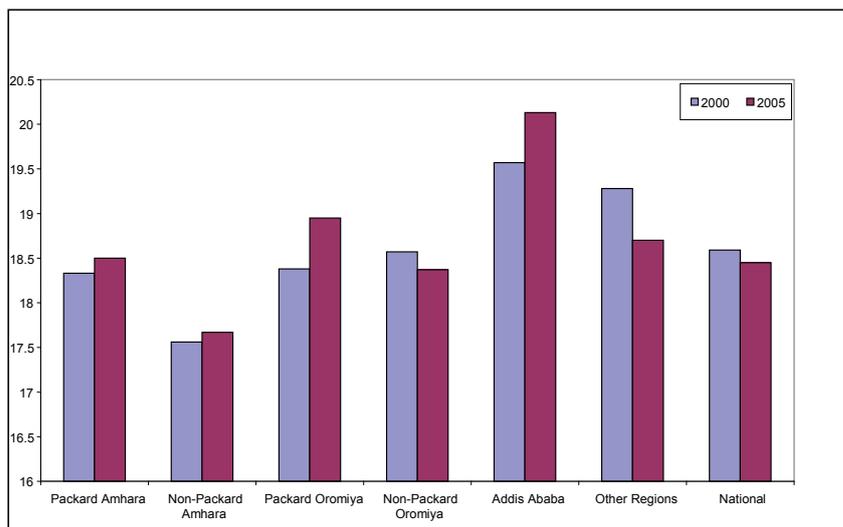
A significant dimension of national and regional differentials in demographic indicators relates to the age at first birth for women of child-bearing age. Generally, child-bearing begins early in Ethiopia but available national level reports suggest a recent rise in the age at first birth in the country (EDHS 2005). Our examination of this indicator as summarized in Figure 2.4 confirms a higher but marginal increase in Packard zones relative to non-Packard zones in Amhara and Oromiya.

We observed a statistically significant increase in age at first birth in Addis Ababa, the national capital relative to other regions of the country, with a 3 percent increase between 2000 and 2005. Despite the activities of Packard grantees in Oromiya and Amhara, particularly those focusing on campaigns against harmful traditional practices (HTPs) such as early marriages and outcomes such as VVF, age at first birth, the areas did not show significant impacts relative to non-Packard Amhara and Oromiya zones, respectively.

While acknowledging the weaknesses of national level surveys in capturing local specific situations, our conclusion based on the DHS data is further limited by the surveys not covering the periods 2006-2007 (the period which, as our desk reviews indicated, witnessed significant increase in activities expected to impact early marriage and early child bearing).

As indicated above, FP/RH programs funded by other donors are being implemented in non-Packard areas and other regions of the country. To that extent, lack of significant differences in outcomes may not be a reflection of lack of significant impact of the Foundation's funded programs. To address quantitative data shortfalls, we complement available surveys data with other data gathering instruments. In this case for instance, other data sources we examined, including reviews of reports, IDIs and KIIs, suggest that Packard funded programs in Amhara and Oromiya regions have had more impact than what is captured in the secondary data analyzed here.

Figure 2.4: Changes in mean age at first birth among Ethiopian women 15-49 (2000-2005)



Source: EDHS, 2000 and 2005

2.5.3 Ideal Family Size

Having too many children has been linked to adverse economic, health and social consequences. Generally, a change in ideal family size preferences is an indicator of the beginning of change in fertility behavior. Information on ideal family size generally provides insight into a couple's attitude towards future childbearing, desired completed family size, the extent of unwanted and mistimed pregnancies, and the prevailing demand for contraception (CSA/ORC-Macro, 2000, 2005; Robinson, 1992). Ideal family size preferences are influenced by a host of factors including age, women's level of education and socioeconomic status, and modernization (Benefo, 1990: *Population Action International* (not dated).

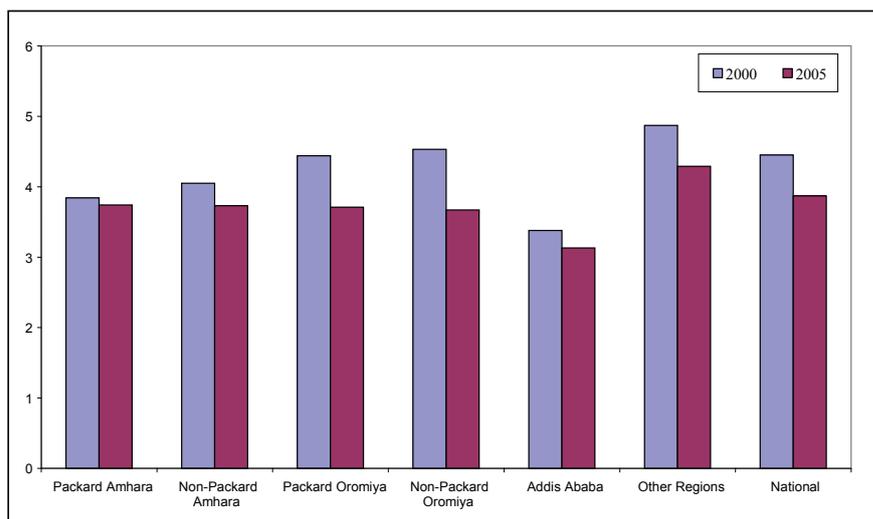
Following the Foundation's investments in the area of family planning and reproductive health including IEC campaigns, which aim to change not only people's attitudes towards large families but also to inculcate small family size norms, we examine emerging changes in family size norms in the two regions of Amhara and Oromiya. The baseline survey in the three initial Packard program zones of Amhara found a strong pronatalist belief that children are gifts from God and that to have large numbers of children is considered a blessing. The mean ideal number of children for the zones at baseline was 4.3 and this ranged from 3.5 for those aged 15-19 to 6.0 for those aged 45-49. Nationally, the mean ideal number of children among all women who gave numeric responses was 5.3 and 5.8 among currently married women in 2000; this dropped to 4.5 among all women who gave a numeric response in 2005 and 5.1 among currently married women (CSA and ORC Macro, 2000, 2005). Between 2000 and 2005, mean desired family size declined by about one child for both men and women although men reported one child more than women on average in each survey year.

Data on ideal number of children for Packard and Non-Packard areas in Amhara and Oromiya regions (as shown in Figure 2.5) confirm an overall reduction in family size aspirations nationwide. However, our results further suggest a more substantial percentage reduction in areas where the ideal number of children was more than four at the beginning of observation.

Further evidence of positive change towards smaller family size norms can be located in the reduction of the number of women who gave non-numeric responses from about 70 percent during the 1999 baseline survey in Amhara to 15 percent in the 2005 EDHS. While comparing these two surveys may be problematic, the increase in the number of women giving numeric response to the number of children they preferred in 2005 suggested that the conditions for change in fertility behavior are in the horizon. Generally, women who gave non-numeric responses are associated with high fertility aspirations. Further, by 2005, a sustained decline had occurred in desired family size, contradicting the high family size preferences observed between the baseline and 2000 in the Packard project zones.

A key feature of the Foundation's funded programs from 1998 to 2007 is the use of IEC campaigns at both local and national levels. Beginning in 2001, Packard-funded CBRH programs in Amhara and Oromiya zones extensively distributed IEC materials (leaflets, posters, magazines, que-cards). Similarly, the Private Sector Franchise Initiative, the LTPM projects, the social marketing program, the strategy seeking the reduction of maternal mortality and unsafe abortion, including adolescent RH programs invested heavily on the production and distribution of IEC materials.

Figure 2.5 Changes in ideal number of children among Ethiopian women 15-49, 2000 and 2005



Source: EDHS, 2000 and 2005

In most cases the electronic and print media were utilized at the local and national levels reaching a wider audience of Ethiopians. The impact of these campaigns that may have gone beyond Packard project zones, together with the activities of other actors in other regions of the country may account for improved knowledge and elements of behavior change in both Packard and non-Packard zones and other regional states.

2.5.4 Contraceptive Knowledge and Use

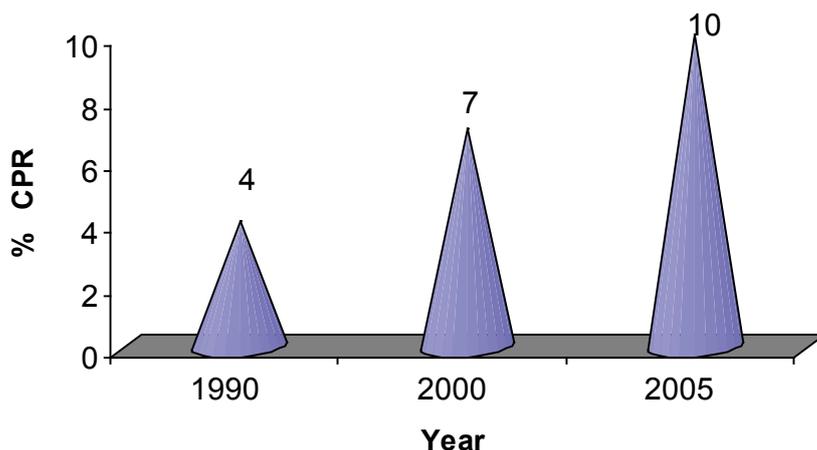
Knowledge and use of family planning services provide insights into one of the principal determinants of fertility and serve as an indicator of the success of family planning programs. The 2000 and 2005 EDHS reports indicate that knowledge of any method of family planning was not universal in the country, with 82 percent and 86 percent women and men reporting knowledge of any method in 2000, respectively. These increased to 86 percent and 91 percent, respectively by 2005. Ever use of any modern method for all women and men in the 2000 EDHS was low at 11 percent and 12 percent, respectively, increasing to 17 percent and 15 percent, respectively in 2005. In 2000, current use of any modern method for men and women of all ages was 4.7 percent and 6.9 percent, respectively. In 2005 the contraceptive prevalence rate for women of all ages that were current users of any modern method was only 9.7 percent. Trends in contraceptive use summarized in Figure 2.6 indicate a threefold increase in the 15-year period between 1990 and 2005.

The Packard Foundation made substantial investments towards expanding access to family planning and reproductive health information and service delivery through funding a variety of projects in the Amhara and Oromiya regions since 1998. The variety of innovative service delivery models supported by the Foundation include community-based programs, private sector franchise initiatives, improving access to permanent and long term family planning methods through clinics and social marketing, linking FP/RH services with women's economic empowerment projects, reducing maternal morbidity and mortality through the prevention of unsafe abortion, provision of post-abortion care and promoting the use of antenatal and postnatal care services, and the creation of awareness concerning HIV/AIDS.

At the onset of the Packard's program in Amhara, the baseline survey identified relatively high levels of knowledge of family planning at 73 percent, but the rate of contraceptive use was very low in these zones, with ever use at 12 percent and current use of any method at 7 percent. Baseline data from Oromiya zones where the Foundation initiated the population intervention programs showed that about 67 percent of all married women knew of at least one method of family planning. Ever use was 15.7 percent while current use of any method of family planning was only 8.7 percent. Knowledge of any method of family planning in the Packard and non-Packard zones in Amhara and Oromiya are summarized in Figure 2.7, showing significant changes between 2000 and 2005. In Amhara, the significant increase ($P < .05$) was in non-Packard areas of Amhara. In Oromiya, however, although percentage change was slightly higher in Packard zones, the difference in non-Packard zone was not statistically significant.

In terms of ever use of any family planning method, Figure 2.8 shows that there is an increase for all regions of the country except Addis Ababa and Packard zones of Oromiya. Despite a significant increase in non-Packard zones in Amhara and Oromiya, ever use in those zones were lower in 2000 and 2005 relative to Packard Amhara zones and Addis Ababa. The increase in non-Packard Oromiya enabled ever use to measure up to percentage of ever use in Packard Oromiya in 2000 and 2005.

Figure 2.6: Trends in contraceptive prevalence rate



Source: CSA, Family and Fertility Survey, 1990; CSA, Demographic and Health Surveys 2000 and 2005.

In terms of current use of contraceptives, Figure 2.9 shows significant increase in all regions of Ethiopia between 2000 and 2005. Again, as with ever use, percentage change in contraceptive prevalence rate was higher in areas with lower levels of CPR at the onset of observation in 2000, particularly in non-Packard areas of Amhara and Oromiya regions.

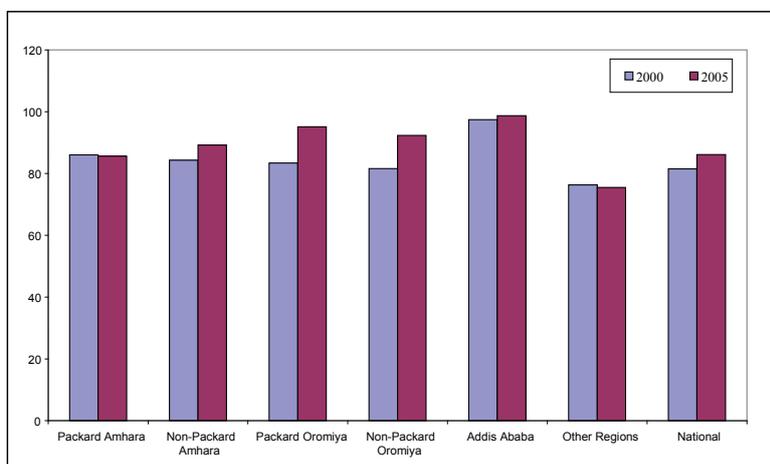
One key dimension of our finding is evidence that current use of all and modern contraceptives are gendered with men more likely to be current users than women in all regions, except in Amhara zones where Packard projects were located.

In Amhara Packard zones there was no significant difference in current use of FP for women and men in both 2000 and 2005, but for all other parts of the country including Addis Ababa, the proportion of men who are current users are significantly higher than that of women. Despite investments in this area, the obvious fact remains that CPR is generally low in Ethiopia, including Packard and non-Packard zones of Amhara and Oromiya. However, it is important to note that CPR increased nationally by 74 percent between 2000 and 2005, though the growth was driven more by places outside the Packard zones in Amhara and Oromiya. One feature of our data which may have accounted for capturing little significant changes in Packard zones in Amhara in 2005 may relate to the fact that 91 percent of women interviewed in Amhara in 2005 were living in rural areas of Ethiopia as opposed to 77 percent in 2000. Yet this highlights the limited coverage of programs in rural areas of the country and defines some of the challenges for the Packard program moving forward.

2.5.5 Unmet Need for Family Planning

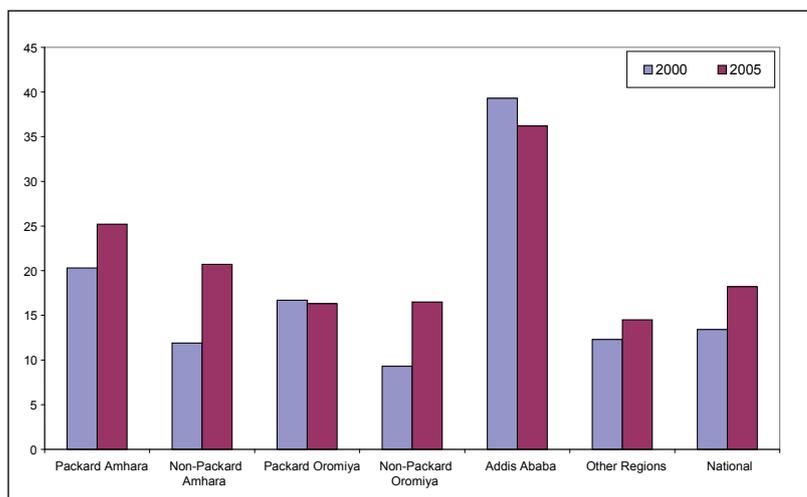
Unmet need for family planning is defined with reference to women who have family planning needs but who are not currently using any method of family planning for child spacing or limiting. Unmet need usually results in unwanted or mis-timed pregnancies and/or childbirth. This indicator identifies the extent of need and the potential demand for

Figure 2.7 Changes in Knowledge of FP methods among Ethiopian aged 15-49, 2000 and 2005



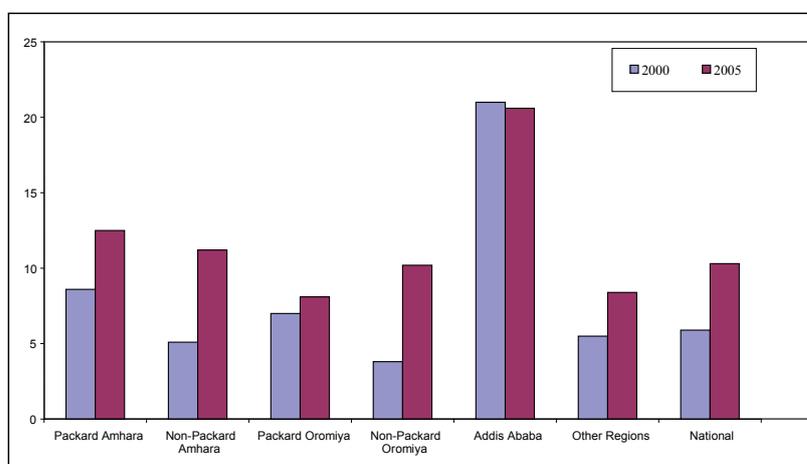
Source: EDHS 2000 and 2005

Figure 2.8 Changes in ever use of contraception among Ethiopian women 15-49, 2000 and 2005



Source: EDHS, 2000 and 2005

Figure 2.9 percentage change in current use of FP among Ethiopian women 15-49, 2000 and 2005.



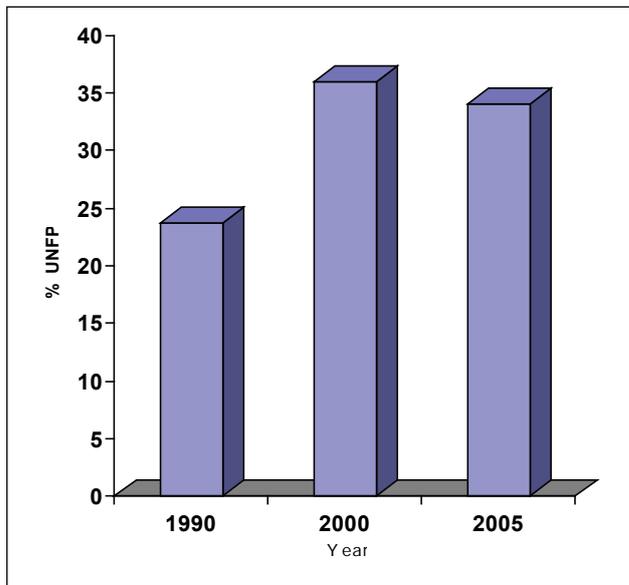
Source: EDHS, 2000 and 2005

family planning services. In 2000, 36 percent of currently married women had an unmet need for family planning with 22 percent having an unmet need for child spacing and 14 percent an unmet need for limiting. In 2005, the level of unmet need slightly decreased nationwide to 34 percent, with 20 percent having an unmet need for child spacing and 14 percent having an unmet need for limiting. The national trend in unmet need for family planning is summarized in Figure 2.10. In terms of the roles of the Packard Foundation’s intervention programs in Ethiopia on these changes, we examined the unmet need for family planning in Packard and non-Packard zones in Amhara and Oromiya regional states using data from the 2000 and 2005 EDHS.

In Figure 2.11, unmet need for family planning for Packard Amhara zones was 27.5 percent in 2000, decreasing to 17.3 percent in 2005 (37 percent decrease in unmet need). For non-Packard Amhara, unmet need decreased from 30.3 percent to 21.2 percent (a 30 percent decrease). In Oromiya however, unmet need for FP increased by 9.8 percent in Packard and 10.8 percent in Non-Packard zones. Although the changes in Amhara and Oromiya regions were not statistically significant, the outcome in Amhara suggests a positive impact of the FP campaigns and services expansion in the region. The challenge here is the observed increase in unmet need in Oromiya region, including the Foundation’s program zones. But this could also be positive to the extent that the outcome is an indicator that many more women were expressing a desire to stop or limit childbearing, then an increase in unmet need is quite positive and expected. Against the backdrop of the increase in small family size preferences above, an increase in unmet need can be a logical indicator of the desire to achieve desired small family size, suggesting growing demand for family planning services.

It is important to note that Addis Ababa remains the region with the lowest unmet need for family planning, and there was about 58 percent decrease in the region’s level of unmet need in the five years under review. There has been little change in unmet need for family planning over the past five years in other regions of the country (21.4 percent in 2000 and 20.4 percent in 2005).

Figure 2.10 Unmet Need for Family Planning (UNFP)



Source: CSA, Family and Fertility Survey 1990 CSA and ORC Macro, Ethiopia Demographic and Health Surveys 2000 and 2005

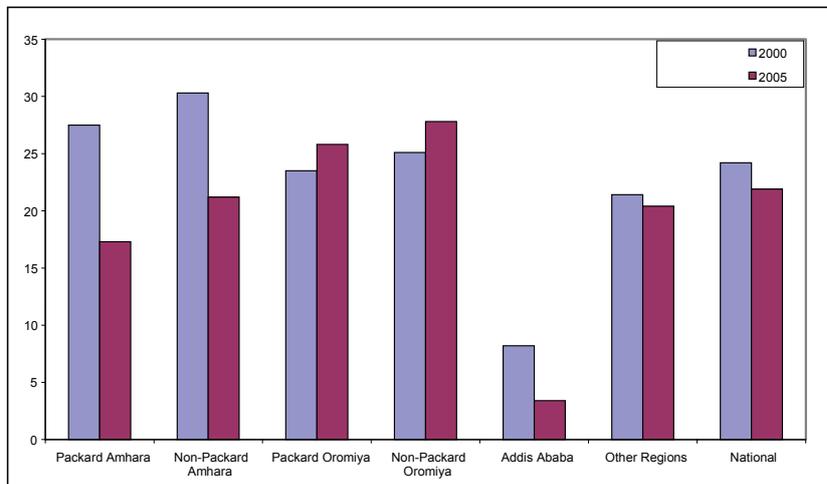
A decreasing unmet need in Packard, non-Packard Amhara and Addis Ababa, coupled with increases in current contraceptive use and desire for smaller family size, could indicate increasing effort to meet existing demand and suggest the need to increase or stimulate further demand as a priority program focus in the future. The increase in unmet need in Packard and non-Packard Oromiya with a relatively less than commensurate increase in contraceptive use, points to the immediate and future need to increase supply of family planning methods to meet created demand.

2.6 Focus on Ethiopian Youths

Ethiopian youths aged 10-24 years constitute about a third of the population and most of them are exposed to life-threatening sexual and reproductive health problems, including sexual coercion, early marriage, polygamy, female genital cutting, gender inequality, unplanned pregnancies, closely-spaced pregnancies, abortion, sexually transmitted infections (STIs), and HIV/AIDS. Lack of education, unemployment, and extreme poverty further exacerbate and perpetuate the reproductive health problems faced by Ethiopian youths.

In response to the vulnerability young Ethiopians face in their daily lives, the Packard Foundation defined Adolescent Sexual and RH (ASRH) as one of its three core areas of work. Started in 2000, programs funded under the ASRH cluster amounted to about 28 primary grants, which constituted about 19.4 percent of all funds expended by the Packard Foundation Ethiopia Population Sub-program in the last 10 years. The program focused on three key areas, namely

Figure 2.11 percentage of unmet need for family planning, 2000 and 2005



Source Ethiopia DHS reports 2000 and 2005

provision of youth-friendly services (including information, education, and counseling services); establishment of youth self-help initiatives, creating and strengthening youth club network, and the promotion of youth development and protection, among others. In recognition of the negative consequences of joblessness among the youth on their risk-taking behavior and their sexual and reproductive health status, the Foundation funded the integration of marketable vocational skills training and ASRH. This goal was pursued through the establishment of Adolescent Reproductive Health (ARH) centers in Amhara and Oromiya regions. These centers trained youths in computer and entrepreneurial skills, including life skills components, together with offering family planning/reproductive health information and counseling services to the youth, as well as entertainment facilities and libraries.

One of the key goals of the Packard Foundation's Population Sub-program in Ethiopia over the period under review was to reach more than 500,000 adolescents with family planning information and services and to increase contraceptive prevalence rate by more than 20 percent in areas served by grantees. Previous evaluation of these projects (*Packard Foundation Ethiopia: Background Paper, 2008*) identified over nine million young people as having received information on RH/FP, with more than 200,000 receiving RH services and 100,000 counseled and referred to health facilities. Also the ASRH programs were linked to the provision of diversified skills, vocational and leadership development training to over 2,000 young people. In a particular Packard-funded program in Oromiya region, the evaluation demonstrated that the overall goals of the youth intervention were largely met with knowledge of ARSH and interpersonal communication regarding HIV/AIDS, family planning and other ARSH matters, with both parents and sexual partners significantly improved. The use of youth friendly SRH services, such as VCT, family planning and counseling services were reported to have improved significantly. The age at sexual debut was reported to have increased, especially in males and the number of sexual partners and incidence of casual sex decreased significantly.

To evaluate these programs and success stories, we focus on national and regional RH indicators of Ethiopian youth using the EDHS 2000 and 2005 data. We identify changes over time in ASRH indicators particularly in regions served by the Packard Foundation Programs focusing specifically on age at first marriage and first sex, youth pregnancy and motherhood, young people's knowledge, ever and current use of contraceptives, HIV/AIDS knowledge and prevention.

2.6.1 Age at First Marriage

Defined as the age at which a man/woman starts living with his/her first spouse, age at first marriage for a woman, marks the point in her life when childbearing becomes socially acceptable with implications for the risk of pregnancy and lifetime fertility. In 2000, 69 percent of Ethiopian adolescents aged 15-19 were not married and this increased to 73 percent by 2005. Over the same period, the proportion of Ethiopian youths aged 20-24 who were not married was 30.3 in 2000 and 26.9 percent in 2005. Generally as shown in Figure 2.12, there were marginal changes in the mean age of first marriage across all regions of the country between 2000 and 2005, including Packard and non-Packard Amhara and Oromiya zones.

The Packard Foundation's grantees in both Oromiya and Amhara regions addressed issues regarding harmful traditional practices (HTP), including early marriage with reported successes.

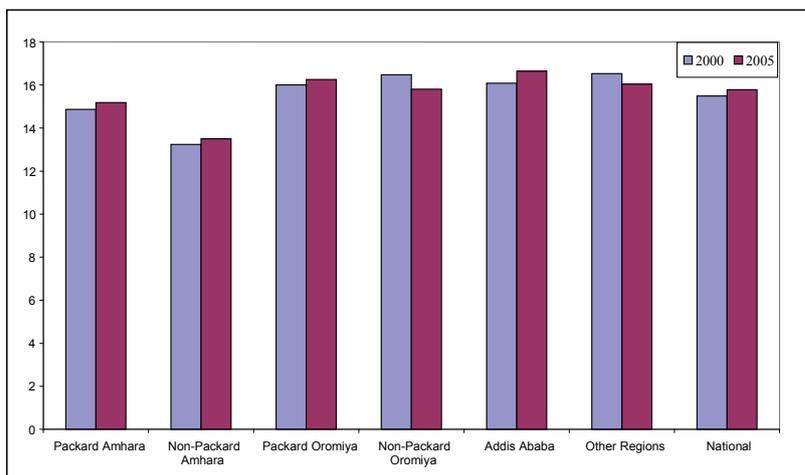
Although our analysis of the EDHS data in the period covered by the survey does not lend strong support to the impact of these campaigns, the lack of secondary data to examine the last two most recent years of the Foundation's Ethiopian Sub-program (2006 and 2007) remains a key limitation. However, other methods employed for the evaluation identified concrete achievements. For instance, apart from changes in the policy environment orchestrated by activities of the Foundation's grantees, concrete achievements were reported above in terms of rescuing girls from early marriages and provision of funds for the education of bright but poor girls.

2.6.2 Age at First Sex

Age at first sex has generated particular interests following findings that the timing of first sexual intercourse is highly associated with exposure to sexually transmitted diseases (STDs) and HIV/AIDS, human papilloma virus and precancerous changes of the cervix, use of contraception, pregnancy and pregnancy-related complications (Gage, 1998; Blum, 2002, Abanihe & Oyediran, 2004). Following investments by the Packard Foundation, through its grantees, to improve ASRH in Ethiopia over the last ten years, we examined changes in age at first sex among Ethiopian youths. Figure 2.13 shows marginal increase in age at first sex of female youths in Packard Amhara zones between 2000 and 2005 from age 15.17 to 15.28 (2.1 percent change).

In Packard Oromiya, there was a change from 16.01 to 16.37 (2.2 percent increase). In non-Packard Oromiya, there was a 3.4 percent reduction in age of first sex, indicating a more substantial change than the outcome in Packard

Figure 2.12: Age at First Marriage among Ethiopian youths, 15-24, 2000 and 2005



Source Ethiopia DHS reports 2000 and 2005.

Amhara zones. One key outcome from our analysis is that the mean age at first sex was higher for male youths by over two years on the average across all regions of Ethiopia. The gap is even more pronounced in Packard and non-Packard zones of Amhara where male youths delay sexual initiation by over three years relative to female youths. It is important to further underscore the vulnerability of young Ethiopian women to early sexual exposure relative to male youths, with age at first sex for Addis Ababa and the national average showing marginal decline over the period for female youths. As indicated above, data for the most recent two years of the program may have yielded more substantial outcomes. It is important to underscore, once more, the fact that Packard-funded programs were primarily rural-based and evidence of comparable indicators for these rural places and more urbanized areas of the country may suggest more positive outcomes of programs located in these rural communities.

2.6.3 Youth Pregnancy and Motherhood

Figure 2.14 shows that pregnancy and motherhood among Ethiopian women aged 15-24 declined nationally by 17 percent between 2000 and 2005. Packard Amhara experienced a 12.5 percent decline in youth pregnancy and motherhood, while non-Packard Amhara witnessed a 29.5 percent decline. Packard and non-Packard Oromiya zones witnessed about 7.3 percent and 7.4 percent decline in youth pregnancy and motherhood between 2000 and 2005, respectively. Again, Addis Ababa with a 50 percent decrease primarily drives the national indicator over the period under observation.

2.6.4 Contraceptive knowledge, Ever and Current Use among Ethiopian Youth

The different programs supported by the Packard Foundation in Ethiopia attempted to address the sexual and reproductive health problems of youths through the provision of youth-friendly information, education and counseling services. Following the huge emphasis on IEC, we specifically focus on changes in knowledge of contraceptives among Ethiopian youths and how it is translated to use of contraception. The knowledge of modern contraceptive methods is very high among youths aged 15-24. In 2000, knowledge of any modern method was 74 percent and increased to

Figure 2.13 Age at first sex among Ethiopian female youths age 15-24, 2000 and 2005

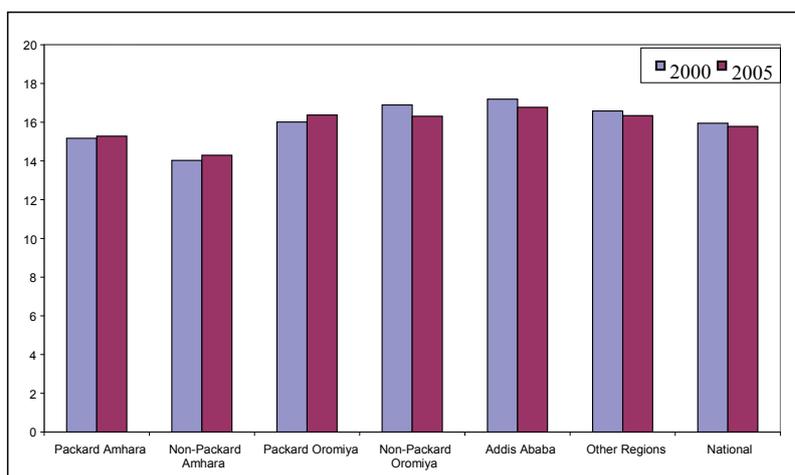
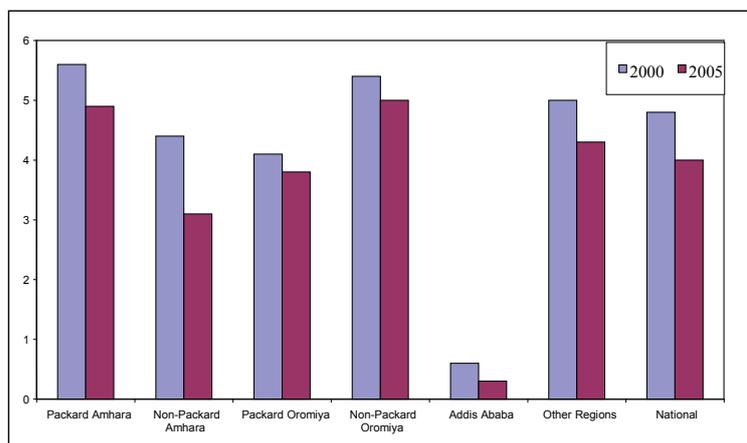


Figure 2.14 Youth pregnancy and motherhood among Ethiopians 15-24, 2000 and 2005



Source: EDHS, 2000 and 2005.

84 percent by 2005. Knowledge was equally high among youths who had not been initiated into sexual activities. On ever use of modern contraceptive methods, the percentage of ever users is very low. For 2000, 6.5 percent of youths aged 15-24 had ever used any modern method of contraception, increasing to 10.3 percent by 2005. For current use, the national figures stood at 2.6 percent in 2000 and increased to 5.9 percent in 2005. In essence, ever and current use of modern methods of contraception are generally low among youths in the entire country.

In terms of the regions of the country, evidence from Moore et al. (2008) suggests that knowledge of contraceptive methods was higher in regions where Packard interventions were ongoing in 2000, the level of knowledge reversed in favour of non-Packard areas in both Amhara and Oromiya regions in 2005. However, they indicate a significant difference in favour of areas of Packard interventions in ever and current use of modern contraceptive methods. However, in a comparison among women who had ever had sexual intercourse, they found no significant difference in ever use. In Table 2.1, we show that the percentage increase in knowledge of modern contraceptives was highest among girls in Packard Oromiya zones, declined in Packard Amhara but increased in all non-Packard zones. The highest percentage of girls who had ever used modern family planning in 2005 was in Packard Amhara zones, though that was only an 11.6 percent increase from 2000. The highest increase was in non-Packard Amhara and Oromiya with increases of 96 percent and 134 percent, respectively, between 2000 and 2005.

On current use, despite the abysmally low national average, the highest percent of current users was in Addis Ababa, Packard and non-Packard Amhara zones. However, the highest percentage increases were recorded in non-Packard Oromiya (500 percent) and non-Packard Amhara (200 percent). We compared these female indicators to male indicators but found no consistent gendered pattern. While male youths indicate marginally higher levels of knowledge, the reverse was the case in terms of ever and current use.

Despite the inconsistent outcomes and the limitation of our secondary data in terms of lacking observations for the last two years (2006-2007), the overall low levels of ever and current use of modern contraceptives among youths underscore the challenges associated with translation of knowledge to practice. The high levels of knowledge highlight the successes of IEC programs but the disparity between high levels of knowledge and low levels of ever and current use suggests that the FP challenge lies beyond IEC campaigns. Our IDIs and KIIs, including review of relevant literature, identified availability and sustainability of FP services, and poverty among the key hindrances to ever and current use of FP services. In fact most grantees point to the inability of their programs to meet the demand for services created by the huge successful IEC campaigns. Other hindrances identified by Packard grantees include infrastructural limitations, particularly those related to lack of key personnel, health facilities, transport infrastructure and transport facilities.

2.6.5 HIV/AIDS Knowledge and Prevention

The first evidence of HIV infection in Ethiopia was found in 1984 and the first AIDS case was reported in 1986. Although the prevalence was low in the 1980s, estimates by the end of 2000 put those living with HIV/AIDS at 2.6 million, of whom 250,000 were children below age five. The U.S. National Intelligence Council (2002) projected that the next wave of the AIDS epidemic in Ethiopia will grow astronomically by 2010. Estimates in Ethiopia were primarily derived from testing pregnant women who received antenatal care at sentinel surveillance sites (CSA/ORC Macro, 2001). The 2005 Ethiopia DHS was the first national survey to include population-based HIV testing, offering the opportunity to obtain information on the magnitude and patterns of HIV infection in the general reproductive age population for both males and females in the country. The 2005 EDHS indicates that 1.4 percent of Ethiopian adults

Table 2.2: Levels Of Knowledge, Ever Use and Current Use of Modern Contraceptive Methods among Youths 15-24 By Packard And Non-packard Regions.

	2000	2005	% Change
Knowledge			
Packard Amhara	82.1	80.5	-1.9
Non-Packard Amhara	77.1	87.0	12.8
Packard Oromiya	74.4	92.8	26.8
Non-Packard Oromiya	73.8	89.8	22.1
Addis Ababa	96.1	97.9	1.9
Others	68.0	73.3	7.8
National	74.1	84.0	13.4
Ever use			
Packard Amhara	14.7	16.4	11.6
Non-Packard Amhara	7.5	14.7	96.0
Packard Oromiya	7.0	10.2	45.7
Non-Packard Oromiya	3.5	8.2	134.3
Addis Ababa	13.7	16.0	16.8
Others	6.3	7.4	17.5
National	6.5	10.3	58.5
Current use			
Packard Amhara	5.6	7.7	37.5
Non-Packard Amhara	2.6	7.8	200.0
Packard Oromiya	3.3	5.4	63.6
Non-Packard Oromiya	0.9	5.4	500.0
Addis Ababa	7.1	8.9	25.4
Others	2.9	4.6	58.6
National	2.6	5.9	126.9

Source: EDHS, 2000 and 2005.

aged 15-49 were infected with HIV; and HIV prevalence among women are nearly two percent, while for men it was under one percent (CSA/ORC Macro, 2006).

The most recent estimates from the UNAIDS/WHO indicate that the number of people living with HIV was estimated at 980,000 in 2007, with an overall adult HIV prevalence of two percent. HIV prevalence is 2.6 percent among women and 1.7 percent among men. The adult HIV prevalence in urban areas is estimated at 7.7 percent compared to 0.9 percent in rural areas. The regions with the highest prevalence are Gambela with 8.3 percent in urban areas, Addis Ababa with 7.5 percent and Dire Dawa with 4.2 percent. Other regions with HIV prevalence higher than the national average are Harari (3.2 percent), Amhara (2.7 percent) and Tigray (2.7 percent). Somali is the region with the lowest HIV prevalence in Ethiopia with 0.8 percent.

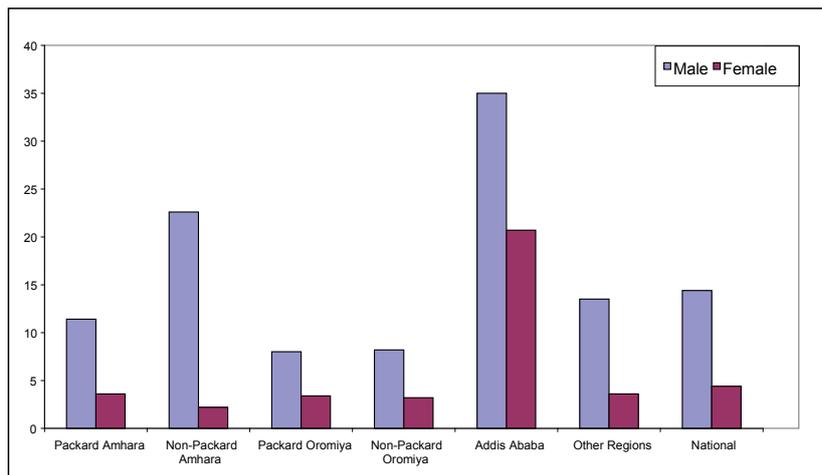
In general, the AIDS epidemic remains a development priority and one of the components of the country's national plan for accelerated development to end poverty. Following the focus of HIV/AIDS prevention campaigns on youths; we evaluated the impact of the Packard Foundation's HIV related projects in Ethiopia on youths age 15-24 using the 2005 EDHS data by examining the level of comprehensive knowledge of AIDS and source of condoms, prevalence of adolescent high risk sexual behavior and prevalence of HIV testing.

2.6.6 Level of Comprehensive Knowledge of AIDS

Comprehensive knowledge of AIDS is defined as 1) knowing that both condom use and limiting sex partners to one uninfected person are HIV/AIDS prevention methods, 2) being aware that a healthy-looking person can have HIV, and 3) rejecting the two most common local misconceptions—that HIV/AIDS can be transmitted through mosquito bites and by sharing food. According to the EDHS results, 16 percent of women and 30 percent of men in Ethiopia generally have comprehensive knowledge of HIV/AIDS prevention and transmission.

The percentages of youth aged 15-24 with comprehensive knowledge of AIDS was 20.5 for women and 33.3 for men. The regional distribution of comprehensive knowledge is presented in Figure 2.15. The key picture that emerged is that comprehensive knowledge of AIDS was gendered, with more male youths across all regions having comprehensive

Figure 2.15 Comprehensive knowledge of HIV among Ethiopian youths 15-24



Source: EDHS 2005

knowledge about AIDS. It is also evident that national comprehensive knowledge of HIV/AIDS, though very low was primarily driven by Addis Ababa. HIV knowledge indicators remain low among men and women in both Packard Amhara and Packard Oromiya zones. Other regions manifest higher levels of knowledge for male youths relative to those in sites of the Foundation-funded operations. Again, while these outcomes do not confirm the enormous work undertaken in the last ten years as other sources of data affirm, it raises the critical issue of what people really know or what they take away from campaigns. The number of people reached by a campaign is important. However, the validity and depth of knowledge that can be applied to achieve desired outcomes are more critical. The female youth disadvantage highlighted by these results underscores once more the gendered nature of Ethiopian society and the disadvantage it entails for young women.

2.6.7 Prevalence of Adolescent High Risk Sexual Behavior

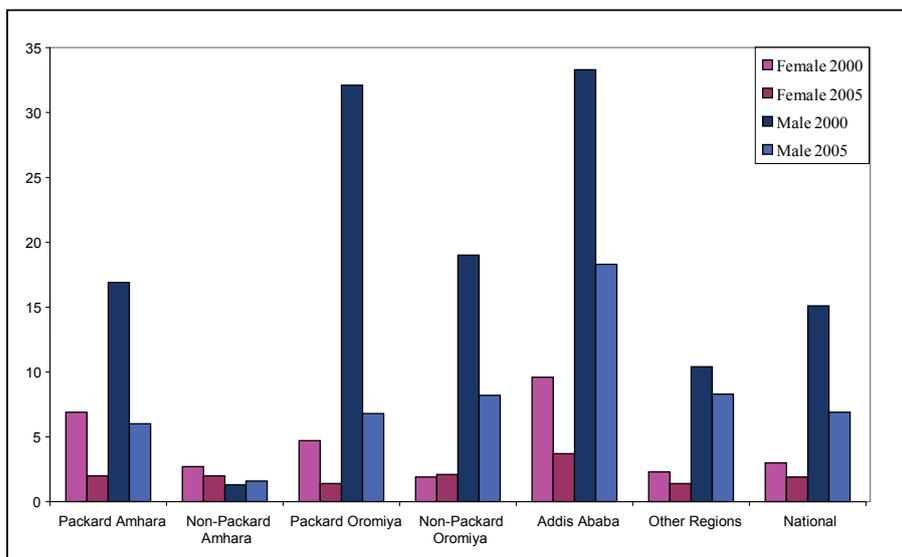
An important measure of the success of reproductive health intervention programs, particularly those dealing with HIV prevention may be related to the level of behaviour change over the period of the campaign and beyond. We assessed the proportion of youths who engaged in high risk sexual relationships 12 months before the survey. High risk sexual intercourse is defined as sex with a non-marital, non-cohabiting partner in the 12 months preceding the survey. The result of our analysis shown in Figure 2.16 identified 3.0 percent of women and 15.1 percent of men aged 15-24 in 2000 engaged in high risk sexual intercourse in the 12 months prior to the survey in the country. In 2005, there was a reduction to 1.9 percent (36.7 percent reduction) for female youths and 6.9 percent (54.3 percent reduction) for male youths. Generally, our result suggests that higher risk sexual intercourse is gendered, with male youths being more likely to engage in sex with non-marital, non-cohabiting partners in the 12 months preceding the survey. Apart from Addis Ababa, high risk sexual behaviour among male and female youths was predominant in Packard Amhara and Packard Oromiya zones in 2000. However, the two zones experienced the largest percentage decline in high risk sexual behaviour by 2005. Packard Amhara zones witnessed a 71 percent and 65 percent decline in high risk sexual behaviour among female and male youths, respectively, over the period.

Similarly, Packard Oromiya zones witnessed 70 percent and 79 percent decrease in high risk sexual relationships between 2000 and 2005 among female and male youths, respectively. Our results suggest a significant and consistent behaviour change in Packard zones in the period we have data. While we may not wholly attribute the outcome to the Packard Foundation programs, the result suggests positive impact of the program in these areas in terms of behaviour change.

2.6.8 Prevalence of HIV Testing

HIV testing is carried out to determine the prevalence of HIV in a population. Following the need for evidence based response to the AIDS epidemic in Ethiopia, information on HIV testing was collected in the 2005 EDHS. Against the backdrop of the role of knowledge about HIV-status in equipping individuals for specific decisions to protect themselves if they are negative or seek care if otherwise, we present the prevalence of HIV testing among young men and women aged 15-24. Our analysis of the 2005 EDHS data shows that 1.5 percent of male youths in 2000 and 5.5 percent in 2005 have tested for HIV and received their results in the past 12 months before the survey. We only have data on female youths for 2005 and 5.7 percent of those aged 15-24 have tested for HIV and received their results in the past 12 months before the survey. In terms of regional coverage, Figure 2.17 shows no statistically significant difference between males and females in HIV testing all over the country.

Figure 2.16: Risky Sexual Behavior among Ethiopian youths 15-24, 2005

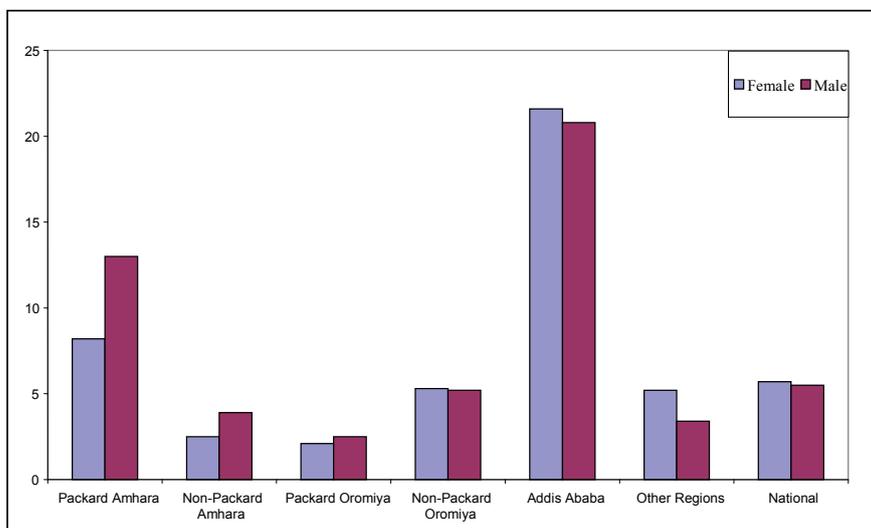


Source, 2000 and 2005 Ethiopia DHS.

It is important to note, however, that there was a statistically significant difference in prevalence of HIV testing in Packard Amhara and non-Packard Amhara zones, with higher prevalence in Packard zones for both male and female youths. However, the reverse seems to be the case in Packard Oromiya relative to non-Packard Oromiya; more so Packard Oromiya in particular and Oromiya region generally have the lowest percentage of male and female youths who had undertaken HIV testing in Ethiopia by 2005. Again, like most indicators considered, there was a general low level of testing countrywide and with the exception of Addis Ababa, regional prevalence was generally under six percent with marginal variations between them.

In concluding this section, it is important to reiterate that the analysis was limited by lack of secondary data for the last two years of the observation period (2006 and 2007), when most of the projects recorded increased activities. Also, the fact that other programs are being implemented in non-Packard areas of Amhara and Oromiya, together with other parts of the country by other key players, may account for the lack of significant differences in outcomes between Packard and non-Packard areas in our analysis. Finally, the fact that the Foundation's projects were generally implemented in rural areas where there are no other services, suggests significant impact of such programs when compared to indicators from urban areas of the country. Evidence of more positive project impacts than captured by our secondary data analysis was supported by project specific reports and responses from IDIs and KIIs. The next chapter discusses the specific strategies employed, and the results they yielded.

Figure 2.17: Prevalence of HIV Testing in Ethiopia, 2005



Source, 2000 and 2005 Ethiopia DHS.

Chapter 3: Packard Foundation Strategies and Achievements

In its work in Ethiopia, the Packard Foundation awarded grants in 12 project areas under three principal strategies, namely 1. expanding family planning and reproductive health service delivery, 2. adolescent sexual and reproductive health, and 3. creating an enabling environment. In this chapter, we examine the extent to which the Foundation has successfully fulfilled each of its strategic objectives, as well as achieve the overall goal of the Packard Ethiopia Population Sub-program. In this assessment, we used reports from desk reviews, key informant interviews, case studies of specific projects, reports from the 1999 and 2000 baseline surveys in Amhara and Oromiya regional states, and results from the secondary data analysis of the 2000 and 2005 EDHS data sets.

3.1 Expanding Family Planning and Reproductive Health Service Delivery

In this sub-section, we examine the level of success achieved by the Packard Foundation in its first strategy, to expand family planning and reproductive health service delivery in Ethiopia. Evidence from our reviews and analysis of data indicates that the projects under this strategy constitute about 40 percent of all Packard Ethiopia funded projects and received about 54 percent of funds dispensed over the ten-year period (1998-2007) under review. Table 3.1 shows the seven projects under Strategy One, and the percentage distribution of funding support for each of the seven projects under this strategy.

Considering Strategy One overall, we found impressive achievements in FP service provision in general, especially through CBRH projects and social marketing of injectables. Significant advances were made in the area of capacity building for health personnel and infrastructure, particularly through the *Biruh Tesfa* network of private clinics. Almost every project had an IEC component, which successfully increased knowledge of FP, RH and HIV/AIDS but also raised concerns about duplication. Networking with various categories of organizations added value to all the projects under this strategy, which was most apparent in the successful advocacy around the revision of the Penal Code relating to abortion. Most projects were successful in leveraging funds for their future sustainability. However, less marked achievements were made in the area of delivering LTPM, ANC, PNC and abortion-related services. The women's empowerment through linking micro-credit to FP failed to fully overcome prevailing gender disadvantages or to integrate micro-credit with FP.

Table 3.1: Projects and percentage distribution of fund awards

Strategies	Fund awarded (%)
1.1 Expanding FP/RH through community-based programs (CBRH)	32.7
1.2 Expanding access to FP through Private Sector Franchise Initiatives (PSFI)	12.6
1.3 Improving access to long-term and permanent contraceptive methods (LTPM)	11.2
1.4 Expanding access to family planning through social marketing	25.2
1.5 Reducing maternal morbidity & mortality, and preventing unsafe abortion	10.2
1.6 Empowerment of women through linking FP/RH/population services with micro-credit	5.3
1.7 HIV/AIDS prevention and integration with reproductive health	2.8
Total	100

Source: The Packard Foundation Head Office, 2008

3.1.1 Community-Based Reproductive Health (CBRH) Program

Community-based distribution has become a generally accepted alternative to clinic-based programs for the distribution of contraceptives in many developing countries, following its potential for reaching out into rural and isolated communities. Such programs have been effective in addressing unmet need for contraceptives and generating demand for family planning in low contraceptive prevalence communities (Phillips et al. 1988). The Packard Foundation made the CBRH program a priority project under Strategy One, allocating to it the largest funding (17.6 percent) of all individual projects of the Foundation's Ethiopia Population Sub-program over the ten-year period under consideration. Among projects focusing on Strategy One, one-third of the funds were awarded for community-based family planning programs. Though all grantees have dimensions of their projects under this program, the grantees who primarily focused on CBRH are Amhara Development Association (ADA), Gurage People's Self-help Development Organization (GPSDO), and Oromiya Development Association (ODA).

Our analysis of EDHS data found a lack of significant changes at the national level, but evidence from document reviews (Path Finder International Ethiopia, 2004; Tawye et al. 2005) and qualitative interviews indicate that the CBRH projects were successful in the pursuit of their objectives in their respective regions of operation. Two key areas of success were in improving knowledge and increased contraceptive prevalence. We identified significant levels of demand for FP services demonstrated by willingness of clients to pay. In the 12-month period (July 2007-June 2008), the fee-for-service collected from the project zones in Amhara and Oromiya was Birr 387, 061 and Birr 459,055, respectively. This outcome supports the longstanding proposition that community programs can generate demand for family planning (Phillips et al. 1988).

The primary thrust of these grants was the provision of RH/FP services via community-based programs, with referral and back up support from health facilities. The key approaches utilized in pursuit of these goals include home visits by community-based reproductive health agents (CBRHA), IEC/BCC, and referral to health facilities. The projects were located in South Wollo, North Wollo, North Shoa, North Gondar in Amhara, eight districts in Gurage Zone and West Wollega and Illibabur Zones in Oromiya region. The program was also linked to the strengthening of 100 public and NGO health facilities with focus on clinical FP/RH, particularly the long-term and permanent methods, as well as the achievement of contraceptive prevalence rate (CPR) of 25 percent in most CBRH program areas, while the national rate stood at 15 percent. Previous evaluations have linked the generation of over 1.5 million active RH clients to community-based, market, and workplace agents (*Packard Foundation Ethiopia Background Paper, 2008*).

Our review of the Foundation's grantees' reports regarding their activities under CBRH program from its inception in 2001 recorded numerous achievements. For instance, an external evaluation of the CBRH programs of the Amhara Development Association (ADA) initiated in 2001 by the Public Health Institute in 2003 identified considerable success of the program in meeting its goals (two years into its implementation). The external evaluation concluded that the program succeeded in the areas of increasing knowledge and use of family planning services, contributing towards reduction in infant and maternal mortality, reducing the incidence of HIV/AIDS and the prevalence of harmful traditional practices (HTPs), and reducing adolescent sexual reproductive health risks. The program was credited with increasing the contraceptive prevalence rate (CPR) from 5 percent in 2000 to 29.5 percent in 2003 in Packard Amhara program zones with CPR reaching 40 percent in South Wollo Zone, one of the project areas (*Packard Foundation Ethiopia Background Paper, 2008*).

The most recent grantees report from the Foundation on the programs in Amhara and Oromiya regional states covering July 2007 – June 2008 indicated that the CBRH programs of ADA and ODA reached over 7.5 million adults and 53,247 adolescents with basic health information on various components of FP/RH and HIV/AIDS issues. They also reached 843,464 females aged over 15 with FP services. Our review found that 47 percent of FP clients were first time users. Of particular interest in these reports was the modest achievement of some level of method mix including Norplant, condoms, and a small number of IUCD, beyond oral contraceptives and injectables, which were the only widely used modern contraceptives in the zones before the onset of the Packard-funded projects in 2001. Although the recorded change in the range of methods used was obviously modest, the method mix is a considerable departure from what the situation was in the 1999 baseline survey in the same region (Birhan Research and Development Consultancy, 2000).

While the above indicators of success are consistent with the objectives of the Packard Foundation Ethiopia Population Sub-program generally and with those of Strategy One in particular, we sought their further validation using data from the 2000 and 2005 EDHS for key FP/RH indicators (Method-mix in Contraceptive use, CPR and Unmet Need for FP) in Packard and non-Packard zones in Amhara and Oromiya regional states and other parts of the country. We also utilized responses to in-depth and key informant interviews. Our assumption is that a successful CBRH program that promotes access to family planning services should be able to achieve a greater use of a wider range of family planning methods, reduce unmet need for FP, and increase CPR.

In examining changes in the FP method mix over the period, our analysis of the 2000 and 2005 EDHS yielded marginal increases in the use of long-term family planning methods among contraceptive users generally. Following over US\$3 million investment by the Foundation to improve access to long-term and permanent contraceptive methods and about US\$6.8 million on social marketing of contraceptive methods, between 1999 and 2007, the changes in the adoption of LTPM in Amhara and Oromiya regions confirm a continued and consistent dominance of injectables among users of FP in all regions of the country, with highest use recorded in Packard and non-Packard Amhara zones and Addis Ababa. This outcome may be testimony to the success recorded in the promotion of injectables through social marketing, yet the success was not as visible in Oromiya as it was in Amhara. Short-term methods such as pills, periodic abstinence and withdrawal remain dominant methods among users and condom use was only notable in Addis Ababa. The kind of success recorded in the promotion of injectables was not recorded for LTPM in most regions except in Addis Ababa, where about 7 percent of female FP users were found to use LTPM over the period.

On current use of FP, we show in Figure 2.10 a significant increase in all regions of Ethiopia between 2000 and 2005. The percentage change in contraceptive prevalence was higher in areas with lower levels of prevalence at the onset of observation in 2000, particularly in non-Packard areas of Amhara and Oromiya regions. An important indicator of success of the projects is the fact that despite the location of Packard project in generally rural Amhara and Oromiya zones with obvious locational disadvantages, positive changes in these indicators were identified as in more urbanized areas of the country. One key dimension of our finding is evidence that current use of all and modern contraceptives are gendered with men more likely to be current users than women in all regions including Oromiya and Addis Ababa, except in Amhara zones where Packard projects were located. In Packard Oromiya, 16 percent of men were current users; whereas the corresponding proportion for women was 8 percent. This raises the critical question of men's role in current use of contraception in the country, an issue that is often ignored.

Contraceptive prevalence remains generally low in Ethiopia, and although there was a 74 percent increase between 2000 and 2005, this growth was more driven in places outside the Packard zones in Amhara and Oromiya. However, the outcome may be related to changes in the composition of the sample population, as described in section 1.5.7 and the programs funded by other donors in non-Packard zones. In terms of unmet need for family planning, our results suggest a mixed bag of outcomes for the Packard zones in the two regions. Figure 2.11 identifies a decrease in unmet need for FP in both Packard and non-Packard Amhara zones. Although the magnitude of the decrease was greater for Packard zones, this was not significant. In Oromiya, unmet need for FP increased by around 10 percent in both Packard and non-Packard zones. It is important to note that Addis Ababa remains the region with the lowest unmet need for family planning, with about 58 percent decrease over the period. There has been little change in unmet need for family planning over the five year period in other regions of the country (21.4 percent in 2000 and 20.4 percent in 2005).

3.1.2 The Private Sector Franchise Initiatives (PSFI)

Packard Foundation introduced PSFI to respond to constraints in access to FP services which were due to limited human resource capacity (both in terms of numbers and skill sets), limited physical infrastructure/health facilities, limited opportunities and scope of involving private providers, among others. The collapse of the socialist government and its central command economic system in 1991 and the subsequent flourish of the private for-profit sector created an enabling environment utilized by the Packard Foundation through funding to Pathfinder International to develop innovative ways of improving access through the engagement of community-based reproductive health agents (CBRHAs), private clinics, marketplace and workplace providers.

The project termed *Biruh Tesfa* (Ray of Hope) was implemented in two phases starting in 2000 and ending in 2006 and has so far received funding support amounting to about 12.6 percent of all funds expended by the Foundation under Strategy One. The project was implemented at the community and facility levels in 16 *woredas* of five zones, and specifically involved the strengthening and expansion of the service delivery capacity of the private franchise clinics, market-based agents, CBRHAs and work place providers, as well as carrying out IEC promotional activities on behalf of the private clinic network. One key approach of the project was the promotion of cost recovery from retailers and fee-paying clients through application of commercial strategies to the promotion of contraceptive methods.

The impact of the PSFI program was externally evaluated in 2005. The results of this evaluation together with subsequent grantee reports concluded that *Biruh Tesfa* was very successful in expanding access to RH information and services in the country's two largest regions of Oromiya and Amhara where it operated. The key indicators of the success of the PSFI project are summarized as follows:

- *Biruh Tesfa* facilities served an emerging clientele that could pay for services;
- Family planning and overall client volume increased in *Biruh Tesfa* facilities;

- Better family planning and RH service quality of care were documented in *Biruh Tesfa* facilities than in most other places, including public sector facilities;
- *Biruh Tesfa* clients were increasingly obtaining long-term contraceptive methods;
- *Biruh Tesfa* facilities experienced less frequent contraceptive stock-out in 2004 than in 2001.
- The recognition of the brand name “*Biruh Tesfa*” or “Ray of Hope” as synonymous with quality FP/RH services;
- The project overshot some of its targets and succeeded in breaking out to other projects.
- The promotion of its sustainability by transferring some oversight responsibilities to local entities.
- Successful leveraging of resources from other sources beyond the Packard Foundation’s support through the involvement of others (SIDA and USAID) in funding the initiative beyond the life of the original grants from Packard.

Marketplace providers were reported to be very successful as community-based agents, accounting for more than their share of new and return-client visits to clinics, and the innovation was being replicated by other organizations in the country.

While the baseline CPR in areas covered by this project in Amhara was 7 – 12 percent in 1999-2000, the CPR at the end of two years of implementation of the PSFI was remarkably higher. According to previous evaluations, the CPR rose to 25 percent, with 50 percent of the increase in some areas attributed to the PSFI project. The Phase 2 of the project was credited with creating widespread awareness of RH/FP, HTP, maternal and child health, post-abortion care (PAC), and STI/HIV/AIDS through one-to-one and group counseling and large IEC meetings. On the FP service delivery target of 110,000 new users over the life of the grant, the program reached 152, 516 new users, 38 percent in excess of the original target. These outcomes were, without question, great improvements in CPR in the project zones since the onset of the program in 2000.

Our analyses of secondary data for the Packard and non-Packard project areas from the 2000 and 2005 EDHS presented in Figure 3.10 and Table 3.1 point to a significant increase in contraceptive prevalence in all regions of Ethiopia between 2000 and 2005. Beyond increase in prevalence, evidence of increased range of FP method options was identified in both phases of the project.

To improve the quality of services, the PSFI project trained providers in a wide range of RH/FP services. The necessary clinical equipment, manuals, reference materials and protocols were also distributed to most of the enrolled clinics. Community-based providers were supplied with CBRH protocols, supplies and materials, which made it possible for CBRHAs to be easily identified as members of the PSFI network, and hence gain credibility and acceptance in their communities.

Against the background of the acute lack of medical facilities at the 1999 and 2000 baseline surveys, the combined impact of *Biruh Tesfa* under the PSFI project had a major impact on building capacity and infrastructure in both Amhara and Oromiya regions. For instance, the service delivery point – population ratio in Oromiya zones, which was particularly low at the onset of the project (one health center to over 200,000 persons and one health post to 170,000 persons) changed dramatically, with the development of a network of facilities under the *Biruh Tesfa*, together with huge investments in capacity building under the PSFI project.

A number of milestones in promoting PSFI’s sustainability were achieved. PSFI leveraged funds to support the establishment of the Medical Association of Physicians in the Private Sector (MAPP-Ethiopia), which played a vital role in strengthening the Franchise Clinics network. MAPP-Ethiopia with assistance from the PSFI and SIDA provided technical support and capacity building assistance to private clinics in the *Biruh Tesfa* network. As a consequence of the project’s success, USAID took over the funding of PSFI through 2007 in 16 *woredas*, with Pathfinder (a Packard grantee) as the leading implementing agency.

3.1.3 Increasing Access to Long-Term and Permanent Contraceptive Methods (LTPM)

One key challenge of contraceptive use in Ethiopia is the record of poor method mix among women who use contraceptives. The baseline survey in Amhara region in 1999 showed that 87 percent of current users were using pills and injectables, two percent used condoms, and four percent were abstainers. The use of long-term and permanent methods was minimal or virtually non-existent. A number of impediments to the uptake of long-term methods such as IUD were identified including inadequate information about the methods, lack of access, and unfounded rumors about their side effects.

In an attempt to improve access to and use of long term and permanent family planning methods, the Packard Foundation, through a US\$3 million grant to Engender Health Ethiopia, implemented a project that aims at strengthening health systems and building healthcare providers' capacity to provide quality sterilization, Norplant implants and IUDs services. The project provided clinical training, equipment supplies, and conducted improved quality IEC and advocacy concerning LTPMs.

Evaluation data from an array of sources reveal that the increases in adoption of LTPM achieved under this project were marginal. However, the key achievement of the project and the potential of positive impacts moving forward may be located at the level of investments in training of health personnel, improving facilities and increasing awareness. Project and related reports reviewed recorded substantial achievements in capacity building, provision of services, IEC and networking between 2001 and 2007. Capacity building involved both training of individual health officials and the development and strengthening of health facilities for the provision of LTPM services. Table 3.2 outlines the considerable advances in training health officials. An increase in demand for LTPM services, particularly IUCD and Norplant, was achieved in the 2001- 2008 project period, as shown in Table 3.3. Considerable effort was made to promote awareness around LTPM through multi-media IEC/BCC activities. Community health workers and HEWs were supported through training to carry out IEC about LT&P methods and referrals.

Table 3.2: Health Officials and LTPM Training Received

Health Personnel	Number	Trainings Received under the Project
Doctors /Nurses	73	Basic FP with IUD insertions and removals, FP consulting, ML/LA and NSV, Norplant and IUD, National TOT level LAPM standardization
Health/RH personnel (providers, public sector health manager, civil service reform officers, and supervisors)	1,439	Basic FP methods including ML/LA and NSV, IUCD and Norplant insertion and removal, VSC, Infection prevention Practices, principles of good interpersonal communication and client counseling, quality improvement intervention, facilitative supervision, and clinical skills training
Medical directors	20	Improvement/Facilitative Supervision
HEWs	465	IUCD refresher training
CBRHA	1183	LTPMs, on-the-job training on IUCD, VSC and implants insertion and removal.

Source: Compiled from data presented in the Foundation and Grantees Reports, 2001-2008

Table 3.3: Distribution of LTPM Services Provided between 2001- June 2008

Types of Service	No of Cients Served
IUCD	15,344
Norplant Implants	17,453
Sterilization	1,073
ML/LA and NSA	706
Voluntary surgical contraception (VSC)	886
LTPM by mobile teams in under served areas	6121
LTPM not categorized	15,043
Referrals	2,732
Total number of services to individual clients	59358

Source: Compiled from data presented in the Foundation and Grantees Reports, 2001-2008

Table 3.4 : Changes in FP methods mix among Ethiopian women aged 15-49, 2000 and 2005

	P.Amhara Amhara		Non-P Amhara		Packard Oromiya		Non-P. Oromiya		Addis Ababa		Other Regions		National	
	2000	2005	2000	2005	2000	2005	2000	2005	2000	2005	2000	2005	2000	2005
Methods	2000	2005	2000	2005	2000	2005	2000	2005	2000	2005	2000	2005	2000	2005
Condom	2.2	2.6	0.0	0.4	8.5	7.3	7.1	1.0	13.1	10.2	7.3	2.4	6.7	2.8
Injectable	29.2	66.4	51.8	73.9	35.4	74.4	18.0	59.6	22.8	36.9	46.2	75.2	35.0	65.7
Short –term ¹	61.8	27.6	46.8	22.9	51.2	18.3	69.4	35.0	50.3	40.1	43.6	20.1	52.8	27.5
Long-term ²	6.7	3.4	1.4	2.8	4.9	0.0	5.5	4.4	13.8	12.7	2.9	2.2	5.5	4.1

¹Pill, Periodic Abstinence, Withdrawal; ²IUD, Norplant, Female Sterilization

Source: EDHS 2000 and 2005.

The project was successful in using networking and coordination in its efforts to promote LTPM. The project grantee chaired the National Advocacy Network established to advocate for RH issues in Ethiopia, was part of the National RH Task Force and also a member of the Logistics and Contraceptive Security Sub-task Force. The collaboration in these groups strengthened the referral linkages and coordination in Amhara and Oromiya regions. The increased uptake of LTPM as shown in Table 3.3 is an indication of the achievements of the LTPM project. The use of other short- and long-term methods decreased in all regions over the period. While the outcomes indicate positive changes from the 1999 and 2000 baseline surveys for Packard areas in Amhara and Oromiya regions, the uptake recorded in project specific reports between July 2007 and June 2008 suggests that had the EDHS data covered most recent periods, the percent increase in the use of LTPM would have been more profound. That the use of injectables among all users of contraceptive methods increased from 35 percent in 2000 to 66 percent in 2005 underscores the success of the social marketing project. Although the main objective of the Foundation's support to this project was to promote the use of LTPM, the grantees also included injectables in their activities. Evidence from quantitative analysis (Table 3.4) suggests that the success in promoting LTPM was low relative to their achievements in promoting injectables. Our review of project-specific reports and responses from KIIs and IDIs suggest that this may be related to problems with sustainability of LTPM supply and lack of qualified personnel in some places.

3.1.4 Expanding Access to Family Planning through Social Marketing

The Packard Foundation funding for the social marketing project specifically aimed to expand access to injectables. Over the period however, DKT – a social marketing company which is also the Foundation's grantee partnered with other grantees to also promote other permanent family planning methods. Between 1999 and 2007, DKT received four grants worth about US\$6.5 million to implement this strategy nationally. Over the period, the grantee aggressively marketed injectables and other family planning methods through existing private market and distribution outlets. Through its network of salespeople, grantees suggest that these products reached the remotest areas and pharmacies enabling Ethiopians to find the health products they need. The project also included a program component providing voluntary surgical contraceptives (VSC) in partnership with Family Guidance Association of Ethiopia (FGAE) and Marie Stopes International – Ethiopia (MSI-E).

Successes of the social marketing project were recorded in FP service provision, capacity building, IEC, and networking/coordination; however duplication of efforts between this project and others was observed. A major focus of the project was to socially market injectable contraceptives under the name *Confidence*; however the project also marketed other forms of contraceptives, as shown in Table 3.5. The figures reflect significant input into the contraceptive campaign system in the country over the period, not only in terms of supplies but also in terms of distribution to remote areas, which was facilitated by the use of mobile teams in service delivery. An estimated 1,578,664 contraceptive person years (CYP) of protection was generated via the social marketing project. Though not a significant improvement on the 1.44 million CYPs generated between July and December 2005, it represents sustenance of the generated momentum. The key challenge was the sustainability of this momentum over time. Evidence from our IDI and KII interviews highlighted the current challenge in the country as that of meeting the demand for contraceptives created by the success of the early campaigns. In fact by June 2005, DKT identified its challenge as that of meeting the increased demand for hormonal contraceptives and sustaining ORS product in the market following costing constraints.

An important dimension of the social marketing project was on IEC activities, including brochures, road shows, and adverts in public transport, print and electronic media. These activities were sustained on all fronts and expanded in most cases between 2001 and 2008. The program also initiated a periodic retail audit system to track rural reach and

Table 3.5: Contraceptives distributed under social marketing program1

	Jan-Dec 2001	Jul-Dec 2002	2003	Jan-Dec 2005	2006	July 2007- June 2008
Injectables	292,840	227,260	638,859	2,356,454		1,854,067
Condoms	27,106,816	33,681,168	31,632,130	61,600,896		62,592,512
Oral pills	790,340	710,845	883,151	3,395,465		3,202,270
ORS		535,110	1,489,136			2,093,503
IUDs						5,308
Implant Kits						20,000
Emergency contraceptives					10,000 ²	9,810
MVA kits						2,501
Misoprostol						61,480
Sanitary Napkins						8,900

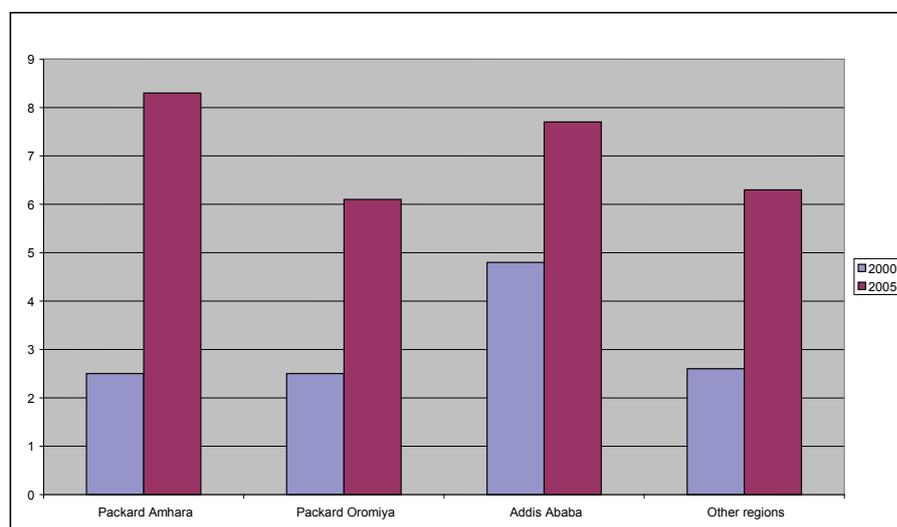
Source: Compiled from data in Packard and grantees records, 2001-June 2008.

proper distribution of commodities. The social marketing project focused substantial attention on building strategic alliances and coordination through provision of a revolving fund and credit sales schemes for NGOs such as DKT International, PACT Ethiopia, Pathfinder International and the Amhara and Oromiya Development Associations to obtain contraceptives.

Evidence from many sources, including national-level reports, confirms overall national improvements in contraceptive knowledge and use over the period under review. This was particularly the case for injectables, as shown in Figure 3.1. Our analysis indicates similar changes in non-Packard zones within Amhara and Oromiya regions, which may be related to the fact that some of the IEC efforts were national in scope.

While the increase in use of injectables was substantial, we observed a resistance from health providers and restrictions on the provision of injectables to rural drug vendors in spite of demand by women. One critical concern with this project relates to duplication of efforts. For instance, although not one of the project’s original objectives, abortion-related work was carried out under this project. This may have represented a contribution to the Foundation’s strategy of “expanding family planning and reproductive health service delivery.” However this kind of ‘overshooting’ or working beyond project boundaries may have contributed to the issue of duplication of efforts among grantees raised in the IDIs and KIIs.

Figure 3.1 Change in the use of injectables in Ethiopia, 2000 and 2005



Source: EDHS, 2000 and 2005

3.1.5: Reducing Maternal Morbidity and Mortality, and Preventing Unsafe Abortions

The high incidence and challenge of maternal morbidity and mortality, and high levels of unsafe abortions in Ethiopia are well documented (DHS, 2005; Sebetu et al, 2005; MOH, 1996). Pregnancy, poor health and nutritional status, communicable diseases, high workload, early marriage, high fertility, inadequate access to and under-utilization of health services, induced abortion, and the low status of women in the society have been identified among the many underlying causes of high maternal mortality in the country. Against the backdrop of high reproductive health risks among Ethiopian women, the Packard Foundation supported intervention projects targeting the reduction of maternal morbidity and mortality by creating improved access to maternal health services, abortion care, post-abortion care, provision of emergency obstetric care (EmOc), improving access to FP, and improving the sexual and reproductive health and rights of women in the country. Professional associations, namely the Ethiopian Society of Obstetricians and Gynecologists (ESOG) and the Ethiopian Nurses and Midwives Association, and Ipas Ethiopia received about 10.2 percent of all grants awarded for expanding FP service delivery in the country and have been implementing these interventions in selected communities and health facilities.

Achievements under this project have included increased availability of RH technologies to women and providers, expanded public knowledge and positive attitudes on abortion and other reproductive health rights, networking and coordination in training and service provision, and leveraging funds for future sustainability. The project also contributed to the Foundation's strategy on "creating an enabling environment for Family Planning and Reproductive Health", through its contributions to the enactment of the abortion law and its implementation. However, outcomes in relation to availability and use of services and provision of services by highly trained professionals remain low across the nation, with the exception of Addis Ababa, where some noticeable improvements were observed.

In the particular area of advocacy, one of the highpoints of the project's success is related to influencing the revision of the Penal Code that expanded the circumstances under which abortion is legal, by mobilizing community participation in the debate over the draft bill by the Ethiopian Parliament in 2004. This significant revision of the Penal Code served as a precedent for abortion-law reform in other African countries. The project grantee was an important link in the development of national standards and guidelines for providing safe abortion services to the extent allowed by the revised abortion law. Part of the advocacy success over this period was the endorsement of the proposal for sanctioning midwives to provide abortion services by the Ethiopian Minister of Health and the inclusion of the proposal in the *National Guideline for Abortion*.

In the area of capacity building, achievements were recorded in the areas of pre-service and in-service training, establishment of training centers, monitoring of PAC services, and equipping of health facilities. Capacity building under this strategy was strengthened by training collaborations with organizations such as Family Guidance Association Ethiopia (FGAE) and Save the Children (USA) in training the trainers on PAC and other services. Among the high points of capacity building under the project was the strengthening of health professional training curricula in relation to PAC and abortion care, and the supply of materials and equipment to universities.

In terms of service delivery, women with abortion complications in Amhara and Oromiya regions received PAC services through facilities and teaching institutions equipped to provide the services. The project also involved the provision of reproductive health technologies for women, providers and health systems. An important milestone achievement was the listing of drugs for medical abortion – Mifepristone and Misoprostol – in the Ethiopian National List of Essential Drugs. Finally, 5,653 pills, 2948 condoms, and 1,786 vials of injectables were distributed as well.

The extent of achievements in service delivery by two of the project-grantees was illustrated through a facility-based survey on the activities of Ethiopian Nurse Midwives Association (ENMA) and Ethiopian Society of Obstetricians and Gynecologists (ESOG), which observed a 39 percent increase in service delivery in three hospitals compared with the base line figures; a 190 percent increase in the number of caesarean sections (C/S) performed; a 120 percent increase in the number of mothers referred to the hospital; a 150 percent decrease in the number of mothers referred out; and a 13 percent increase in post-abortion care services.

One major thrust of the project was a focus on building a broad network of support across groups. Among the achievements in the first year of the program was the launching of a post-abortion care network (PACNet) in Addis Ababa and efforts at expanding its membership. The capacity building activities with medical schools involved collaboration with the Oromia Development Association (ODA) and the Carter Center while the advocacy concerning the Penal Code involved the Ministry of Health and the Health Education Center.

Following the focus on reducing maternal morbidity and mortality and preventing unsafe abortions over the last 10 years, together with the records of achievements above, we examined EDHS data to identify changes in access to

quality antenatal and postnatal care (ANC/PNC) in Ethiopia over the period. This is premised against the backdrop that the quality of health care that a mother receives during pregnancy, at the time of delivery and soon after delivery, is important for the survival and well-being of both the mother and the child (CSA and ORC Macro, 2005). This, in turn, is determined by among other factors, the type of ANC/PNC provider. Figure 3.2 shows no positive improvement in the use of ANC among women in Packard program zones in Amhara and Oromiya regions between 2000 and 2005. In Packard zones of Amhara and Oromiya, PNC provision increased but insignificantly, though there was a marginal decrease in non-Packard Oromiya and other regions of the country. A similar scenario emerged when we examined the percentage of deliveries by skilled health professionals.

These outcomes suggest that there remain great challenges with reducing maternal morbidity and mortality through improved access to maternal health services in Ethiopia, despite the achievements reported by Packard grantees. The project's success in leveraging funds to the tune of US\$ 15 million from an anonymous donor for the expansion of Comprehensive Abortion Care (CAC) and contraception in five regions of the country holds hope for the sustainability of the effort and the achievement of more significant outcomes at the national level.

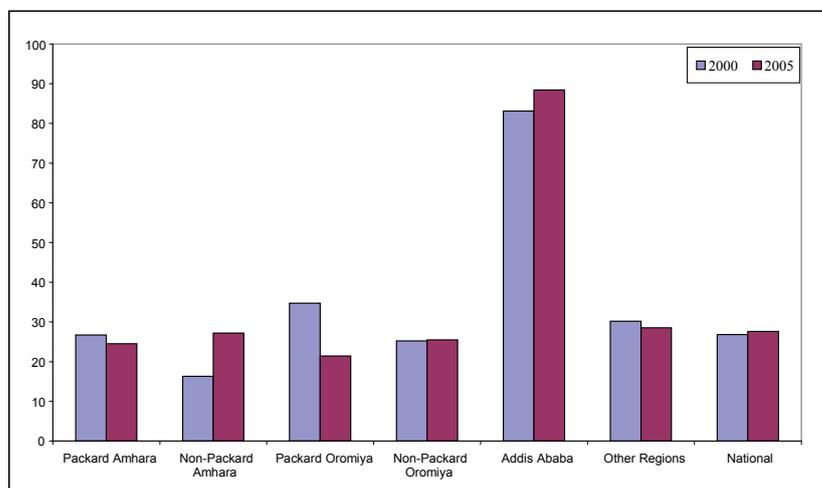
3.1.6 Empowerment of Women through Linking FP/RH/Population Services with Micro-Credit

Researchers have strongly linked contraceptive use in sub-Saharan Africa to access, and poverty constitutes a primary hindrance to accessing contraceptives (Campbell et al. 2007; ICASO, 2007; Ntozi et al. 2003; Klein, 2000). The Packard Foundation has supported two projects aiming to link FP/RH with micro-credit in Oromiya and Amhara regions since 2003. The projects seek to empower rural women and young people to make independent decisions through access to integrated credit facilities and family planning services. By linking micro-credit activities with family planning programs, it was anticipated that women and young people's receptiveness to family planning and contraceptive use would improve. The key approaches adopted by the programs were the provision of loans to rural women and the promotion of the use of family planning.

Looking back in the last five years and six months of the integrated micro-credit scheme (2003-June 2008), a cumulative disbursement of over Br. 49,634,470 has been made to over 17,200 people in Amhara zones where Packard programs were located, out of which approximately 60 percent were to women. In addition to the loan disbursement, clients were reportedly given access to education programs on reproductive health, Family Planning, HIV/AIDS, and other health issues. In Oromiya, OCSSCO cumulatively disbursed Birr 49,211,155 to 28, 2554 borrowers, of which women accounted for 46 percent. It collected matured outstanding loan of Birr 38,251,044 (Birr 34,610,892 principal, and Birr 3,640,152 interest). The savings culture promotion mobilized Birr 6,772,493. The program continued to offer micro-insurance to micro-business operating clients.

In examining the achievements recorded by the project, one major shortcoming is the near absence of activities around family planning. The entire program focused on micro-loan disbursements with no mention of FP in Oromiya and a marginal mention of FP IEC in Amhara over the entire period of the program. The reports from the grantees suggested an obvious lack of capacity among ACSI staff on delivering "integrated" micro finance and FP services. This may have accounted for the focus on loan disbursement, with little or no attention on the family planning component. Our findings therefore support those of a previous evaluation, which did not find any added value of the projects on contraceptive use over what can be attained by separate microfinance and FP programs (FHI, 2007).

Figure 3:2 percentages of women who received ANC from a health professional 2000 and 2005



Source: EDHS, 2000 and 2005.

One key challenge of the programs under this strategy which was acknowledged by grantees in the earlier years was the lack of gender-focused products to empower women and to provide services that fit their demand. At the onset of the program in 2003, only 33 percent and 21 percent of loan recipients among ACSI and OCSSO clients, respectively, were women. Whether this was a problem of absorptive capacity was not clearly spelt out, but initial lack of capacity among program officers on gender issues was reported. Reports in the last two years of the program suggested improved gender awareness by program officers, with women constituting a significant proportion of beneficiaries of the loan facilities through the program (60 percent of clients in Amhara and 45 percent in Oromiya). However, those fell short of the objective of focusing on women empowerment; moreover loans given to women were reportedly smaller and their profit margins much lower. In the same token, the youth microfinance development fund of the ACSI over the period disbursed close to Birr 2 million to 1,269 youths with 45 percent being girls.

The main challenge with the project, which was linked to Ethiopian traditional culture, was the report that the loans were frequently targeted at men directly. In addition, evidence from previous research in Ethiopia suggests that husbands commandeer loans given to their wives, thereby thwarting the goal of women empowerment. This speaks to the point that programs in Ethiopia that target only women for poverty alleviation activities may be missing the second half of the fundamentally vulnerable group: poor men (Mberu, 2006).

Despite evidence that the loans were widely disbursed, the challenge of meeting increasing demand for loans was a major problem of the project. For instance, ACSI was unable to satisfy the demand for higher loan size by mature clients as well as new clients in more areas. In addition, the demand for youth microfinance increased without adequate resources to meet the challenge.

In conclusion, there was a clear failure of the program to affect family planning and reproductive health significantly. At the end of the observation period, ACSI loan officers were generally lacking basic capacity in disseminating information in the areas of family planning and reproductive issues. However, the implications of the projects for poverty alleviation was largely positive, although the goal of women empowerment was substantially shortchanged.

3.1.7 HIV/AIDS Prevention

The HIV/AIDS burden in Ethiopia is linked to behavioral, socio-cultural and economic factors that operate at individual as well as contextual levels. The factors that fuel the spread of the epidemic have been identified to include women's low socio-economic status, increasing levels of poverty leading to sex work, lack of open discussion about sex, high incidence of sexually transmitted infections (STIs), and stigma and discrimination, among others. Over the past two decades, efforts have been made to increase public awareness regarding HIV/AIDS through various IEC channels and organizations.

The organizations with the primary focus on HIV/AIDS prevention were the Ethiopian Orthodox Church Development and Inter-Church AID Commission (EOC-DICAC). Other organizations which worked on HIV/AIDS and other issues were the Population Media Center (PMC), and Walta Information Center (WIC), which carried out integrated HIV, population and RH advocacy. The Ethiopian Orthodox Church (EOC) received funding from the Packard Foundation to implement HIV/AIDS prevention and care, and the building of greater commitment and capacity within EOC to address HIV/AIDS and related social issues.

The Church in particular recorded considerable progress in HIV/AIDS prevention and awareness raising, focusing on church-compliant themes of moral responsibility, including abstinence before marriage, faithfulness in marriage, avoidance of stigma and discrimination and delivery of food, clothes and related moral support to HIV/AIDS patients. In this way, the program addressed two of the key hindrances to HIV/AIDS prevention—lack of open discussion about sex and stigma and discrimination—among the most vulnerable groups. One outstanding feature of the IEC/BCC aspect of the program was that the clergy of the EOC spearheaded it, together with her collaboration with other organizations, including Tigray Regional State HIV/AIDS Prevention and Control Organization (HAPCO), Income Generating Activities (IGA), and the Christian Relief Development Association (CRDA). Another dimension of the success of the EOC project was its ability to leverage funds from other donors. Although the project started at five diocesan levels of the church, and the Foundation's funding ended in 2006, USAID awarded a US\$10million grant to EOC to implement the program nationwide, following its success.

As knowledge and beliefs about HIV/AIDS affect how people treat those they know to be living with HIV and following the focus of EOC campaigns on reducing HIV/AIDS stigma, we examined changes in attitudes towards those with HIV/AIDS by religious affiliation, using the 2000 and 2005 EDHS. The relevant question posed to respondents to measure their attitudes towards HIV-infected people in the two surveys was their willingness to take care of relatives who are infected with AIDS.

Table 3.6 shows that a higher proportion of Orthodox Ethiopian Christians indicated more positive attitudes to their relatives with AIDS than Catholics, Protestants or Moslems. Though there is a general increase in positive attitudes toward the epidemic across Ethiopians of all religious persuasions between 2000 and 2005, the percentage increase in positive attitude was highest among Orthodox Christians than Catholics, Protestants and Moslems. For questions that were asked only in 2005, Ethiopians of Orthodox faith were more likely than other religious groups to know a place to obtain AIDS test, more likely to be tested, and more likely to support someone with AIDS to continue as a school teacher.

Notwithstanding its recorded achievements, a major weakness of the program was the selective avoidance of promoting modern and effective contraceptive methods, particularly condoms, which are critical for HIV/AIDS prevention.

3.2 Focus on Adolescent Sexual and Reproductive Health and Livelihood

In order to address the vulnerability of young people to various sexual and reproductive health (SRH) problems, the Packard Foundation has supported two strands of projects since 2000, the first aimed at developing adolescent-focused SRH services and the second focusing on integrating skills and employment promotion services with SRH services. While other grantees have some of their program components tailored to address ASRH as stated above, projects primarily funded to specifically implement the ASRH strategy amounted to 28 grants, which constituted about 19.4 percent of all funds expended by the Foundation’s Ethiopia population sub-program.

The major projects under Strategy Two were implemented primarily by Deutsche Stiftung Weltbewoelkerung (DSW), Save the Children (USA), Family Guidance Association of Ethiopia (FGAE), Relief Society of Tigray (REST), Christian Relief and Development Association, and Pact Ethiopia.

The projects under the first strand focused on the provision of youth-friendly information, education, and counseling services, by supporting and strengthening youth self-help initiatives (clubs), creating and strengthening youth club network, and the promotion of young people’s development and protection, among others. The programs focused on both in- and out-of-school youths in selected urban and rural parts of the country, including Addis Ababa. The second strand under the adolescent strategy was an effort to address unemployment among the youth and its negative implications for risk-taking behavior and sexual and reproductive health of adolescents. The Opportunities Industrializations Center Ethiopia (OICE) was funded to integrate marketable vocational skills training and ASRH by establishing two adolescent reproductive health (ARH) centers in the towns of Jimma (Oromiya Region) and Kombolcha (Amhara Region).

Previous evaluation of projects under the ASRH program strategy indicated that over nine million young people received information on RH/FP, more than 200,000 youths received RH services, and 100,000 were counseled and referred to health facilities. Also ASRH projects provided diversified skills as well as vocational and leadership development training to over 2,000 young people.

In the sections that follow, we examine the two projects of the ASRH strategy through two anchor grantees³ funded by the Foundation—DSW and FGAE—in both Oromiya and Amhara regions. We verified the records of achievements using responses from our KIIs and IDIs, together with reports from our analysis of the 2000 and 2005 EDHS. We focus on identifying changes in knowledge of family planning and HIV/AIDS, the use of family planning services, VCT, changes in age at sexual debut and marriage, changes in risky sexual behavior (number of sexual partners and incidence of casual sex). Looking at the record of Strategy Two overall, we found impressive achievements in the area of promoting reproductive services to young people. However, similar achievements were not recorded in the skills and employment aspects of the strategy. The training activities were not always well linked to local employment opportunities, and there were limited opportunities for trainees to access micro-credit in order to start

Table 3.6: percent of Ethiopians willing to take care of AIDS-infected relatives by religion.

Religion	2000	2005	percent Change
Orthodox	62.9	79.6	26.6
Catholic	45.1	53.2	18.0
Protestant	46.9	53.3	13.6
Moslem	47.3	57.9	22.4
Traditional/Other	34.0	46.6	37.0

Source EDHS 2000 and 2005

their own businesses. Looking to the future, there may be a need to expand projects that have been shown to enhance the participation of women and girls, such as tailoring and embroidery. Leveraging activities for sustainability may be key to this strategy moving forward.

3.2.1 Improving Adolescent Sexual and Reproductive Health (ASRH)

Under this project, about 23 grants amounting to 86 percent of all financial grants were awarded under the adolescent focused strategy. The DSW implemented projects on ASRH from 1999 and continued to work in this area up to 2008. The programs implemented were anchored on four key objectives: strengthening capacity of youth self help initiatives (clubs); production and dissemination of IEC materials; Provision of RH services; and networking, advocacy, coordination and capacity building. Available records show great successes in these strands of programs, particularly in the area of IEC. The DSW projects strengthened their activities over the last two and half years for which we got records.

Networking and advocacy were significant dimensions of DSW's approach of the program over this period with advocacy sessions on women rights, HTPs, sexual assaults and HIV/AIDS, and the training of youth clubs on entrepreneurship for social marketing of contraceptives. Also working under this strategy, the Family Guidance Association of Ethiopia (FGAE) received funding for six years from 2001 to increase and strengthen access to and use of SRH services information by young people in six and seven sites of Oromiya and Amhara regional states respectively. Our review of FGAE project-specific records also found impressive records of success, including leveraging of funds beyond the Foundation's grants amounting to about ETB 52.2 million from a network of donors: the IPPF, RNE, Irish Aid, JOA & IPPF, JTF, UNFPA, FHI, ECI-Africa, DKT, Global Fund, CIDA, CORHA, SAFE HANDS, SWISS Embassy, RHAPCO, and Interact Worldwide.

We examined data on adolescent knowledge, behavior and use of family planning from the 2000 and 2005 EDHS and the KIIs and IDIs to independently confirm project recorded achievements. Our analyses focusing on youths in Chapter 2 confirm positive changes in knowledge, sexual behavior and use of FP methods. In particular, results from our analysis confirm a decrease in risky sexual behaviors, an increase in comprehensive knowledge of HIV/AIDS, and an increase in use of wider range of FP methods among Ethiopian youths in both Amhara and Oromiya regions. However, the same was also true for Addis Ababa and the rest of the country. While we are not able to attribute these positive changes only to the Packard Foundation-funded projects following several confounders including other groups working in RH issues locally and nationally, responses from in-depth and key informant interviews, as well as case studies strengthened our conclusion that these changes are largely related to the pioneering work of Packard grantees on RH issues in Ethiopia generally and youth focused programs in particular. The national focus of the IEC campaigns using a variety of media, may have contributed to the positive changes beyond Amhara and Oromiya regions, where Packard Foundation programs are primarily concentrated.

Despite the achievements recorded, the projects under review were ill-equipped to manage growth and expansion and therefore unable to maximize potential benefits. The recorded successes of IEC campaigns were not matched with the provision of services. Available human and financial resources were not compatible with supporting the demand for large numbers of clubs and instead of expanding the program to address needs, grantees and partner organizations were constrained to develop strategies that consolidated support for a limited number of clubs. Similarly, the library centers established under the program were overloaded with time, as reading rooms became too small to accommodate and satisfy the needs of young people who wanted to use the center.

3.2.2 Improving Adolescent Livelihood through Life Skills and Vocational Training

The Opportunities Industrializations Center Ethiopia (OICE) received US\$ 1,375,000 from the Foundation between 2001 and 2007, to establish two central clubs in Amhara and Oromiya regions. The centers, in consultation with other adolescent reproductive health programs, were to provide diversified training to youths that included reproductive health education and services, life skills development, and computer, entrepreneurial and vegetable gardening trainings. Over the seven-year period of the program, available reports suggest important achievements of the program objectives in collaboration with ADA, ODA and local *woreda* administrators. Achievements of the program against its objectives were recorded in the areas of life skill training, provision of adolescent reproductive health (ARH) education, library services, family planning services, and dissemination of IEC materials with focus on HIV/AIDS, risky sexual behavior, use of FP methods, abortion, and harmful traditional practices.

One important dimension of the youth program relates to achievements in the area of networking/collaboration and leveraging funds. The project collaborated with the zonal administration, the Oromiya and Amhara Associations, FGAE, DKT, Society of Red Cross, and National HIV/AIDS Secretariats in establishing the training centers and in the

provision of services. The project also mobilized additional resources from Canaan Baptist Church of Philadelphia and USAID to strengthen the RH services and computer-assisted learning to students and members of the community.

As noted above in Section 3.2.1, our reviews of other materials and quantitative and qualitative analyses indicate significant positive change among young people on issues relating to ASRH, particularly in the areas of knowledge, sexual risk behaviors, HIV testing and use of FP methods in relation to Packard program zones. The question of the program's achievements in the area of youth economic empowerment, however, remains largely unanswered. This is related to the fact that the project goals of skills training and employment provision were generally drowned by the focus on expanding FP. Apart from the limited amount of funds allocated to the project, which approximates 14 percent of funds awarded to ASRH strategy, very little attention was devoted to skills and livelihood training. This is a critical omission that needs to be addressed in moving the program forward, as poverty and youth unemployment are highly correlated with poor ASRH outcomes.

In the face of high levels of youth unemployment and limited employment opportunities nationally, the project lacked the structure for arranging employment opportunities for trainees. Budget constraints did not help matters in this regard and administrative and financial barriers hindered access to youth microfinance fund, where it was available, such as ACSI. With no credit service for skilled trainees to obtain start-up capital for their businesses, the primary goal of the project for poverty alleviation was greatly hindered. High turnover of project staff was reported and this was related, among other things, to issues of adequate remuneration.

Grantees reported that repetitive provision of certain vocational trainings tends to saturate the job market in that particular area and lack of constant power supply in project areas over the period under consideration undermined both computer skills training and the involvement of trainees in productive ventures. Funding for activities to diversify the vocational skills training program will therefore be critical for the next steps of the program. Activities to help trainees identify and access micro-credit opportunities need to be enhanced. It was found that particular skills training in areas such as tailoring and embroidery helped to increase the participation of women and young girls in the project, and this may need to be expanded in the future. Moving forward, the program's need for funds, particularly attracting multiplier funding will be critical. Activities in the area have already yielded positive results with the two-year grant from USAID to supplement informal primary and secondary education and other support, including that from the Organization of Women's Development Initiative Project, supported by the World Bank.

3.3 Enabling Environment for Family Planning and Reproductive Health

The objectives of this strategy were to create an enabling environment for expanding and improving FP and RH services by developing reproductive health leaders, advocacy on reproductive health and rights, and building institutional and local capacities to generate knowledge and provide services. Our review and data analysis found considerable progress in building cadres of FP and RH leaders who were able to engage with Ethiopian government officials, other policy-makers and community members. One challenge that has not completely been addressed despite efforts in this regard was the difficulty in reaching women leaders. Advocacy activities played a tangible role in changes to government policy on RH. There was evidence of success in building the capacity of service providers, individual researchers and universities. However, there was less success with linking research and local RH information needs. There was evidence of successful efforts to leverage funds for sustainability of projects; however concern was expressed in the KIIs about lack of effective coordination of activities under this strategy.

3.3.1 Developing Reproductive Health Leaders

The primary goal of the leadership program of the Packard Foundation was to create a core set of leaders with the vision, commitment, skills, and knowledge to vastly expand FP/RH choices and services at community, regional and national levels in the focus countries. In Ethiopia the Foundation's program provided opportunities for short- and long-term RH leadership training to candidates from the public, private, and NGO sectors. The trainings were organized through the Public Health Institute (PHI), University of Washington, International Institute of Education (IIE), Visionary Leadership Program (VLP) of Partners, Center for African Family Studies (CAFS) and The International Council on Management of Population Programs (ICOMP).

The key approaches of the International Institute of Education (IIE)'s Leadership Development Mechanism (LDM) included provision of advanced leadership training, and organizing study tours, meetings and conferences on leadership. The key approaches adopted by the PHI included the provision of intensive California-based leadership program to Ethiopian *International Family Planning Leadership Program (IFPLP)* fellows, establishing a national taskforce for leadership development in RH, and replicating the IFPLP leadership development training in Ethiopia. The University of Washington (UW) Population Leadership Program (PLP) offers one academic year's intensive leadership training and a Master in Public Health program for participants. The Partners for Population and Development's Visionary

Leadership Program (VLP) pursued the development and implementation of advanced leadership training, exposure, and mentoring for potential leaders. The Department of Community Health, AAU, served as a national anchor for the program, selecting and training VLP fellows, developing leadership curriculum, and other activities.

Earlier evaluation of the leadership programs identified 170 established and emerging leaders who were trained through the four international future leader programs. There were also more than 300 people from the public and NGO sectors who were reported to have completed leadership development training. Finally, the national taskforce, in collaboration with teaching institutions, developed modules and conducted training in Population/RH leadership for both emerging and established leaders. For specific achievements, challenges and the future of the leadership program, we selected the IIE-LDM program for detailed study.

CASE STUDY: Institute of International Education (IIE); RH Leadership Development Program in Ethiopia

Since 2000, the Institute of International Education (IIE) has been implementing the Leadership Development for Mobilizing Reproductive Health (LDM) program in Ethiopia in partnership with the David and Lucile Packard Foundation. This program was aimed at designing and implementing a leadership development mechanism to support the Packard Foundation's long-term goals and strategies in the population field.

Achievements of the IIE Leadership Program

Our review of project reports found achievements by IIE in the area of advanced leadership training, both locally and abroad, study tours to remote regions, conferences for fellows from all regions of the country to share experiences and form alliances, advocacy training for fellows, a leader mentoring program, and activities to establish and strengthen regional networks across the country. A highpoint of IIE activities was the engagement between fellows and government officials at the highest level, particularly the participation of the President of the Federal Democratic Republic of Ethiopia in a panel discussion with private sector and civil society organizations in February 2008. This initiative of engaging political leaders was replicated at regional levels. One positive outcome of these activities is that fellows have continually been empowered to seek out leaders in the country in order to raise awareness and discussion on important matters regarding population and reproductive health. Another successful element of IIE's project was the building of capacity among fellows to design and implement FP/RH projects and to leverage additional funding beyond the contributions made by the Packard Foundation.

The innovativeness of the program in establishing a selection committee composed of different professionals from the government and non-governmental organizations contributed to the success of the project's activities. This was complemented by the focus on networking and coordination with other population/reproductive health leadership programs and leaders in the country. A key challenge that plagued the program from the early stages was reaching women leaders. Most of the fellows were men. This challenge was recognized and efforts were made to target women leaders. Appreciable progress was achieved in addressing this imbalance. By the last report cycle (July 2007 to June 2008) the gender gap was narrowed to 54 percent male and 46 percent female fellows. Yet this is notably different from the result of similar IIE leadership projects in Nigeria, where there was gender parity, and in India, where there was disparity in favor of women.

3.3.2 Advocacy on Reproductive Health and Rights

As part of creating an enabling environment for promoting FP and RH, the Packard Foundation has been one of the major funding agencies of population, FP, and sexual and reproductive health and rights advocacy efforts in Ethiopia. About 20 grants were awarded under this project, worth an estimated US\$3.8 million. The key grantees were Network of Ethiopian Women's Association, Christian Relief Development Association (CRDA), Consortium of Reproductive Health Association in Ethiopia (CORHA), Pathfinder International Ethiopia, Population Media Center (PMC), Ethiopian Society of Obstetricians & Gynecologists (ESOG), and Walta Information Center (WIC). The key targets of the advocacy-related programs included:

- Awareness creation of the policies and strategies concerning population, RH/FP, and reproductive rights to policy-makers, funding agencies, the news media, health care providers, women's organizations, and religious and community leaders
- Advocacy and leadership development to bring reproductive health issues to the center of the development process in the country
- Empowerment of Ethiopian women through enhancing the advocacy efforts of women's rights organizations
- Media advocacy on RH/FP, environmental protection, HIV/AIDS, gender, and ASRH through educational entertainment programs, panel discussions and publishing and distribution of advocacy materials.

Most of the advocacy programs had national level targets, while others focused on Addis Ababa, Amhara, and Oromiya sites. The key approaches adopted by grantees included training member organizations on reproductive rights, relevant policies, new criminal laws, conducting workshops, forums, panels, and meetings on reproductive rights, newsletters, TV talk shows, community sensitization peer education, rallies, and targeted broadcast of serial radio dramas in local languages. Other approaches include advocacy activities on SRH rights with law enforcement bodies, community leaders, administrators, health workers, teachers, religious leaders, media organizations and managers.

In terms of substantive achievements, a previous evaluation of the Population Media Center's radio serial dramas concluded that the broadcast generated a huge audience, was highly liked by the listeners and that both radio serial dramas significantly improved the knowledge and use of family planning services, knowledge of and attitude towards HIV/AIDS, as well as the uptake of HIV voluntary counseling and testing (VCT) among the regular listeners as compared to the non-listeners (*Packard Foundation Ethiopia: Background Paper, 2008*).

There is general consensus in relevant policy documents and IDIs and KII data of linkages between these advocacy activities and the government enactment of various health policies and strategies related to FP/RH. Key components of these changes include the National Youth Policy and Strategy, the Family Law and the Penal Code. The liberalization of the abortion law and the inclusion of population issues in government strategy documents such as the PASDEP and the HSDP, as noted above, were also important dimensions of advocacy-related positive developments in Ethiopia. The consensus among respondents is that over the ten years of the Packard Foundation's Sub-program in Ethiopia, there has been increased commitment from leaders, decision makers and the government in prioritizing population and reproductive health issues. The consensus among respondents is aptly characterized by the following responses from a grantee and a government official during the qualitative interviews:

The adolescent reproductive health conference, which is well known as the Bahir Dar conference, was directly attributed to the formulation of the national youth policy and strategy. The conference was in 2000 if I am not mistaken more than 100 people from the parliament and major donors and stakeholders were present.

DI Grantee

On policy, there are now health policies and strategies in place which have the RH/FP component included.

-KII Government

Again over the last 10 years, many civil society organizations have not only focused on social issues but have increasingly included health issues in their agenda with population and reproductive health issues being addressed from a rights perspective. There has also been an increase in funding committed to these areas by other development partners.

In RH there are a lot of players. But there is tremendous change in the civil societies which are involved on the RH activities. More NGOs are coming. In 2001 it was only the Packard Foundation that was funding RH programs. But now there are about 6-7 donors on RH.

These changes in policies, health service delivery and commitment from leaders, policy makers and the government appear to have contributed to the increase in the use of contraception as the CPR increased from eight percent to 14 percent between 2000 and 2005⁴ following awareness creation and availability of different methods of contraception.

Even though respondents were unable to credit all the changes that have occurred in the population and reproductive health environment to the Packard Foundation, they cited some areas where the impacts of the Foundation's work were most evident. The areas identified include the injection of funds, recruitment and training of community health workers to supplement government services at the grassroots level, and the creation of awareness about population and reproductive health among government officials and members of parliament. Most importantly, respondents acknowledged the Foundation's pioneer role in addressing population and reproductive health issues in Ethiopia at a time when very little focus was being paid on these areas. These quotes from some beneficiaries of the Foundation's support clearly underscore the role that the Packard Foundation and its grantees have played:

Because of their organization and of course other efforts, post-abortion care was identified as one program area in HSDP document.-
IDI Grantee

As a result of the Packard Foundation prioritizing issues; the government and decision makers were able to understand what reproductive health is and its relationship with development and the environment. Previously there seemed to be a disconnect between RH, development and the environment but our advocacy made a change in the attitude of policy makers.-IDI Grantee

Some regions have started to build health posts but still their efforts were not adequate. The Packard Foundation and Pathfinder International-Ethiopia tried to fill this gap by recruiting and training community health agents. Following their effort the government is now working in the formation of the same structure in which about 30,000 health extension workers are trained and deployed on a permanent basis and health posts will be constructed along side. This will help to reach the underserved population in the rural parts of the country.-IDI Grantee

Six years back a Packard official was invited to make a speech in parliament. He talked about population growth and its effect on development. The response from the parliament was not encouraging at that time. But now they have taken the issue seriously.-KII Government Official

A project that our review found to be particularly effective in promoting Strategy Three at the community level was the Pathfinder International's project on 'Women's and Girls' Empowerment Program in Ethiopia. In the project, the target community played a lead role in identifying and addressing problems affecting the RHRs of women and youths. The project focused on Family Planning (FP), harmful traditional practices (HTP) such as female genital cut, forced extraction of milk teeth, and early marriage, gender-based violence (GBV), and HIV/AIDS. The project approach helped communities break the silence on these sensitive topics, fostered discussion on the social construction of gender roles, and take appropriate action. It also promoted community ownership, which have been linked to lasting results and program sustainability.

3.3.3 Building Organizational and Institutional Capacity

The Packard Foundation awarded about six grants with an estimated value of US\$5,864,000 for building FP/RH organizational and institutional capacity in Ethiopia. The four primary grantees that received capacity building grants were Center for African Family Studies (CAFS), Brown University, The Carter Center, and Ethiopian Public Health Association (EPHA). The key focus of CAFS' program was providing technical support to Amhara and Oromiya Community-based RH programs, and strengthening management information system (MIS) of ADA, ODA, and other government and NGO partners. Brown's program focused on building of research infrastructure, information, and evaluation capacity at Jimma University and Demographic Training and Research Center (DTRC), Addis Ababa University. The Carter Center focused on increasing access to reproductive health services by building the capacity of national health institutions to incorporate reproductive health training in their curricula. The Ethiopian Public Health Association (EPHA) focused on repositioning family planning/reproductive health services in Ethiopia through strengthening the health extension program (HEP).

Our reviews of project specific records across all grantees under Strategy Three identified particular achievements in the areas of individual and institutional capacity building. In particular, there was training of primary health-care providers, TBAs, CBRHAs, NGO staff and community leaders. Institutional support was provided for university faculty and graduate research training, integration of family planning and reproductive health in health science curricula, building of school laboratories, and the creation of RH information databases across several Ethiopian universities. Evidence from KIIs and IDIs lends support to the records of achievements enumerated above. In response to the question on the role of the Foundation in the institutionalization of FP and RH, a major grantee under this strategy since 1999 stated:

We are playing an important role in upgrading research and training capacity in the public university sector. During the time of our involvement with the public health faculty at Jimma University, the level and quality of reproductive health research being produced at Jimma have increased substantially. Our partners at Jimma University have successfully conducted several large-scale surveys in Jimma zone and nationally, and have been exceptionally productive in publishing policy-relevant research for both stakeholders and scientific audiences. The use of on-going, local data collection projects to inform reproductive and health service delivery programs is a new idea in Ethiopia, and I believe that our Jimma project can serve as a model research program for other universities.

In terms of what has been achieved in capacity building, the grantee's response corroborates reviewed reports as the following series of quotes shows:

A total of 19 faculty members from Jimma, Gondar, and Addis Ababa Universities have participated in our training workshops. Workshop participants have projects in the Amhara and Oromiya regions. They received training in demographic methods for the collection and analysis of fertility and contraceptive use data. Five of the participants from Jimma University are currently working closely with the grantee institution and on their own on issues of adolescent reproductive health.

We have made reproductive health a greater part of faculty research agendas and graduate training at Jimma University. Prior to our involvement with faculty in the Department of Population and Family Studies none of the faculty members were conducting research in the area of fertility and adolescent reproductive health.

We have been very successful in increasing research and dissemination capacity in the area of reproductive health at Jimma University. The visibility and reputation of our partners for conducting solid research has grown substantially. Members of our team have implemented and directed national and regional surveys and studies of population health and well-being, and are sought after by international organizations as consultants.

Project specific reports and key informants acknowledged success in leveraging of funds. A grantee under this strategy pointed to their great success in leveraging funds and the role of Packard Foundation in it:

We have received two other foundation grants, two NIH grants and one NSF grant for our work in Ethiopia. Our success is directly related to the fact that the Packard Foundation took a risk and supported our activities at an early stage. During our most recent three year funding cycle from the Packard Foundation, we received approximately \$450,000 from the Packard Foundation and raised grants from other sources worth a total of approximately \$460,000. The financial support of the Packard Foundation has been critical to our success. We could not have raised the external funds without first having the research infrastructure in place that we built with the support of the Packard Foundation. The Foundation has also been flexible in allowing us to adapt to changes in our environment and the challenges of working in Ethiopia.

Despite the foregoing achievements, the program recorded key challenges and hindrances. First, there was a disconnection between individual capacities built at the universities and the communities they are supposed to serve with their acquired skills. One of the goals of the institutional and individual capacity building projects was “to build a university-based research capacity to assess the demand for reproductive health services and evaluate program effectiveness.” To meet this objective, university-based investigators needed to be more closely linked to service providers but a grantee that implemented this strategy from 1999 to 2008, reported difficulty in establishing such required linkages in the following words: “We have also experienced difficulty in linking our university partners with local reproductive health stakeholders. [...] To meet this objective, university-based investigators need to be more closely linked to service providers.” Secondly, getting university faculty fully invested in collaborative research with an international grantee and more broadly in research on reproductive health was a major challenge. A related challenge was maintaining a high level of involvement of faculty in project activities in the face of other demands on their time. Third, lack of proper coordination of the activities of grantees was identified as leading to the visible duplication of efforts across the overall project. One international grantee expressed his concern thus: “I would like to see more coordination between my project and other Packard- sponsored projects that involve my university partners. Frequently I find out from my team members about their involvement in other Packard-sponsored activities. It would be better if I were consulted in advance so that we could work together to integrate our activities and look for ways to reinforce the impact of our efforts.”

Endnotes

- ¹ The numbers given here are pulled together from project-specific reports. We do not have reports for all the months in 2001, 2002, 2003, 2007 and 2008. We had no reports for 2004 and most of the activities between July 2006 and June 2007 were in the areas of networking, capacity building and registration of new drugs.
- ² The 10,000 emergency contraceptives were procured for Ipas, another Packard grantee.
- ³ Anchor grantees are defined as those receiving the highest level of support during the period under review and /or those that played a central role in the subprogram strategy (see David and Lucile Packard Foundation, 2007)
- ⁴ Central Statistical Agency [Ethiopia] and ORC Macro. 2006. Ethiopia Demographic and Health Survey 2005. Addis Ababa, Ethiopia and Calverton, Maryland, USA: Central Statistical Agency and ORC Macro.

Chapter 4: Other Achievements of Grantees and Support from the Packard Foundation

This chapter focuses on further achievements made by the Foundation's grantees to further develop their work on FP, RH and population beyond the activities funded by the Foundation. It also highlights the Foundation's support to its grantees beyond financial awards.

4.1 Success of the Program in Leveraging Resources

This evaluation addressed the question of how successful the Ethiopian sub-program was in leveraging resources for population and reproductive health programs and how the grantees perceive the Packard Foundation in this regard. Detailed investigation of the degree of success of particular grantees and particular projects was outlined in Chapter 3.

Evidence from triangulation between our various data sources showed that the Foundation's support enabled the leveraging of funds to implement projects that would not otherwise have been accomplished. Most of the grantees indicated that they were able to leverage additional funds for the same or related projects following their work with the Foundation, sometimes getting more than what they had received from the Foundation. This quote clearly captures the appreciation of Packard Foundation's role in getting additional funding by a grantee. "Initially we didn't have any donor. Thanks to the Packard Foundation, that is what I always say, after the first cycle of the Packard project, we were able to get a US\$ 1,673,834 from USAID through Pathfinder in 2002. This happened because when Packard was going for field visit they invited other donors to come with them." -IDI Grantee

There was a general consensus among grantees that the Packard Foundation played a critical role in helping them to leverage resources: "They provide us with important information where we could get more money to run our projects."

IDI Grantee

"Packard was proud of our job. In every meeting they appreciated us. They were telling everyone what we have done. This helped us to get more resources from other donors." -IDI Grantee

Notable examples of successful leveraging and its contribution to project sustainability include the following:

- Under the Private Sector Franchise Initiative (PSFI), DKT Ethiopia received additional funding from DFID, Irish Aid and The Royal Norwegian Embassy, and Venture Strategies, which enabled the DKT to strengthen the supply chain of the PSFI in the country.
- In its work on reducing maternal morbidity and mortality and preventing unsafe abortions, Ipas - Ethiopia reported the leveraging of funds to the tune of US\$15 million from an anonymous donor for the expansion of PAC and contraception in five regions in the country and another US\$1 million from the Netherlands, SIDA, and Ipas International to be used on non-Packard funded areas like staff salaries and administrative costs.
- Grantees working on the ASRH Strategy were particularly successful in leveraging additional funding, for example, FGAE leveraged a total of US\$6.5 million from numerous donors for its work on improving adolescent sexual and reproductive health; DSW secured a total of \$375,000 to supplement their Y2Y program; EngenderHealth received \$150,000 from ACQUIRE; Guraghe People's Self-Help Development Organization (GPSDO) got \$42,000 from PACT, \$117,500 from Save the Children Denmark and \$27,500 from UNAIDS; Pathfinder International Ethiopia leveraged nearly \$125,000; and Save the Children (USA) attracted \$303,079 from Health Communication Partnership and \$150,000 from Save the Children sponsorship program.
- Although the environment was a new area of focus for the Foundation, ongoing initiatives in this area were able to leverage \$180,160 from different embassies and international funding agencies.

4.2 Unexpected/Unplanned Consequences of the Sub-program on Other Vertical Health Programs

The evaluation also sought to ascertain whether there were unexpected/unplanned consequences (both positive and negative) of the Packard Population Sub-program on other key vertical health programs (e.g. maternal, neonatal and child health) and the health system (e.g. work force). The health extension programs supported by the Foundation using Community-Based Reproductive Health Assistants (CBRHAs) and Health Extension Workers (HEWs) were door-to-door health service delivery programs that promoted contraception at the lowest administrative level among other services. The Ethiopian Health Ministry is also increasingly involving these CBRHAs to provide key social and reproductive health services, including condom distribution and awareness creation. This has led to greater awareness about health issues, including HIV/AIDS and contraceptives and more keenness on the part of Ethiopians to seek and utilize formal health services. Underscoring this, a ranking female government official maintained that:

“There is now expanded service delivery to people at the local levels. For example, we now have the CBRHAs and the health extension workers who go door-to-door providing RH/FP services, including counseling and referrals for fistula and abortion cases.”

Another outcome on the health sector was the strong referral system developed by the CBRHA to enable mothers, children, HTP victims and other clients to access health services including VCT. However, it was reported that absence of clear functional guidelines between HEWs and CBRHAs hampered delivery of services. There was also lack of a system to obviate duplication of efforts among different service providers in general.

Institutionalization of RH in the national health program, of which Packard played a leading role, was identified as fundamental in the attainment of sustainability in reproductive health programming. This had major transformative potential for the health sector as a whole, with a rapidly expanding base of committed local consultants, a teeming population of people who are increasingly aware of the importance of reproductive health, a government committed to promoting family planning, contraceptive use and community health, and a growing body of committed funders. This point was very aptly made in the following quote by a government respondent:

Increasingly, Packard’s work in Ethiopia is creating the required significant technical expertise for us to be able to do things by ourselves. I foresee future tremendous improvements in many areas... and we will have greater coverage of health services in the community. The future generally looks brighter.

One of the government health officials indicated that increased usage of family planning has contributed to reduced maternal and child mortality because with family planning, women have been able to space their births, a practice which has reduced complications during pregnancy and delivery. This, he reported, was as a result of mothers taking enough rest in between births, thereby giving themselves enough time to recuperate and enabling the children to be properly nourished before the mother gives birth to another baby. This was captured in the following quote: “With increased usage of FP, there has been reduction in maternal mortality and child mortality because with FP, women are able to space their births and hence have very few complications during pregnancy and delivery because mothers take enough rest after a birth before embarking on another.”

Our analysis of the 2000 and 2005 EDHS data on changes in Ethiopia’s population shows modest but positive changes in population and RH indicators beyond Packard project sites. While it is important to recognize that these changes may be related to other actors in the RH environment in Ethiopia, the pioneering work of the Foundation in Ethiopia, places it in an advantageous position to be linked to these positive outcomes. Moreover, some of the Packard Foundation’s funded programs were national campaigns, particularly those related to IEC, which have created a nationwide boost in the level of knowledge and positive attitudes towards FP and RH issues.

4.3 Other Support Services of the Packard Foundation to Grantees, Quality of Support and Ways to Strengthen Them

Information seeking to understand other support beside grant awards that the Packard Foundation extended to its grantees were collected primarily from in-depth interviews, open-ended interview questionnaires with grantees, and case studies of beneficiary organizations. Our analysis of data from this combination of sources identified the Foundation’s non-financial assistance to its grantees in the area of leadership development and strengthening their organizational effectiveness.

4.3.1 The Leadership Program

The most common support area identified by grantees during the in-depth interviews was in the leadership development program. The Foundation’s strategic emphasis concerning leadership development is already discussed in the preceding section of the report. The role of the leadership program in raising leaders beyond financial awards received by grantees was well articulated in the following three comments by different grantees:

“...the leadership program was able to train people from government organizations, faith based institutes, community members etc.”

“The leadership program is one of the additional supports we get from the Packard Foundation. They have trained our staffs in Ethiopia and abroad...”

“Leadership training followed by networking was given to our former country director. It was part of the capacity building plan of the project. The training is very helpful especially if it were given to more than one person in the organization.”

4.3.2 Organizational Effectiveness

The Packard Foundation’s organizational effectiveness (OE) fund was found to play a useful role in strengthening grantees’ operations and assisting them to achieve their respective goals. The fund helped to improve grantees’ management, governance and leadership through the development of strategic plans, strong governance systems, structures, and skills. By working with organizations like The Center for African Family Studies (CAFS), the Foundation has helped some of the grantees to develop personnel manuals for leadership and organizational effectiveness training. Managers and project coordinators cited the opportunity provided by such projects for identifying challenges in their organizations and to work together to find solutions. The following views elicited from in-depth interviews bear testimony to the importance of this assistance: “Packard invited Center for African Family Studies (CAFS) to do an institutional assessment. They identified six major challenges within the organization and we are working to improve these identified challenges.”

“We have got leadership training and organizational effectiveness training. We developed a personnel manual.”

Monitoring and Evaluation, was cited as an area where the Foundation has given full support to grantees. One approach employed was the organization of regular field visits to project sites, where ongoing projects were monitored and feedback given. The Foundation maintained the biannual submission of project reports by all grantees. These project reports are often reviewed and comments fed back to grantees to re-adjust their approaches for better results. The quote that follows clearly highlights the activities of the Foundation in terms of physical monitoring of activities: “Ato Sahlu with FGAE team used to go to the field to see activities. We have shared our experiences and challenges. They also give us support in assessment of our financial issues.”

The Foundation organized several grantees’ fora, such as the bi-annual grantees/partners meetings which offer opportunities for grantees and other partners to exchange information and share their experiences with stakeholders. The subprogram also arranged travel to other developing countries for its grantees and government officials for experience-sharing with other grantees. During the 2008 grantees’ meeting in Addis Ababa, there was consensus among grantees concerning the enhancement of their human resource capacity through technical and leadership skills training offered by the Foundation. Out of the 21 responses received, 20 were very positive about this support. Only one respondent indicated dissatisfaction. When asked about the quality of support beyond primary grants during in-depth interviews, grantee representatives responded that they regarded it as important, since it is comprised of different components including training and capacity building.

In addition, grantees explained that the supportive working style of the Foundation’s country-level staff made them easy to work with effectively. Grantees described the Foundation’s staff as flexible, collaborative and supportive. The perception that the Foundation’s staff are flexible and transparent when dealing with grantees was said to have boosted their confidence and fostered trust between the parties. One of the respondents expressed the quality of support as follows: “Well, it is very important support because it has all dimensions. They give you training, build capacity and fund programs. So for me their support is all-rounded and flexible.”

4.4. Management Structure of the Sub-program, Successes and Drawbacks

Information regarding management of the Packard Foundation Ethiopia Sub-program was collected during this evaluation from questionnaires and in-depth interviews with grantee representatives. The Foundation employs one person working on the Ethiopia Sub-program in the Californian office and two program officers and one administrative staff in the Ethiopian office. Asked about their opinion of this management arrangement, most grantees considered it as transparent. They reported that information is well communicated and grantees can contact the subprogram office whenever they need assistance.

In terms of the relationship between the Ethiopia Sub-program and the Foundation headquarters, Packard Ethiopia officials and one of the grantees reported that they got support from the Foundation’s head office in California if and when necessary. “We have a program officer in California and we have two program people and one administrative

person. The good thing is everybody is willing to work. We have very dedicated staff. We believe that we have a good relationship with our partners”-Packard staff.

“We make direct contacts with their office at the headquarters in California, the population desk. If there is a need, we also make contacts with the local office, country director in Ethiopia”-IDI Grantee

Communication with the Foundation was seen as easy and not having complicated bureaucracy compared to some other donors. One of the grantees expressed the simplicity of communication with the Foundation thus:

“In most other organizations it is very common to find high bureaucracy and no flexibility, where 90 percent of their time would be spent on bureaucracy and only ten percent spent on programmatic issues. But the reverse situation is true with working with Packard.”

Grantee representatives responding to the in-depth interviews reported that staff are available and give prompt responses to grantees’ requests. However, a number of grantees expressed concern about the small number of staff in the Addis Ababa office, which they said undermined the Foundation’s ability to follow up adequately with grantees. Out of the 11 in-depth interview responses obtained on this issue, seven were positive about the management of the subprogram at the country office, indicating that despite the number of staff available, working with grantees was smooth. Yet some grantees felt that the number of staff in the sub-program office is too small to give all the necessary technical support. This was linked to delays in giving timely feedback to grantees. Some grantees indicated that they did not receive feedback from the sub-program and for some, such feedback was most of the time given orally, a practice they felt was less helpful than written feedback for implementing all the ideas. Four respondents reported that it took a lot of time for their needs to be attended to and highlighted the need for Packard Foundation to reconsider the staffing of its office and to intensify its engagement with grantees in order to make the most out of the projects that it funds. This position was clearly conveyed in the following two quotes:

“...maybe if Packard was staffed differently so that there are more officers on the ground then probably they would have participated more...”

“The problem with Packard is its low number of man power. It would be therefore better to improve their manpower so as to work more closely with grantees and partners.”

Regarding the use of funds, the Foundation was lauded as being timely in its financial settlements and flexible enough to allow grantees to make minor adjustments on their budgets. The ability to use 10 percent of the budget line flexibly without prior consultation with the Packard Foundation is appreciated by most grantees.

Further, most interviewees reported that they agreed with the Foundation’s strategy of focusing on the Amhara and Oromiya regions, including Addis Ababa, because they are the largest regions in the country, and addressing RH issues in these regions means that a larger proportion of the country’s population is reached. However, some respondents insist that they did not understand how the Foundation selected these geographic areas. A few interviewees felt that they were forced to work in regions/towns they did not want to work in.

For some of the grantees, the grantees’ selection criteria are not clear, and some suggested that since the Foundation works with people at the grassroots, it would be more valuable to select grantees that are positioned at these levels; as one grantee representative suggested: “There is need to look at those working at the kebele levels, including looking at the objective of the grantees to ensure that they are in line with the objectives of the Foundation’s work.”-IDI Grantee

The next chapter presents the lessons learnt and some recommendations for improved performance in the future.

Chapter 5: Lessons, Recommendations and Way Forward

Over the last ten years, the Packard Foundation's Ethiopia Population Sub-program developed its grant-making under three key strategies: Expanding family planning and reproductive health service delivery, improving adolescent sexual and reproductive health (ASRH), and creating an enabling family planning and reproductive health environment. We have highlighted in chapters 2 to 4 of this evaluation report some of the key strengths and challenges of the program. This chapter summarizes the key strengths and successes, as well as weaknesses and highlights the opportunities and challenges for the sub-program moving forward, given Ethiopia's current reproductive health environment, the experiences of the sub-program, and the emerging directions of the overall Packard Foundation Population Program Strategy.

5.1 Strengths and Successes of the Sub-program

In this section, we underscore the strengths and successes under the following themes:

1. Pioneering of FP/RH issues in Ethiopia
2. Capacity building of local research institutions and NGOs in FP/RH research and service delivery
3. Project sustainability through leveraging of funds
4. Strong and successful networking and advocacy
5. Comprehensive IEC campaigns
6. Collegial and flexible management approach.

5.1.1 Pioneering of FP/RH issues in Ethiopia

Undoubtedly, the most remarkable strength of the Packard Foundation's Ethiopia Sub-program was its pioneering spirit. Interviewees from a variety of backgrounds (governmental and non-governmental organizations, and international agencies) gave credit to the Packard Foundation for its uniqueness in focusing on neglected programs and locations in Ethiopia. For example, the choice of Amhara and Oromiya regions was informed by their unique disadvantages in FP/RH indicators, and the choice of rural areas in these regions underscores this perspective. The programmatic focus was on population and reproductive health, adolescent sexual and reproductive health, environment, and eradication of harmful traditional practices, including early child marriages, school drop-outs, gender-based violence and unsafe abortion, and equipping young people with life skills. It is important to note that the Packard Foundation was the first agency to focus greater attention and invest more resources towards addressing these issues in Ethiopia.

Besides pioneering funding on population and reproductive health activities, another key strength of the Foundation's Ethiopia Sub-program was its deliberate efforts to ensure FP/RH activities were not clouded by HIV/AIDS activities, an area to which many donors have shifted their primary focus. Our review of the activities under the Community Based Reproductive Health programs indicated numerous achievements in improving general population awareness of sexual and reproductive health, family planning and harmful traditional practices; increased uptake of VCT and testing before marriage; notable positive attitudes toward condoms; and improved adolescents' knowledge and use of sexual and reproductive health services.

The challenge of HIV/AIDS was also given specific attention by the sub-program. One of the seven specific project areas under the Foundation's strategy to improve access to FP/RH services focused on HIV/AIDS prevention and integration with reproductive health. Although a number of organizations like the Population Media Center (PMC), and Walta Information Center (WIC) implemented integrated HIV, population and RH advocacy activities, the organization that had primary focus on HIV/AIDS prevention was the Ethiopian Orthodox Church Development and Inter-Church AID Commission (EOC-DICAC). The Church's project received about 2.8 percent of the grants awarded under the strategy¹, with remarkable successes, linked to the commitment of the top echelon of the Church, together with its huge following in the country (over 50 percent of the population).

Given the significant role of the sub-program in addressing issues of unsafe abortion and in successfully supporting advocacy efforts to change reproductive policies – especially the legislation on abortion – the Foundation’s work with EOC may have potentially positioned the Foundation as a genuine development partner and lessened strong religious opposition to such campaigns. Often, many RH organizations and funders fail because they antagonize religious establishments or are perceived by such establishments as having an unstated agenda. By working with EOC on abstinence, fidelity, and HIV/AIDS awareness campaigns, the Foundation demonstrated to the Church its genuine commitment to the wellbeing of Ethiopians. The Foundation officials pointed out that the revised Penal Code was considerably broad in the circumstances under which it authorized abortions, despite lobbying from US anti-abortion campaigners. What needs to be highlighted is the fact that such challenges did not come from the Ethiopia Orthodox Church, which is conservative and the dominant religious group in Ethiopia. Our conclusion is that the outcome for the abortion law may have been different, had the EOC stood in opposition or supported such external advocacy groups. In all what we are learning here is the need for the Packard Foundation and indeed other donor agencies to further explore and pursue such strategic partnerships with religious groups. In fact, researchers in sub-Saharan Africa have identified how for some young people, religion offers or at least solidifies an important area for individual choice, namely refraining from premarital sexual intercourse entirely or ‘secondary abstinence’ for people who were sexually active. Following this logic, Smith (2004) stated that the possibility that some young people heed strongly promoted religious messages can no longer be ignored by FP and RH practitioners.

5.1.2 Enhanced Capacity of Local Institutions in FP/RH Research and Service Delivery

The sub-program identified the need for local capacity *ab-initio* and channeled substantial investment in capacity building of local universities and NGOs for family planning and reproductive health research and service delivery. Between 1999 and 2001 for instance, six grantees: International Family Health, CAFS, Consortium of Family Planning NGO’s in Ethiopia, Pathfinder International, Carter Center, Inc and Brown University, received substantial grants specifically focusing on capacity building of Ethiopian institutions. The activities of these grantees in Ethiopia covered capacity building for community-based distribution programs, management training of local NGOs in such areas as book-keeping and financial reporting, building and strengthening coordination and networking capacity to advance population and reproductive health issues, public health training initiatives, and research training in universities for improving reproductive health. The large number of local NGOs that received or are receiving support from the Foundation, and have become major players in FP/RH program activities in Ethiopia bears testimony to the Foundation’s success in this area over the last ten years.

5.1.3 Project Sustainability through Leveraging of Funds

The sub-program was very successful in leveraging additional funds from other sources. As already elaborated in Chapter 4, leveraging of funds enhanced sustainability for most of the projects, and the Packard Foundation was credited with enabling grantees to leverage funds by linking them to other donors. Further, grantee respondents to our survey conducted during the 2008 grantees’ meeting in Addis Ababa emphasized that by merely implementing Packard-funded activities, they got opportunities to attract funds from other donors. They also gave credit to the Foundation for placing the initial faith in them; this gave them the opportunity to be attractive to other donors. As shown above, the Private Sector Franchise Initiative (PSFI) project typifies the success in leveraging of funds as a sustainability strategy. It is important to note that quite often the Ethiopian Sub-program stopped funding a specific project activity after other donors stepped in with much larger grants, for example the EOC HIV campaign and the Pathfinder PSFI program.

In other instances, the Foundation left specific geographic areas because other donors, drawn by the Foundation’s pioneering work in the area, stepped in to provide larger funding resources. In some cases, more successful pilot programs initiated by the Foundation were taken to scale or adopted nationally by either the government (as with the CBRHA program) or other donors (like the EOC HIV program being funded by USAID). Despite the achievements these represented, such situations complicated the methodology for evaluating the impact of the Foundation’s specific projects in such areas because there were no comparison areas.

5.1.4 Networking and Advocacy

From our desk review and analysis of the qualitative data, the Packard Foundation’s networking and advocacy was a key strength and anchor for success in many areas. The project on reducing maternal morbidity and mortality and preventing unsafe abortions created a network of NGOs, community and women groups and a firework of advocacy unprecedented in Ethiopian history, leading not only to the revision of the Penal Code in favor of legalized abortion, but also to an enabling environment for legal abortion services nationally through other initiatives already outlined above. It also increased the availability of RH technologies to women and providers; expanded public knowledge and positive attitude related to abortion and other reproductive health rights; and improved the policy environment for RH and rights, particularly through the enactment of the abortion law and its implementation. The program’s

success in leveraging funds to the tune of US\$15 million from an anonymous donor for the expansion of PAC and contraception in five regions of the country holds hope for the sustainability of the effort and the achievement of more significant outcomes.

Further, the adolescent sexual and reproductive health project achieved strong referral linkages and partnership with line departments, periodical in-school teaching programs and the *woreda* education office. To ensure youth SRH rights and services, the integration of the activities of volunteers (HBC providers, PSPs, Girls clubs & Drama & Music clubs) was achieved together with the launching of panel discussion fora on youth SRH issues at *private sector participation* (PSP) intervention areas and project offices. A total sum of about US\$ 6.5 million (Birr 52.2 million) was granted to FGAE by IPPF, RNE, Irish Aid, UNFPA, FHI, ECI-Africa, DKT, Global Fund, CIDA, CORHA, SAFE HANDS, the Swiss Embassy, RHAPCO, and Interact Worldwide to support on-going efforts at improving ASRH in Ethiopia.

There is a general consensus in relevant policy documents, and responses from our IDIs and KIIs, that civil society advocacy activities funded by the Packard Foundation influenced government enactment of various health policies and strategies which have improved national policy on RH/FP, including the National Youth Policy and Strategy, the Family Law, and the Penal Code. The liberalization of the abortion law and the inclusion of population issues in the government strategy documents like the PASDEP and the HSDP were also noted above as important dimensions of these positive developments. The Foundation through the activities of its grantees not only influenced government officials to have a free standing Reproductive Health and Population sector but also helped the government in designing and implementing such policies as PASDEP and HSDP, not forgetting its support of the Community Based Reproductive Health Program. Overall, there was a consensus among respondents that under the leadership of the Packard Foundation Sub-program in Ethiopia, there has been increased commitment from political leaders, decision makers and the government in prioritizing population and reproductive health issues in the country's development agenda.

5.1.5 Comprehensive IEC Campaigns

Closely related to the success in networking and advocacy are the strengths of the comprehensive information, education and communication (IEC) projects. Most Packard-funded projects focused on IEC activities, and as a result, the sub-program was successful in raising the level of knowledge of FP/RH among the Ethiopian population of all ages and gender. Data from in-depth and key informant interviews, project specific reports, and secondary data analysis converge in support of IEC campaigns were carried out through all available media outlets and in various languages, with recorded tangible impacts. While the flood of activities in this area by all grantees has its own downside which is discussed in the subsequent section, it is safe to conclude that Packard-funded IEC activities were the backbone of the successes recorded in advocacy, leadership and youth skills development projects and HIV prevention projects, including increased positive attitudes towards those infected with HIV/AIDS. Our findings on the strengths and achievements of the IEC programs are supported by a previous evaluation of the Population Media Center's Radio Drama Series aired in local languages during the 2002 and 2004 period. The evaluation concluded that:

The broadcast generated a huge audience, was highly liked by the listeners and that both radio serial dramas significantly improved the knowledge and use of family planning services, knowledge of and attitude towards HIV/AIDS, as well as the uptake of HIV voluntary counseling and testing (VCT) services among the regular listeners as compared to the non-listeners (*Packard Foundation Ethiopia: Background Paper, 2008*).

5.1.6 Collegial and Flexible Management Approach

A key strength of the Packard Ethiopia Sub-program that underlies the other accomplishments and achievements is its collegial management approach. Interviewees freely gave credit to the good working relationship between the Foundation officials and its partners. Other positive attributes linked to the strength and success of the sub-program were identified as flexibility and timeliness in the release of funds, and willingness to accept innovative ideas from grantees, and to working well with local organizations. The openness to innovation was exemplified in the partnerships built by the sub-program with local religious and government institutions, as well as linkages created between private and public sectors of the Ethiopian society. These strategic partnerships won over the opinion leaders who in turn influenced population growth policies and programs; hence more changes in population and reproductive health were achieved. Some grantees praised the Foundation's capacity building initiatives, for instance the leadership program, which equips grantee staff with project management skills. The various networking mechanisms enabled grantees to leverage funds from other donors as well as share experiences with other grantee organizations. The investments made by the Foundation in building a grand coalition of stakeholders cannot be over-emphasized and a Packard Foundation official summarized the resultant cooperative strength of the sub-program built over the years among stakeholders in the following words: "We have excellent personal relationships with grantees, with government officials, and with other donors—good political connections and ability to influence various processes together with our grantees."

5.2 Weaknesses and Failures

Despite the significant strengths and successes of the Ethiopia population sub-program outlined above, a number of perceived weaknesses were identified by this evaluation. These are discussed under the following themes:

1. Weakness in coordination and supervision
2. Multiplicity of activities and duplication of efforts
3. the Foundation's inadequate staffing level
4. Weaknesses in translating enhanced capacity into outputs
5. Weaknesses in service delivery
6. Failure to address gender disparity
7. Favoring international grantees
8. Limited geographic focus.

5.2.1 Multiplicity of Activities and Duplication of Efforts

The first and most commonly mentioned weakness of the Packard Foundation's Ethiopia Sub-program relates to concerns over multiplicity and duplication of project activities and efforts of grantees. Our review showed that there was no clear delineation of boundaries for the various project activities across most grantees. The concern for multiplicity and duplication are clearly identifiable in the area of capacity building and strategies around IEC/BCC. A very good example can be drawn from, but not limited to grantee reports submitted to the Foundation for the period July 2007 to May 2008. Over the period, Walta Information Center transmitted 30 TV and 30 radio programs focused on FP/RH, HIV/AIDS, gender, environment, and related issues. The program covered Oromiya Region (Woliso, Mojo, Menagesha, Welmera, Fentale); Amhara Region (Bahir Dar, Chilga, Awi, Fogera and Debarke); Tigray Region (Mekele, Aksum and Maichew) Addis Ababa and Dire Dawa Administrations.

Over the same period, Pathfinder International, whose project covered three regions Amhara, Oromiya and Addis Ababa reported reaching 2,175,379 people with information on different FP/RH issues with different approaches and another 247,084 youths with youth-friendly RH information, including the provision of services to 56,084 people in Packard- and other donor-supported sites. On its part, Oromiya Development Association educated 4,472,622 people and 53,247 adolescents on selected components of RH and distributed 2,496 different kinds of IEC materials (343 leaflets, 15,323 posters, 1379 magazines, 608 que-cards) in Oromiya over the same period. The Family Guidance Association of Ethiopia (FGAE), with a focus on providing comprehensive youth friendly SRH information and services to adolescent and young people in 11 intervention sites (Woliso, Fiche, Zeway, Mettu, Bedele, Gimbi, Kemissie, Debre Sina, Wolkite and Addis Ababa), reported serving more than 77,988 young people with library services; about 30 percent of the people were females. It distributed more than 82,299 different kinds of IEC materials to young people, and involved more than 3,006 participants in youth dialogue sessions that addressed SRH and related issues.

How much overlap there was between clients reported by these grantees is not clear nor do we know the extent to which the same clients were interacting with and using services provided by different providers/grantees. Many of the quantitative outcomes reported by grantees (e.g. number of clients reached/served) could refer to the same group of individuals. This would imply that any one of the various programs could have achieved the same observed results, and that there may have been an over-saturation of program efforts with grantees tripping over each other and achieving little extra value.

With many actors implementing similar activities, it is quite challenging to assess the effectiveness or weakness of each project; and where changes are observed, it is difficult to attribute them to a particular actor or strategy. While acknowledging some levels of unavoidable duplication and the great efforts reported by the Foundation's officials in addressing issues relating to duplication and overlap through grantee fora and the like, one of the questions for the program moving forward is the extent to which the Foundation could be more critical in the award of grants, with clear delimitation of project/strategy boundaries and definition of measures of success.

5.2.2 Weakness in Coordination and Supervision

Related to multiplicity of activities and duplication of efforts is the problem of the Foundation's weakness in coordination and supervision, as illustrated by the following statement of a grantee: "The programs focused on so many things, the reach is so wide, but coordination and supervision are out of control."

Indeed, most grantees repeatedly identified the lack of coordination of grantee activities as a major weakness of the sub-program, and this contributed to the duplication. One international grantee expressed his concern thus:

I would like to see more coordination between my project and other Packard-sponsored projects that involve my Ethiopian partners. Frequently I find out from my team members about their involvement in other Packard-sponsored activities. It would be better if I were consulted in advance so that we could work together to integrate our activities and look for ways to reinforce the impact of our efforts.

The challenge of supervision of program activities was identified in particular project sites. For example, the delay in the construction of the Debresina Youth Center was attributed to less frequent supervision by the consultant. Further illustrations of lack of coordination reported by study participants included the perception of weak capacity of the Foundation in follow up, providing feedback to grantees and monitoring and supervision of grantee activities. As a consequence, the field performances of grantees were perceived as not sufficiently scrutinized. The Packard Foundation's lack of effective monitoring was noted by some respondents as something that could promote corruption and lack of accountability among grantees.

A key grantee expressed his expectation of better coordination in the following words during our in-depth interviews: "Now that my Packard-sponsored activities are focusing more on dissemination, I would like to see more involvement of the Foundation in coordinating and integrating activities across the different partners with whom I will be working... In some instances the Foundation may have to use its financial support strategically to leverage better coordination and cooperation among the stakeholders."

In some cases, lack of coordination was extended to other donor agencies in the country. A staff of the Foundation reported that projects in Ethiopia are often relocated when other donor agencies come into project locations. While this may be outside the control of the Foundation, it may be an issue to be addressed for the program moving forward as evidence shows that such coordination of efforts, where they have been reported, has yielded maximum benefits for all stakeholders. For instance, such collaboration in the past with the Carter Center was identified as useful in inserting FP/RH into the training curriculum of government health officers. A Packard official lauded the effective nature of collaboration with USAID in the establishment of the population-health-environment network and with the Nike Foundation on girls' economic empowerment in Amhara Region.

5.2.3 Inadequate Staffing Level at the Foundation's Office in Ethiopia

Linked to lack of adequate supervision and monitoring is the problem of inadequate staffing. The concern about lack of supervision was almost always excused by the grantees as resulting from inadequate staffing levels of the Foundation's office in Ethiopia. The Packard Foundation's staffing level in Ethiopia was seen as too small to promote any useful and sustained engagement with government, communities, and grantees. Clarifying this point, one respondent noted that: "At their Addis Ababa office, you find only two or three people... These people (Packard staff) do not have enough time for all the activities. Sometimes there is nobody there to attend to you. They are too few and they are overstretched." This point was further reiterated by another grantee thus: "Packard staff members are too few and are not able to address grantees' issues adequately and in a timely fashion...I think they have to increase their staff number."

Respondents argued that a larger workforce is critical to the long-term sustainability of the Foundation's efforts in Ethiopia. This weakness was acknowledged by a Packard official in the following words:

"The Ethiopia office is feeling over-stretched because of the large number of grantees that it has to monitor at any given time who are spread out in a large geographic area, and the increasing number of processes (legal, administrative, reporting to the board using dashboards, etc.) that are required by the Foundation in running grant making programs. International travel has also increased as we try to tie up country and global grant making. Thus, I have always felt that if there is a way to decrease the number of grantees and still have a way to support smaller local NGOs, we would do it—but I don't have a solution to that."

The need to address the issues of staffing at the Ethiopia office seems to be critical for the sub-program's future development. It is important to note that this situation becomes more challenging following the call by some of the respondents for the Foundation to extend its programs beyond the regions where projects have been primarily located in the last ten years.

5.2.4 Weaknesses in Translating Enhanced Capacity into Outputs

The evaluation revealed that in the area of institutional and individual capacity building, there was a disconnect between individual capacity at the universities and the communities they are supposed to serve with their acquired skills. One of the goals of the institutional and individual capacity building projects was "to build a university-based research capacity to assess the demand for reproductive health services and evaluate program effectiveness." To

meet this objective, university-based investigators needed to be more closely linked to service providers; but a key grantee that has implemented this strategy since 1999, lamented the difficulty in linking its university partners with local reproductive health stakeholders in the following words: “Another major challenge is maintaining a high level of involvement of faculty in project activities in the face of other demands on their time. We . . . experienced difficulty in linking our university partners with local reproductive health stakeholders.”

Getting university faculty fully invested in collaborative research with an international grantee university and more broadly in research on reproductive health was a major challenge, and rapid staff turnover was recorded in the universities as in other projects under the sub-program. This may have been exacerbated by political and economic uncertainties, environmental challenges, drought, poverty and war that have characterized the country in the last three decades (Mberu, 2006; Berhanu and White, 2000; Lindstrom and Berhanu, 1999; Bariagaber, 1995).

The youth empowerment training programs lacked mechanisms for engaging trainees in gainful employment. Due to limited employment opportunities in the economy, training in particular skills easily saturated the market leading to unemployment of trainees. The projects lacked the mechanisms to either anticipate these outcomes or to manage them in terms of being flexible and moving into training in other skills. For instance, there was a lack of electricity infrastructure needed to support rural youths trained in computer operation skills. Budget constraints did not help matters in this regard and administrative and financial barriers hindered access to youth microfinance, where it was available, such as the ACSI. Despite some reported successes in this regard, the lack of access to credit services for skilled trainees to obtain start up capital for their businesses greatly hindered the primary poverty alleviation goal of the program. High turnover of program staff was reported and this was related, among other factors, to the lack of benefit packages for them. Consequent upon these, funding for activities to diversify the vocational skills training program, creating opportunities for employment and access to micro-credit will therefore be critical for the next steps of the sub-program.

5.2.5 Weaknesses in Service Delivery

Most quantitative indicators, interviews and syntheses from desk reviews show that the sub-program was generally weak in service delivery. One key problem identified a number of times was the lack of capacity to meet the huge demand for services created through IEC campaigns. For example, activities under adolescent sexual and reproductive health were ill-equipped to manage growth and expansion; and therefore were unable to maximize potential benefits. At several points over the period, there was absence of FP method choices and grantees consistently reported a shortage of contraceptives, especially injectables and Norplant. There were also client overload in some clinics causing longer waiting times and overwork of providers. The failure of the sub-program to anticipate increased demand from the onset of the projects was identified by a Packard official as one of the key challenges of the program in the 10 years of its existence: “Contraceptive shortages—demand for injectables and implants outstripping the erratic supply of these commodities. Contraceptive shortages continue to be a serious problem and we should have predicted the rapid increase in demand when we began our program.” Similar to shortfalls in contraceptive services was the overload in the library centers established under the sub-program. For instance, grantees reported that reading rooms became too small to accommodate and satisfy the needs of young people who wanted to use the center, having been mobilized through the IEC campaigns.

5.2.6 Failure to Address Gender Disparity

The goal of alleviating gender disparity was critical to the program of women empowerment, leadership program of the IIE, and youth empowerment schemes yet the evaluation shows that these projects did not adequately address this challenge. For example there were gender biases in outcomes on knowledge, current and ever use of FP methods, training programs, women empowerment projects, and the projects on leadership. It has been largely shown that women are disadvantaged under the Ethiopian traditional patriarchal society; and the evaluation suggests that they remained disadvantaged in most projects implemented under the three strategies.

The major challenge of IIE project on RH leadership development was the difficulty in reaching women leaders. The project made appreciable progress in addressing this imbalance and by the last report cycle (July 2007 to May, 2008) the gender gap was narrowed to 54 percent male and 46 percent female fellows, which was an improvement, although it was still less successful than similar leadership projects in Nigeria and India.

The project for women empowerment through skills training and loans did not achieve such level of parity. At the onset of the program in 2003, only 33 percent and 21 percent of loan recipients among ACSI and OCSSO clients, respectively, were women. Whether this was a problem of absorptive capacity was not clearly spelt out in the project-specific reports we reviewed; but initial lack of capacity among program officers on gender issues was reported.

Reports in the last two years of the sub-program suggest improved gender awareness by program officers and concerted efforts at increasing women beneficiaries of loans. However, project-specific reports indicating significant increase in the proportion of women beneficiaries of the loan facilities showed that in the latest project-specific report cycle (July 2007 to June, 2008) 60 percent of clients in Amhara and 45 percent in Oromiya were women.

Apart from failing to meet the primary objective of women empowerment, loans given to women were reportedly smaller and their profit margins much lower than those given to men. It was also reported that men were usurping the loans specifically targeted to women, confirming previous research reports on Ethiopia suggesting that husbands commandeer loans given to their wives, thereby thwarting the goal of women empowerment. In the Oromiya region, the majority of clients of the skills training and loans for women's empowerment continued to be male, despite the long duration of the project. Also, resistance of parents/husbands to send their daughters/wives to youth clubs and to the programs prepared by clubs was and remained a clear challenge to the sub-program grantees.

5.2.7 Favoring International Grantees

A common negative perception among some of the respondents (especially those representing local NGOs) was that the Foundation favored foreign organizations in the disbursement of larger grants. Data gathered from the leaderships of many local organizations indicated that although they often did (or felt that they did) the same type and quality of work as the international organizations, they always received smaller and often insufficient amounts of grants for their work. This was not only considered unfair, but also discouraging. However, there is evidence linking local NGOs with "relatively small absorptive capacity" (except for the large groups like ODA and ADA). It was reportedly for this reason that the Packard Foundation had to invest much more in the last 10 years in institutional capacity building of local organizations, in order to get desired programmatic outcomes.

Currently, the management is still identified as weak in many of the anchor organizations in terms of HR policies, MIS, M&E, sometimes book-keeping and financial reporting. Further our close analysis of the largest single individual grant awards by the Foundation in the last 10 years did not suggest any significant skew in favor of international grantees. In fact, while the three largest single grants were awarded to international grantees, ten of the overall 21 largest single grants were awarded to local grantees. It is however important to not only note but also re-examine this perception and address it in appropriate ways in the future.

5.2.8 Limited Geographic Focus

The Foundation's focus on a few regions in the country, while strategic, was also viewed as ill-considered. The problems associated with high population growth, lack of access to contraceptives, and the scourge of HIV/AIDS were reported to be pervasive in Ethiopia. They were not region-specific issues and therefore required a comprehensive, multi-region strategy to be addressed. The view of many respondents was therefore that the Foundation's regional focus made it difficult for its efforts to deliver the desired level of impact. Again, this position was countered by evidence that other donors are working in other regions of the country and that some of the Foundation's funded activities also have a national reach, and that some have grown from local sites to become nationwide projects through leveraging of resources. Notwithstanding, some of those interviewed in the course of this evaluation called for expansion of the Foundation's projects to other regions of the country beyond the places of primary focus in the last 10 years.

5.3 Opportunities for the Sub-program Moving Forward

Apart from the lessons that can be drawn from different sections of the evaluation report, we present key recommendations for consideration in moving the Ethiopia Population Sub-program forward.

1. There is need for a clear delineation of program boundaries and definition of measures of success in the review of project proposals and award of grants. As indicated above, with most projects engaged in similar activities in sometimes overlapping geographical areas, it becomes difficult to know who is actually doing what and the evaluation of the independent contribution of each grantee becomes difficult.
2. Following successes recorded in the area of IEC and capacity building, the Foundation should consider shifting the sub-program's focus to service delivery. The leading view is that the Foundation can take advantage of the existing positive policy environment and the networks it has created with other grantees, development partners, the media and research organizations in moving its agenda forward. A Packard grantee puts this enabling environment in these words: "The Packard Foundation has formed a link with important organizations like ADA, ODA, media, research organizations and NGOs. Besides it has created a network from community to high level officials."

Similarly, government representatives interviewed in the course of this evaluation reported that with the government's increased efforts in restructuring its activities at the woreda levels, it will require partners to supplement these efforts, an opportunity that the Foundation could exploit in its programs. They also reported the existence of many

institutions at the local levels both formal and non-formal that the Foundation could offer its support to and work in partnership with the government in evaluating these activities. Even though the CBRHA program being supported by the Foundation was reported to have registered a lot of success in addressing RH/FP issues at the grassroots levels, it was noted that the Health Extension Worker's (HEWs) program still represents an opportunity for the Foundation to optimize its success in offering services to people at the local levels thereby working to meet the Millennium Development Goals (MDGs). These partners could work with the Foundation to make even greater changes in the area of contraceptive distribution especially in the rural areas. Improving the country's unmet need for contraception was reported by a grantee as an area that if addressed, could bring down the birth rate substantially.

The government is also increasingly structuring its activities at the woreda levels and this is an important opportunity for the Foundation to seize and give support to these institutions, even the Edirs can be supported if they have development activities and the government will be very keen to evaluate these activities

3. The need to intensify activities around coordination of grantee activities is critical for the program moving forward. This will help the sub-program to ensure greater accountability and reduce duplication.
4. Related to the above is the need for coordination with other development partners to enhance impact. The reported distortion of the health system by HIV funding in sub-Saharan Africa together with donor collaboration and coordination challenges needs to be addressed by the Foundation in its future population and reproductive health work in Ethiopia.
5. The entire program needs an organic monitoring and evaluation component at vital points in time: base-line, mid-term and endlines. Each program component needs to define measurable success indicators, which the monitoring and evaluation activities will seek to measure at defined intervals. As pointed out by grantees on the limitations of the sub-program, there is recognition that having logic models, theories of change as well as indicators of success will help the Foundation achieve its work and assess the impact of its programs on the population and reproductive health situation in the country.
6. There is general consensus that there is need to expand the Ethiopian Packard office to create more capacity in field operations. If field supervision of on-going projects will be effectively undertaken and if expansion to other regions will be implemented, then expanding the staffing capacity at the country office cannot be overemphasized. The need for adequate staffing is made stronger following the numerous grantee reports that are periodically sent to the Foundation, which need prompt response mechanisms, including officers who will review such reports as they come in so that doubtful facts can be timely contested, and revised. This will enhance the feedback mechanism, enable the Foundation maximize its goals, and speak to the complaints by a handful of grantees that it really takes time to receive feedback from the Foundation if at all.
7. There seems to be a need for the Foundation to expand activities beyond population and reproductive health to include other related areas, such as the challenges associated with the environment and climate change.
8. Finally, in the area of youth and women empowerment, funding to diversify the vocational skills training program will be critical for the next steps of the sub-program. Additional investments will be needed to assist trained beneficiaries in finding jobs and/or identifying sources and enhanced access to micro-finance for those who would like to start their own businesses. Particular skills training in areas such as tailoring and embroidery to benefit women and young girls was identified as something that could enhance their participation and the overall goal of the sub-program. Moving forward, the youth empowerment program's need for funds, particularly through leveraging from other donor agencies will be critical. Activities in the area have already yielded positive results with the two-year grant from USAID to supplement informal primary and secondary education. Another similar support for the empowerment program was from the Organization of Women's Development Initiative Project, supported by the World Bank.

In conclusion, the Packard Foundation's Ethiopia Population Sub-program has shown substantial progress in terms of meeting its three primary strategic objectives. However, as has been shown in detail in this report, ample room exists for necessary changes to enhance not only the performance of program partners but also to maximize the benefits accruable from the Foundation's impressive investments in Ethiopia.

Endnote

¹ The strategy received 54 percent of funds dispensed by Packard Ethiopia over the ten-year period (1998-2007)

References

- Aronson, J. (1994). "A Pragmatic View of Thematic Analysis". *The Qualitative Report*, 2(1). Available online at <http://www.nova.edu/ssss/QR/BackIssues/QR2-1/aronson.html> (Accessed 14/08/2008).
- Baker, T. L. (1994). *Doing Social Research* (2nd Edn.), New York: McGraw-Hill Inc.
- Bariagaber, A. (1995). Linking Political Violence and Refugee Situations in the Horn of Africa: An Empirical Approach. *International Migration*, 33(2): 209-234.
- Benefo, K. D. (1990). *The Determinants of Family Size Preferences and Traditional Child-Spacing Practices in West Africa*. Ann Arbor, Michigan: University Microfilms International, 279 p.
- Berhanu, B. and M. J. White (2000). "War, Famine and Female Migration in Ethiopia, 1960-1989". *Economic Development and Cultural Change*, 49(1):91-113.
- Birham Research and Development Consultancy. (2000). *Baseline Survey on a Community-Based RH Project*. Implemented by Amhara Development Association.
- Blum, R.W. (2002). *Mother's Influence on Teen Sex: Connections That Promote Postponing Sexual Intercourse*. Minneapolis: Center for Adolescent Health and Development, University of Minnesota.
- Campbell, M., Ndola Prata and Malcolm Potts (2007). "The Impact of Freedom on Fertility Transition: Revisiting the Theoretical Framework." Paper Presented at the Fifth African Population Conference, Arusha 10-14 December 2007.
- Central Statistical Authority (2004). *The 2004 Statistical Abstract of Ethiopia*, Addis Ababa
- Central Statistical Authority, [Ethiopia] and ORC Macro (2006). *Ethiopia Demographic and Health Survey 2005*. Addis Ababa, Ethiopia and Claverton, Maryland, USA: Central Statistical Authority and ORC Macro.
- Central Statistical Authority (2003). *CSA Statistical Abstract*. Addis Ababa, Ethiopia.
- CIA, World Factbook-Ethiopia, 2007. Central Statistical Authority (1998). *The 1994 Population and Housing Census of Ethiopia*. Results at Country Level. Vol. 1 Statistical Report. Addis Ababa, Ethiopia: Central Statistical Authority.
- Federal Ministry of Health (2005). *The Essential Health Service Package*. Addis Ababa: Federal Ministry of Health, Ethiopia
- Gage, A. J. (1998). "Sexual Activity and Contraceptive Use: The Components of the Decisionmaking Process". *Studies in Family Planning*, Vol. 29, No.2:154-166.
- ICASO (International Council of AIDS Service Organizations) (2007). *Barriers to Condom Access: Setting an Advocacy Agenda*. http://www.icaso.org/publications/condom_access2007_eng.pdf
- Ipas (2003). *Youth-friendly Sexual and Reproductive Health Care Pilot Projects to define Services*. July 2003
- Isiugo-Abanihe, U.C. and Oyediran, K.A. (2004). "Household Socioeconomic Status and Sexual Behavior among Nigerian Female". *Youth African Population Studies*, 19(1): 81-98.
- Klein, M. (2000). *Increasing The Availability of And Access to Condoms in Urban Zambia. Research Briefs No. 8*. Washington, D.C.: *Population Services International [PSI]*, Research Division.
- Lindstrom, D. P. and Berhanu, B. (1999). The Impact of War, Famine, and Economic Decline on Marital Fertility in Ethiopia. *Demography*, 36(2): 247-261.

- Macro International Inc. (2007). *Trends in Demographic and Reproductive Health Indicators in Ethiopia Further analysis of the 2000 and 2005 Demographic and Health Surveys Data* Calverton, Maryland USA: Macro International Inc.
- Mberu, B.U. (2006). Internal Migration and Household Living Conditions in Ethiopia. *Demographic Research: Volume 14* (21): 509-540.
- Ministry of Health, Planning and Programming Department. (2005). *The Federal democratic Republic of Ethiopia Health Sector Strategic Plan (HSDP-III) 2005/6-2009/10*. Addis Ababa: Ministry of Health, Planning and Programming Department; 2005,
- Ministry of Health (2002). *The Federal Democratic Republic of Ethiopia Health, Sector Development Programme II EFY 1995 – 1997*. Addis Ababa: Ministry of Health, June, 2002.
- Ministry of Health (2006). *National Reproductive Health Strategy 2006-2015*. Addis Ababa: Ministry of Health.
- Moore, Z., P. Govindasamy, J. Da Vanzo, G. Bizuneh, and A. Themme (2008). *Trends in Youth Reproductive Health in Ethiopia, 2000 and 2005*. Claverton, Maryland: Macro International. National Intelligence Council (2002). *The Next Wave of HIV/AIDS: Nigeria, Ethiopia, Russia, India, and China*. Washington, D.C. National Intelligence Committee.
- Ntozi, J. P. M., I. N. Mulindwa, F. Ahimbisibwe, N. Ayiga, and J. Odwe (2003). “Has the HIV/AIDS Epidemic Changed Sexual Behaviour of High Risk Groups in Uganda?” *Africa Health Science* 3(3):107-116.
- Office of the National Committee for Central Planning [ONCCP] (1989). *Conference on population issues in Ethiopia's national development. Conference proceeding. Addis Ababa*.
- Pathfinder International/Ethiopia [PIE] (2004). *Findings of a Survey on KAP of Family Planning in Amhara, Oromiya, SNNP, and Tigray Regions of Ethiopia*. Addis Ababa.
- Phillips J. F., Greene W.L., Jackson E.F. (1988). “Lessons from Community-Based Distribution of Family Planning in Africa”. *Studies in Family Planning*; 19[1]:29-38.
- Population Action International (undated) *Africa Population Challenge: The Social and Cultural Context for Reproduction..* www.populationaction.org/Publications/Reports/, Accessed on 10 November, 2008.
- Population Reference Bureau (PRB) (2007). *The 2006 World Population Data Sheet*. Washington D.C.: Population Reference Bureau.
- Robinson, W. C. (1992). “Kenya Enters the Fertility Transition”. *Population Studies*, 46 (3): 445 – 457.
- Sibanda, A., Z. Woubalem, D. P. Hogan and D. P. Lindstrom (2003). “The Proximate Determinants of the Decline to Below-Replacement Fertility in Addis Ababa, Ethiopia”. *Studies in Family Planning*, 34(1):1-7.
- Smith, D. J. (2004). “Youth, Sin, Sex in Nigeria: Christianity and HIV/AIDS-Related Beliefs and Behavior among Rural-Urban Migrants”. *Culture, Health and Sexuality*, 6(5): 425-437.
- Tawye Y, Jotie F, Shigu T, Maggwa N. (2005). “The Potential Impact of Community-Based Distribution Programmes on Contraceptive Uptake in Resource-poor Settings: Evidence from Ethiopia”. *African Journal of Reproductive Health*; 9(3):15-26.
- UNAIDS (2008). *Report on Global AIDS and Epidemic, 2008*.
- UNAIDS (2006). *Report on the Global AIDS Epidemic, 2006*.
- United Nations (2005). *World Population Prospects: The 2004 Revision*. Population Division of the Department of Economic and Social Affairs of the United New York: United Nations.
- United Nations (2007). Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat, *World Population Prospects: The 2006 Revision and World Urbanization Prospects: The 2005 Revision*, <http://esa.un.org/unpp>
- Van Teijlingen E.R. and V. Hundley (2001). The Importance of Pilot Studies. *University of Surrey: Social Research UPDATE* Issue 35.
- World Food Programme. (2006). *Draft Country Programme Document for Ethiopia (2007-2011)*.
- YouthNet. 2004. *Assessment of Youth Reproductive Health Programs in Ethiopia*. April 2004.

Appendix 1: Methods used to address the evaluation questions

	DR ^a	SDA ^b	KII ^c	ID ^d	EPR ^e	CS ^f
A. Contribution to national/regional population and RH sector						
1 Changes in Ethiopia's population, demographic and RH indicators, and achievements of the Packard Foundation and its grantees in these areas	X	X				
2 Changes in Ethiopia's population and RHR environment, and contribution of the Packard Foundation and its grantees.	X		X		X	
3 Packard-funded programs' contribution to HSDP and PRSP	X		X		X	
4 Sub-program contribution to the institutionalization of RH in the national health program			X	X	X	
5 Perception of the Packard Foundation's work, networking and advocacy			X			
B. Assessment of specific strategies						
6 Success of the Packard Foundation strategies and resulted outcomes at the local, regional and national levels	X	X	X			X
7 Unexpected/unplanned consequences of the Subprogram on other vertical health programs		X	X			X
8 Success of the Subprogram in leveraging resources for population and RH, and grantees' perception in this regard	X			X		X
9 Other support services provided by the Packard Foundation to its grantees; quality of this support; and ways to strengthen it				X		X
10 Management structure of the Subprogram; its strengths and drawbacks; and ways to improve it				X		
C. Lessons learnt, recommendations and way forward						
11 Key strengths/successes and weaknesses/failures of the Subprogram; their explanation; and lessons learnt			X	X		
12 Opportunities and challenges for the Subprogram moving forward	X	X	X	X	X	X

^aDesk Review; ^bSecondary Data Analysis; ^cKey Informants Interviews; ^dIn-Depth Interviews; ^eEnvironment and Policy Review; ^fCase Studies

Appendix 3: Inventory of documents Reviewed for the evaluation

No.	Document/Organization	Title of document
1	Detail Work Plan	ACIPH/APHRC's 10-Year Evaluation of the Packard Foundation Population Program's Ethiopia Subprogram (1998-2007)
2	Summary of the Grants History (1999-2008)	Organizational Effectiveness Grants History (1999-2008)
3	Summary of the Evaluation Progress by May 16 th 2008	<i>ACIPH & APHRC 10-Year Evaluation of the Packard Foundation Population Program's Ethiopia Subprogram (1998-2007)</i>
4	Evaluation Tool	List of Grantees, partners, stake holders and the questions to be forwarded to them
5	A List of Government and civil society institutes identified for interview	Government and civil society institutes identified for interview
6	Packard Foundation Ethiopia's Subprogram grantees, 1998-2004	Packard Foundation Ethiopia's Subprogram grantees, 1998-2004
7	List of grantees working on programs related to the youth.	Ethiopia (YOUTH)
8	Relevant Packard Foundation Ethiopia's Subprogram grantees (1998-2004) working on Family planning	Packard Foundation Ethiopia's Subprogram grantees, 1998-2004(Family Planning)
9	Packard Foundation Ethiopia's Subprogram grantees (1998-2004) working with adolescents	Packard Foundation Ethiopia's Subprogram grantees, 1998-2004(Adolescents)
10	Packard Foundation Ethiopia's Subprogram grantees (1998-2004) working on Environment	Packard Foundation Ethiopia's Subprogram grantees 1998-2004(Environment)
11	A summary of the Packard Foundation Ethiopia's Subprogram grantees (1998-2004)	Packard Foundation Ethiopia's Subprogram grantees (1998-2004)
12	Oromiya Development Association (ODA) Annual Report	ODA David & Lucile Packard RH/FP Project – <i>Annual Report</i>
13	FHI Final Report – September 2007 Phase II	Linking Access to Credit & Family Planning Services in Ethiopia
14	ENGENDERHEALTH Year Four Report July 1, 2004 – June 30, 2005	Expansion of Long-term and Permanent Contraceptive Methods in Ethiopia
15	FGAE Project Progress Report	FGAE Project Progress Report for the period (July 1, 2006 to July 31, 2007)
16	Adey Public Relations Consultancy Activity Report (August 19 th – 31 st 2001)	Activity Report on the high level delegation of the David Lucile Packard Foundation. September 2001
17	Marie Stopes International Ethiopia Annual Report 2002	Marie Stopes International Ethiopia <i>Annual Report 2002</i>
18	A report for a meeting	Family Planning and Reproductive Health Collaboration and Coordination Meeting (Jan 17-19, 2000) Sodere, Ethiopia
19	Ethiopia DHS 2000	Ethiopia Demographic and Health Survey 2000
20	Ethiopia DHS 2005	Ethiopia Demographic and Health Survey 2005
21	Bi-Annual Grantees' and Partners Meeting Report	Bi-Annual Grantees' and Partners Meeting Report. Population, Health and Environment in Ethiopia
22	ENGENDERHEALTH Annual Progress Report	Annual Progress Report for the Program on "Expansion of Long-term and Permanent Contraceptive Methods in Ethiopia" (July 1, 2006 – July 31, 2007)

23	East Wollega Zone-ODA-ICBRH Project Quarterly Performance Report (September – December 2000)	ODA-ICBRH Project Quarterly Performance Report (September – December 2000)
24	Pathfinder International Report (January 16, 2003)	Empowerment of Ethiopian Women. <i>A project designed to tackle Gender Issues that impinge on FP and RH rights of Women through a Coalition of Ethiopian Women Associations and Organizations.</i>
25	Population Media Center Evaluation Report	The Effect of Radio Serial Dramas on Reproductive Health Behavior Key Findings from the Evaluation
26	The Amhara Credit & Saving Institution (ACSI) report	Integrating Microfinance and Reproductive Health Services: Status Report.
27	Oromiya Credit and Saving Share Company (OCSSCO)- 2 ND Semi-Annual and Annual Report for the Year 2006/07	Micro Finance and Reproductive Health Integration Programme 2 ND Semi-Annual and Annual Report for the Year 2006/07
28	DKT Ethiopia- Sales/Distribution Report (<i>A Contraceptive Social Marketing Project</i>)	Sales/Distribution Report (<i>A Contraceptive Social Marketing Project</i>)
29	Oromiya Development Association-Annual Progress Report	Reproductive Health /Family Planning (ODA-RH/FP) Project – Annual Progress Report (July 2006 – June 2007)
30	Marie Stopes International – Ethiopia (MSIE)- Annual Report 2001	Marie Stopes International – Ethiopia (MSIE) – Annual Report 2001
31	Family Guidance Association of Ethiopia- Annual Programmatic and Financial Report 2001	Annual Programmatic and Financial Report 2001. Helping People to Cope: A Collaborative, Integrated Sexual and RH Initiative.
32	ADA/PACKARD CBRH Project- Terminal Report (Years 2000 - 2003)	Terminal Report of the Project activities (Years 2000 - 2003)
33	IPAS Ethiopia- Program Report (July 2006 – June 2007)	Program Report (July 2006 – June 2007). <i>Anchored in the belief that each woman has the right to control her own sexuality, fertility and well-being.</i>
34	ENGENDERHEALTH Year Four Report (July 1, 2004 – June 30, 2005)	Year Four Report (July 1, 2004 – June 30, 2005). <i>Expansion of Long-term and permanent Contraceptive Methods in Ethiopia.</i>
35	DSW (German Foundation for World Population)- Progress Report (July 2006 – June 2007)	Progress Report (July 2006 – June 2007). <i>Youth-to-youth, an adolescent sexual and Reproductive Health Project in Ethiopia</i>
36	Amhara Development Association-Baseline Survey Report	Birham Research and Development Consultancy's <i>Baseline Survey on a Community-Based RH Project implemented by Amhara Development Association.</i>
37	The David and Lucile Packard Foundation Book	Improving Lives and Slowing Population Growth. Six Years of International Grantmaking in Reproductive Health
38	Pathfinder International Ethiopia	Phase I: Private Sector Franchise Initiative for Reproductive Health and Family Planning in Ethiopia Final Report (for grant # 99-2172) -Final Report for 1999-June 2002
39	Pathfinder International Ethiopia	Final Report (for grant # 2000-10245).
40	Pathfinder International Ethiopia	Interim Narrative Report of the Women's and Girl's Empowerment Project in Ethiopia (for grant # 2006-29655)

41	Pathfinder International Ethiopia	Final Report for the Private Sector Franchise Initiative, Ethiopia (for Grant # 2001-20622)
42	Pathfinder International Ethiopia	Progress Report of the Private Sector Franchise Initiative (Grant # 2001-20622)
43	Pathfinder International Ethiopia	Final Report of the Empowerment of Ethiopian Women (Grant # 2003-24823)
44	Institute of International Education (IIE)	Report on the LDM Program in Ethiopia
45	Institute of International Education (IIE)	Report of key accomplishments
46	Institute of International Education (IIE)	LDM Final Report to Packard 2003
47	Institute of International Education (IIE)	LDM Final Report to Packard 2006
48	Institute of International Education (IIE)	LDM Final Report to Packard 2008
49	Institute of International Education (IIE)	Packard LDM Concept 2000
50	Institute of International Education (IIE)	LDM Proposal to Packard 2000
51	Institute of International Education (IIE)	LDM Proposal to Packard 2005
52	Institute of International Education (IIE)	LDM Proposal to Packard 2007
53	Institute of International Education (IIE)	Progress Report on the LDM Program in Ethiopia 2002
54	Institute of International Education (IIE)	Progress Report on the LDM Program in Ethiopia 2003 Dec
55	Institute of International Education (IIE)	Progress Report on the LDM Program in Ethiopia 2003 Jan
56	Institute of International Education (IIE)	Progress Report on the LDM Program in Ethiopia 2004 Dec
57	Institute of International Education (IIE)	Progress Report on the LDM Program in Ethiopia 2004 June
58	Institute of International Education (IIE)	Progress Report on the LDM Program in Ethiopia 2005
59	Institute of International Education (IIE)	Progress Report on the LDM Program in Ethiopia 2006
60	Institute of International Education (IIE)	Progress Summary Report on the LDM Program in Ethiopia 2007 June
61	Institute of International Education (IIE)	Interim Report – 2003
62	Institute of International Education (IIE)	Final Proceeding Dec 22-23 2005
63	Institute of International Education (IIE)	Summary Report for Packard 2008
64	Institute of International Education (IIE)	Tentative Plan for LDP Ethiopia 2006
65	Institute of International Education (IIE)	LDM Evaluation Report 2002
66	IntraHealth International	Needs and Resources Assessments of FP/RH Leadership development in Five Countries
67	Final Report-Draft	Leadership Matters: An Evaluation of Six Family Planning and Reproductive Health Leadership Programs Funded by the Packard and Gates Foundations
68	LDM/IIE	IIE Project summary report
69	David and Lucile Packard Foundation	Grantees' Annual Progress Report (July 2007-June 2008)
70	David and Lucile Packard Foundation	Grantees' Annual Progress Report (July 2006-June 2007)
71	David and Lucile Packard Foundation	Report July 2006-June 2007
72	Institute of International Education (IIE)	Report on Key accomplishments
73	Institute of International Education (IIE)	Background paper of D&L PF program in Ethiopia
74	Institute of International Education (IIE)	Report on Proceeding of the Annual Meeting of Population and Reproductive Health Leaders
75	The David and Lucile Packard Foundation Population Program	Reproductive Health/Family Planning and HIV/AIDS: Knowledge, Attitude, Behavior and Services in Three Zones in the Amhara Regional State, July 2000.
76	Oromiya Regional Office of Population in Collaboration with Oromiya Development Association.	A Study of Reproductive Health Issues and Knowledge, Attitude, and Practice of Family Planning Methods, Oromiya regional State, Ethiopia.

